

THE ROLE OF INFORMED CONSENT IN THE
VETERINARY CLINIC: A CASE STUDY IN COMPANION
ANIMAL NEUTERING

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ABSTRACT

In the UK, professional ethical guidance from the Royal College of Veterinary Surgeons requires that informed consent is obtained before treatment is given to animal patients. This consent should protect the patient from inappropriate treatment, the client from unexpected costs and the veterinary professional from complaints by evidencing the client's agreement to proceed. In this thesis, I utilise a socio-legal approach to conceptualise consent in veterinary practice.

Using elective neutering of companion animal patients as a case study, I analyse relevant jurisprudence on informed consent in medicine to illustrate an ideal rooted in the autonomous human patient's right to choose, or refuse, treatment. Acknowledging the animal patient's lack of autonomy, I explore parallels with decision-making for young children, which usually incorporate a 'best interests' calculation.

Tensions between autonomy and beneficence-based consent are explored via three linked empirical studies, involving analysis of veterinary consent forms, observation of consent consultations and interviews with key participants. Resulting data are interpreted in light of doctrinal research, demonstrating the value of interpretive description as a methodology for socio-legal studies.

Finally, I propose a new model of consent for veterinary practice that recognises the appropriate balance between autonomy and beneficence, together with a re-designed consent form.

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Badgers Act 1992

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Human Rights Act 1998

Mental Health Act 1983

Human Fertilisation and Embryology Act 1990

Human Fertilisation and Embryology Act 2008

The Medicines for Human Use (Clinical Trials) Regulations SI 2004/1031

The Mutilations (Permitted Procedures) (England) Regulations SI 2007/1100

The Veterinary Medicines Regulations SI 2013/2033

International statutes:

Animal Welfare Act 2010 (Norway)

Animal Health and Welfare Act 2013 (Ireland)

Animal Welfare Ordinance (TSchV) 2008 (Switzerland)

CHAPTER ONE: INVESTIGATING INFORMED CONSENT TO NON-THERAPEUTIC NEUTERING OF COMPANION ANIMAL PATIENTS

1.0 Consent in veterinary medicine

In the United Kingdom (UK) and in many other Western democracies, the informed consent of the animal owner is essential before any treatment is given to animal patients. According to the Royal College of Veterinary Surgeons (RCVS), the regulatory body for the veterinary profession in the United Kingdom:

“Veterinary surgeons must communicate effectively with clients, including in written and spoken English, *and ensure informed consent is obtained* before treatments or procedures are carried out”¹

This guidance, initially part of the Guide to Professional Conduct (available until 2012), was included in the renamed Code of Professional Conduct from 2012. There is, therefore, a *professional requirement* to obtain consent before giving treatment to an animal, indicated by the use of ‘must’ in this phrase.

However, obtaining informed consent to the treatment of animals is fraught with ethical difficulties. These include the fundamental problem that the person giving consent is not the patient undergoing treatment. An additional problem concerns the status (both moral² and legal) of the animal patient, a topic of intense debate for legal and ethical scholars.³ As the result of differing perceptions of animal status, there is a variety of human uses of animals and, consequently, a variety of human-animal relationships. In the UK, owners are legally

¹Royal College of Veterinary Surgeons, ‘RCVS Code of Professional Conduct’ <<http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/>> Section 2.4. (my emphasis) accessed 15 August 2018

² In this thesis, I use ‘moral’ to describe the philosophical status of humans or animals, and ‘ethical’ to describe normative actions or professional behaviour

³ See, for example, Gary Francione, *Rain without thunder: the ideology of the animal rights movement* (Temple University Press 1996) and Tom Regan, *The case for animal rights*. (2nd ed. University of California Press 2004).

required to seek veterinary treatment when an animal is injured or diseased,⁴ therefore the requirement for informed consent to any proposed treatment is relevant to many different types of ownership scenario.

Informed consent is also a fundamental pre-requisite to medical or surgical treatment of human patients in the UK. This has been confirmed by judicial rulings in medical negligence cases (see Chapter 3), and by the General Medical Council (GMC), which introduces its advice on consent for doctors by stating that:

“This guidance ... (.....) ... requires doctors to be satisfied that they have consent from a patient, or other valid authority, before undertaking any examination or investigation, providing treatment, or involving patients in teaching and research.”⁵

Valid consent requires that the person giving consent must be competent, must be informed about the proposed treatment, and must be making a voluntary and un-coerced decision.⁶

Many empirical studies have been conducted to investigate medical consent, primarily to address the ‘informed-ness’ of the patient through improving patient understanding. These studies aim to increase patient involvement in decision-making for treatment through, for example, simplifying the wording on consent forms and information sheets, or by providing information in alternative formats.⁷

Unlike the situation in medicine, there is little research available on consent in the context of veterinary treatment. Some authors present a normative view of consent procedures, stating what should be included in such discussions, and basing their views on the

⁴ Under Section 9.2(e) of the Animal Welfare Act 2006.

⁵ General Medical Council, ‘Consent: Patients and Doctors Making Decisions Together’ (2008) <<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent>> accessed 22 September 2018, 4.

⁶ Jean V McHale, ‘Consent to Treatment: the Competent Patient’ in Judith Laing and Jean V McHale (eds), *Principles of Medical Law* (4th edn, Oxford University Press 2017) 8.06, 422

⁷ P Kinnersley and others, ‘Interventions to Promote Informed Consent for Patients Undergoing Surgical and Other Invasive Healthcare Procedures’ (2013) 40 *Cochrane Database of Systematic Reviews* 271

requirements for human medical consent.⁸ Others question whether a consent based on the approach used in medicine is valid.⁹ However, relatively few empirical studies have been conducted, some of which replicate previous studies in medicine.¹⁰ There is thus a broad gap in knowledge between the normative, professional ethical and legal requirements for consent, and what actually happens in practice. This study has been devised to start to bridge that gap, by conducting research into consent forms, and consent conversations, in UK veterinary practice and investigating the perceptions of those involved. In the following section, I will explain how the need for this research was identified, before going on to consider the RCVS's current advice on consent. In subsequent sections, I will examine different levels of consent and introduce the parties involved in the veterinary consent process. This chapter continues with an explanation of the reasons for designing an interdisciplinary and mixed methods study, while the final section gives brief overviews of individual chapters.

1.1 The need for research into informed consent to veterinary treatment

The RCVS stipulates a requirement for the informed consent of the animal owner for all treatment and procedures carried out on an animal patient, providing advice on the suggested content for a consent discussion in its Supporting Guidance. In the section on 'Communication and Consent', it states that clients can only give consent if they are given

⁸ See, for example, DD Flemming and JF Scott, 'The Informed Consent Doctrine: What Veterinarians Should Tell Their Clients' (2004) 224 *Journal of the American Veterinary Medical Association* 1436.

⁹ V Ashall, KM Millar, P Hobson-West, 'Informed Consent in Veterinary Medicine: Ethical Implications for the Profession and the Animal "Patient"' (2018) 1 *Food Ethics* 247

¹⁰ See, for example, MC Whiting and others, 'Survey of Veterinary Clients' Perceptions of Informed Consent at a Referral Hospital' (2017) 180 *Veterinary Record* 20 which uses similar methods to A Akkad and others, 'Patients' Perceptions of Written Consent: Questionnaire Study' (2006) 333 *BMJ* 528

“..... the opportunity to consider *a range of reasonable treatment options* (including euthanasia), with associated fee estimates, and had the significance and main risks explained.....”¹¹

Despite a dearth of literature examining informed consent in veterinary practice, previous authors have approached the subject from a normative viewpoint, outlining the process that *should* be followed to obtain consent. Key papers by Fettman and Rollin,¹² and Flemming and Scott,¹³ while originating from the USA, are often cited in international veterinary consent articles. These authors describe how consent should be obtained from a medico-legal perspective but resist critical evaluation of the list of requirements.

The lack of previous empirical work on consent procedures for animal patients contrasts starkly with medicine. A Cochrane review into medical informed consent, focusing on interventions designed to improve the consent process, started with over 11,000 papers.¹⁴ Although only 65 of these papers were included in the final analysis, this review exemplifies the interest in empirical work on the consent process in human medicine.

Therefore, it seems surprising that there has not been a proliferation of similar research in the veterinary context. One explanation could be that it is just not seen as a problem. Figures obtained from one of the profession’s indemnity insurers, the Veterinary Defence Society (VDS), suggest that informed consent appears as the subject of the claim in between 3-6% of claims opened,¹⁵ while 2016 figures from the RCVS suggest that around 16% of concerns raised about veterinary professionals were about “general communication” (which

¹¹ Royal College of Veterinary Surgeons, 'Supporting Guidance' <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/>> accessed 22 September 2018, Section 11.2 (emphasis in original)

¹² MJ Fettman and BE Rollin, 'Modern Elements of Informed Consent for General Veterinary Practitioners' (2002) 221 *Journal of the American Veterinary Medical Association* 1386

¹³ Flemming and Scott (n8)

¹⁴ Kinnersley (n7)

¹⁵ Email from Veterinary Defence Society to author (29 October 2016) based on figures from 2013-2015. Total case figures run at around 1000-1500 per year.

includes consent).¹⁶ However, it appears that veterinary professionals do seek advice on consent. VDS figures suggest that 150-180 advice calls per year pertain to advice on consent.¹⁷ Thus, although the VDS figures suggest that consent is a minor concern for veterinary professionals, they also show that consent is not a major reason for large numbers of client complaints and claims. The lack of prior research in this area parallels the similar deficit in research into other areas of veterinary practice,¹⁸ apart from investigation into various disease conditions.

For the situation in veterinary practice, therefore, I have also used my own experience and knowledge of practice procedures to elucidate some of the problems with consent. For example, it is common for the consent discussion and the signing of the consent form to take place at the same time, especially for elective neutering procedures (the selection of elective neutering as the procedure examined for this study is explained later in this section).¹⁹ Unlike the case with therapeutic surgery, there is often no pre-admission consultation with a veterinary professional to outline options, costs etc. Neutering procedures are often booked via telephone by a receptionist. It is common for the discussion and signing of the consent form to take place on the day of admission for surgery. This often means that the process is rushed, and the animal owner has limited time to consider options or risks, or to ask questions. In human medicine, it is considered 'good practice' to separate the consent discussion and the admission of the patient, especially for elective surgery.²⁰

¹⁶ Royal College of Veterinary Surgeons 'RCVS Facts (2016)' <<https://www.rcvs.org.uk/news-and-views/publications/rcvs-facts-2016/?destination=%2Fnews-and-views%2Fpublications%2F>> at 21, accessed 22 September 2018

¹⁷ VDS (n15) The Society handles around 17000 calls for advice from veterinary professionals per year, so the numbers pertaining to consent (around 1%) are low.

¹⁸ For example, see P Hobson-West and S Timmons, 'Animals and Anomalies: an Analysis of the UK Veterinary Profession and the Relative Lack of State Reform' (2015) 64 *The Sociological Review* 47, who highlight the lack of social scientific studies in veterinary medicine

¹⁹ This has been the case for every practice in which I have worked, around 9 or 10 in total.

²⁰ Owen A Anderson and I Mike J Wearne, 'Informed Consent for Elective Surgery - What Is Best Practice?' (2007) 100 *Journal of the Royal Society of Medicine* 97. See also M G Berry and others, 'A Comparison of the Views of Patients and Medical Staff in Relation to the Process of Informed Consent' (2007) 89 *The Annals of The Royal College of Surgeons of England* 368.

In the veterinary scenario, although often it is the veterinary nurse who admits the patient and obtains the client's consent, in some practices, it is left to the receptionist to "get the form signed," particularly for cats admitted for neutering.²¹ Indeed, in a 2005 study, over 50% of practices allowed receptionists to take responsibility for consent in some situations.²² Attitudes may have changed since then, particularly in view of the RCVS's recently updated recommendations on who should be responsible for obtaining consent; these advise that the person involved should have sufficient training, knowledge of the procedure and the risks involved.²³ The College now lists those whom it would consider suitable for this responsibility as veterinary surgeons, registered veterinary nurses, then student veterinary nurses. The suitability of these members of staff for taking on the responsibility of obtaining consent will be discussed in Chapter 3.6.4.

As a means of undertaking research into informed consent, I chose elective neutering of companion animals²⁴ to provide the 'setting' for the work. Thus, this thesis investigates informed consent in the scenario of elective, non-therapeutic neutering of dogs, cats and rabbits. This is not a study into the *ethics* of elective neutering, although this topic also requires fundamental research; rather, it is a study on informed consent that utilises neutering as its exemplary procedure. I will expand on the reasons for choosing this procedure and these patients in 1.3 and 1.4.3.

The lack of previous research into informed consent in the veterinary context, despite its requirement for authorising veterinary treatment, suggests that this thesis should investigate how it is obtained and seek to determine its underpinning principles. Initially, the advice given by the RCVS provides a useful starting point.

²¹ Again, from personal experience; a cat in a basket can be transferred from the waiting room to the hospital area by a receptionist, as the animal does not have to be taken from the basket. This may also be the case for rabbits, but dogs require physical handling to place them in hospital cages.

²² C A Gray and P J Cripps, "Typical" Veterinary Consultation in the United Kingdom and Ireland' (2005) 156 *Veterinary Record* 381.

²³ RCVS (n11), Sections 11.3-11.5

²⁴ I chose the term 'companion animals' rather than 'pets' to acknowledge the special relationship that exists between owners and these animals

1.2 RCVS advice on consent

Although consent can generally be obtained orally or in writing,²⁵ there are times when written consent should be obtained. The RCVS Code of Professional Conduct does not stipulate when consent should be confirmed in writing, but specific advice on written consent is included in the 'Medical Records' module for the General Practice level of the Practice Standards Scheme (PSS) which the College regulates and administers. The advice includes the requirement for signed consent forms for all treatment:

“Signed consent forms are usually *required for all procedures* when a patient is admitted to the care of a veterinary surgeon. This will include diagnostics, medical treatments, surgery and euthanasia.”²⁶

As the General Practice level sets the minimum standards expected of all practices, this advice is applicable to all practice settings, although the use of the term '*usually*' suggests that there may be exceptions to the requirement for written consent in these circumstances.

Meanwhile, in human medicine, the GMC advises that written consent is required for more complex or risky treatment involving potential consequences for the patient, for research, or for more experimental, innovative treatment.²⁷ However, the GMC guidance does not expand on the criteria for assigning treatments to these categories, therefore the decision regarding whether written consent is required is still left to the doctor.

Consent can be regarded as agreement to a single, specified procedure or treatment (although this still requires an associated discussion) or as a continuous process requiring

²⁵ Exceptions to this, i.e., situations involving a legal requirement for written consent, are considered in Chapter 5.1

²⁶ RCVS, 'Practice Standards Scheme - Small Animal Modules and Awards' at 11.2.1 <<https://www.rcvs.org.uk/document-library/small-animal-modules/>> accessed 18 October 2017, 118 (my emphasis)

²⁷ GMC (n5) S49a-d

regular updating, as in the case of treatment of hospitalised patients, or ‘in-patients’. The approach to these patients is described in the PSS award details for the ‘In-Patients’ module:

“There are procedures in place to update clients on the progress of their animal and to ensure that informed consent is maintained.”²⁸

RCVS practice standards therefore require the ‘obtaining’ of consent, but also refer to ‘maintaining’ it where there is a prolonged course of treatment. Thus, although consent can apply to a single surgical procedure or to a course of treatment, it is a process rather than a single event.

This interpretation is also inherent in advice on consent given by the governing bodies of the medical profession in the UK. For example, the Royal College of Surgeons of England (RCSE) in its publication ‘Good Surgical Practice’, advises surgeons to:

“Recognise that seeking consent for surgical intervention is not merely the signing of a form. It is *the process of providing the information* that enables the patient to make a decision to undergo a specific treatment. Consent should be considered informed decision making, or informed request. It requires time, patience and clarity of explanation.”²⁹

Various lists have been produced by professional associations in an attempt to prescribe the content of the discussion, therefore ensuring that the person giving consent has had appropriate information. This example, also taken from Good Surgical Practice, recommends that the topics that should be covered in a consent discussion are:

“The patient’s diagnosis and prognosis

²⁸ RCVS (n26) at 8.5.4.

²⁹ Royal College of Surgeons of England, ‘Good Surgical Practice’ (2014) <<https://www.rcseng.ac.uk/standards-and-research/gsp/>> accessed 22 September 2018 S3.5.1, 40. (my emphasis)

Options for treatment, including non-operative care and no treatment
The purpose and expected benefit of the treatment
The likelihood of success
The clinicians involved in their treatment
The risks inherent in the procedure, however small the possibility of their occurrence, side effects and complications ... (...)
Potential follow up treatment.”³⁰

For the veterinary profession, the RCVS provides similar advice on what should be included in a consent discussion.³¹ As will be shown in Chapter 3.5.1, the College’s updated guidance on consent now approaches that provided by the medical professional associations in some areas. However, there are some areas of information disclosure that have a unique focus in the veterinary consent scenario, amongst which is the discussion of financial costs.

1.2.1 Consent and contract

As veterinary medicine is a private form of healthcare, requiring fees for service through either direct payment by the client, or via insurance cover, the veterinary practice-client relationship is contractual.³² Therefore, an important part of the veterinary consent process involves disclosure of financial costs. Indeed, the RCVS specifically links consent and contract, firstly confirming that “... the provision of veterinary services creates a contractual relationship...”³³ and later, “...(i)nformed consent, ... (...) ... is an essential part of any contract.”³⁴ Regarding the requirements for disclosing fees, the College advises that:

³⁰ *ibid*, S3.5.1, 41.

³¹ RCVS (n11) Sections 9 and 11.

³² The exceptions to this are veterinary services provided by charity clinics, such as the Royal Society for the Prevention of Cruelty to Animals (RSPCA), the Blue Cross, and the Peoples’ Dispensary for Sick Animals (PDSA).

³³ RCVS (n11), at 11.1

³⁴ *Ibid*, at 11.2

“Veterinary surgeons should offer clients a realistic initial estimate, (....) based on the best available information at the time, of the anticipated cost of veterinary treatment. The estimate should:

1. cover all likely charges
2. include a clear warning that additional charges may arise.....
3. be offered before treatment is commenced.....;
4. be the subject of clear client consent, except where delay would compromise animal welfare;
5. preferably be provided in writing (.....)”³⁵

Thus, veterinary professional guidance emphasises the contractual basis of veterinary treatment and the necessity to include costs in consent conversations. Contract, which is based on an agreement between two parties, is not usually considered as the basis for medical treatment decisions in the UK. Here, medical treatment is provided under a statutory obligation, and there is no consideration (payment) in return for the treatment. Since the formation of the National Health Service (NHS) in 1948, it is accepted that “there is no contractual basis for the relationship between a doctor.... (....)... and the patient.”³⁶ Instead, the doctor-patient relationship is governed by tort law, which places a duty of care on the medical professionals and institutions involved in the treatment. In tort law, specifically negligence, a duty of care is owed by the healthcare professional, or hospital, to the patient.³⁷ Liability in negligence must prove that a duty of care existed, that there was a breach of that duty, and that as a result the patient suffered harm.³⁸

³⁵ Ibid, at 9.10

³⁶ Rachael Mulheron, ‘Duties in Contract and Tort’ in Judith Laing and Jean V McHale (eds) *Principles of Medical Law* (4th edn, Oxford University Press 2017) 3.08, 104

³⁷ This duty of care extends to hospital receptionists. See *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50. The Supreme Court overturned the Court of Appeal’s finding that the Trust was not liable when a receptionist gave incorrect information to a patient in A&E regarding waiting times, leading to the patient leaving the hospital and suffering a brain injury.

³⁸ Mulheron (n36) 3.30, 112

In private medicine, where there is payment for treatment, a contract exists, and the consent form will constitute part of that contract.³⁹ Breaches of that contract, on either side, can lead to litigation. However, as Rachael Mulheron points out, even if treatment is offered on a contractual basis, it does not mean that the doctor guarantees an outcome. When considering the treatment contract in the context of negligence, the term implied into this contract is that the doctor will “exercise reasonable care and skill when diagnosing, advising and treating”⁴⁰ the patient, therefore the duty of care required of the medical professional is, in fact, similar for both tort and contract. It can be taken that a similar term is implied into contracts for treatment between veterinary surgeons and clients.

1.2.2 Client financial autonomy

In addition to the contractual approach that the fee-for-service basis brings to consent, it also gives clients a form of autonomy over what happens to their animals. First, owners can choose innovative and complicated surgery costing thousands of pounds for their pets, a decision that encompasses a debate about “whether the expense of surgery is worth the companionship an animal brings.”⁴¹ Indeed, over-treatment of animal patients may be a concern, as discussed by Grimm and others in their observation that “the client’s willingness to pay for treatment and an increase in treatment options for companion animal patients raise the question of which treatments are morally justified....”⁴²

The ability and willingness to pay for an animal’s treatment are solely the owner’s decision,⁴³ with this aspect of decision-making for a companion animal regarded as a form of financial autonomy that must be respected. However, this is not an unrestrained autonomy. The veterinary surgeon may refuse to carry out the treatment requested by the owner, as is the

³⁹ Ibid, 3.17, 107

⁴⁰ Ibid, 3.27, 111

⁴¹ B Mills, ‘If This Was a Human...: Pets, Vets and Medicine’ (2016) 11 *Critical Studies in Television: The International Journal of Television Studies* 244, p254

⁴² H Grimm and others, ‘Drawing the Line in Clinical Treatment of Companion Animals: Recommendations From an Ethics Working Party’ (2018) 182 *Veterinary Record* 664

⁴³ In this, I include the provision of insurance cover, which is again solely the owner’s decision.

case with treatment of human patients.⁴⁴ Perhaps more importantly, if the veterinary surgeon proposes a treatment for which the owner is unable or refuses to pay, the veterinary surgeon must suggest, or agree with, euthanasia of the animal patient. Indeed, veterinary surgeons are obliged to offer euthanasia in such circumstances, as stated in the supporting guidance to the RCVS Code of Professional Conduct:

“The primary purpose of euthanasia is to relieve suffering. The decision to follow this option will be based on an assessment of many factors. These may include the extent and nature of the disease or injuries, other treatment options ... (....).... and the ability of the owner to pay for private treatment.”⁴⁵

Therefore, it can be seen that animal patients are not entitled to equal treatment under the usual business terms of most veterinary practices. Any notion of ‘justice’ for animals does not extend to equality of treatment when injured or sick. For the individual animal patient, the quality and availability of treatment depends on the owner. The only alternative for the owner may be to seek charity assistance:

“Where the reason for a request for euthanasia is the inability of the client to pay for private treatment, it may be appropriate to make known the options and eligibility for charitable assistance or referral for charitable treatment.”⁴⁶

Thus, animal owners retain financial autonomy over treatment decisions, some of which may result in a decision to end the animal’s life on economic grounds. The huge differences in approach resulting from the client’s ability to pay, besides raising difficult ethical questions about the treatment of animal patients being based on the owner’s financial

⁴⁴ GMC (n5) at 5d, which states “If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment.”

⁴⁵ RCVS (n11) at 8.4

⁴⁶ Ibid, at 8.6. Many practices maintain an ‘in-house’ fund to pay for treatment for animals whose owners are unable to afford it. Sometimes, however, this involves signing ownership over to the practice, with the animal being rehomed after treatment.

circumstances, could also make investigation into consent problematic. For this reason, it seemed sensible to base my research on a veterinary treatment or procedure that placed less reliance on the owner's financial situation, which resulted in the choice of non-therapeutic neutering. Such procedures are offered at broadly similar prices amongst veterinary practices.

1.3 The choice of elective (non-therapeutic) neutering

Although the 'financial autonomy' of the owner in deciding how much or whether to pay for the treatment of the animal led to the choice of elective neutering as the study treatment, the procedure also involves another form of owner autonomy. An owner can decide when, whether and how to have this surgery performed, therefore retaining control over the animal's reproductive capacity. Many owners will, however, make the decision to neuter in conjunction with a veterinary professional.

Consent for the treatment of animal patients is underpinned by a triadic relationship, involving the healthcare professional, the client and the animal.⁴⁷ This relationship exemplifies the requirements of veterinary consent, and contrasts with the traditional doctor-patient consent scenario in medicine. Research on consent in the veterinary context therefore requires investigation of how this relationship impacts on the consent process. The triadic relationship selected was that involving a companion animal, the owner or client, and a veterinary professional.⁴⁸ The relationship and its participants are described in 1.4. In describing the participants, I recognise that there are differing views surrounding the use of

⁴⁷ Fettman and Rollin (n12)

⁴⁸ The research involves veterinary professionals who spend most of their time treating or caring for cats and dogs, although rabbits, rodents and birds are also regarded as companion animals.

the terms, “animal” and “owner.”⁴⁹ I decided to use these terms as they are in common use in veterinary practice settings, and also appear in professional ethical guidance.⁵⁰

Before expanding on the reasons for selecting elective, non-therapeutic neutering surgery as the focus of this research, it is useful to consider the type and level of consent required for this procedure. Consent processes for different treatments and procedures can vary markedly, depending on the level of consent required. For example, Whitney and others⁵¹ suggest three levels of consent for procedures in human medicine:

1. *Simple consent* applies to low risk procedures. It involves an explanation of the procedure, and the patient’s agreement (implied or expressed) or refusal. This level of consent could be applied to such veterinary procedures as routine vaccination or the insertion of a microchip for identification purposes.
2. *Informed consent* applies to higher risk procedures. It involves discussion of options, risks and benefits, and the patient’s expressed consent; this could be applied to most surgical procedures, both therapeutic and non-therapeutic. This category applies to elective neutering.
3. *Shared decision-making* applies to situations where there is more than one treatment available, such as when evaluating several medical and/or surgical options.⁵² The decision is shared between healthcare professional and patient. In the veterinary context, it would be shared between veterinary professional and client.

In the veterinary context, Passantino and others suggest two levels of consent: consent for “routine activities” such as vaccination, which can be carried out with implicit or oral

⁴⁹ Critics of these terms argue that humans are also animals, and ownership demonstrates the power imbalance between humans and nonhuman animals. See, for example, Steven Wise, in ‘The Legal Thinghood of Nonhuman Animals’ (1996) 23 B.C. *Environmental Affairs Law Review* 471. See also David Wood, in ‘*Comment ne pas manger – Deconstruction and Humanism*’ in H Peter Steeves (ed.) *Animal Others: On Ethics, Ontology and Animal Life* (State University New York Press 1999) 16. Wood criticises the anthropocentric views of humans towards nonhumans.

⁵⁰ Additionally, these are the standard terms used in statute and case law, which I will use extensively during this research.

⁵¹ SN Whitney, AL McGuire, LB McCullough, ‘A Typology of Shared Decision-Making, Informed Consent and Simple Consent’ (2004) 140 *Annals of Internal Medicine* 54, 57.

⁵² *Ibid*, 55

consent, and consent for “extra-routine” activities such as euthanasia or surgery, which requires written confirmation.⁵³ In view of the different options and complexities of veterinary treatment, and the requirement for different levels of consent, the choice of a single veterinary procedure that fitted into Whitney’s “informed consent”⁵⁴ and Passantino’s “extra-routine”⁵⁵ categories simplified the approach to the research.

First, it was necessary to decide between medical and surgical treatment. The difficulty of selecting a procedure involving similar levels of risk, and therefore requiring similar levels of risk disclosure, led to the decision to focus on an elective surgical procedure. Elective surgery is scheduled in advance, and may be either therapeutic or non-therapeutic, i.e., it is not required to treat an illness or to save the animal’s life. As a non-urgent procedure, it can be scheduled to suit the animal owner and the practice.

Situating the research in the UK, for several practical and pragmatic reasons that are covered in Chapter 2, Section 2.7, enabled the choice of elective neutering as it is legally permitted. There are many other European countries where neutering is not carried out routinely (e.g., Sweden and Denmark), and in Norway, until recently, it was illegal to neuter dogs of either sex, unless for health reasons.⁵⁶

Elective neutering is a non-therapeutic procedure carried out to reduce unwanted sexual behaviour or to provide future health benefits in the individual animal, and to contribute to population control in the species.⁵⁷ It is therefore an example of one of the consequences of animals’ legal status as property, demonstrating their owners’ rights to request non-

⁵³ A Passantino, V Quartarone, M Russo, ‘Informed Consent in Veterinary Medicine: Legal and Medical Perspectives in Italy’ (2011) 01 *Open Journal of Animal Sciences* 128.

⁵⁴ Whitney and others (n51) 56

⁵⁵ Passantino and others (n53) 131

⁵⁶ A much lower proportion of Swedish pets are neutered, compared to the UK. See, for example, M Sallander and others, ‘Demographic Data of a Population of Insured Swedish Dogs Measured in a Questionnaire Study’ (2001) 42 *Acta Veterinaria Scandinavica* 71. In Sweden, the procedure is permitted under current animal welfare legislation, whereas in Norway, routine neutering was illegal until the Animal Welfare Act was updated to allow neutering procedures to be performed on health and welfare grounds by the Norwegian Animal Welfare Act 2010, s9.

⁵⁷ MV Root Kustritz, ‘Effects of Surgical Sterilization on Canine and Feline Health and on Society’ (2012) 47 *Reproduction in Domestic Animals* 214.

therapeutic treatment on their behalf. Further discussion of the legal and moral status of companion animals is undertaken in Chapter 4, Section 4.1.

Non-therapeutic treatment is sometimes referred to as “treatment designed for the benefit of others.”⁵⁸ In this case, it is designed to benefit the individual animal owner (through removing unwanted aspects of sexual behaviour) and wider society (through reduction in the numbers of unwanted animals). However, it is not without risks; these range from death under general anaesthesia to post-operative haemorrhage, wound infection or increased risk of certain cancers.⁵⁹ It is a procedure that is performed daily in many veterinary practices, therefore providing abundant opportunities for observation of its associated consent process. As a procedure that is usually performed on (younger) healthy animals, the risks involved should be similar for each individual patient. Therefore, for multiple reasons, elective neutering was considered a suitable procedure to choose for this consent research. Additionally, most animal welfare organisations run campaigns to promote neutering, advising all animal owners to have this procedure performed.⁶⁰ This ‘pressure to neuter’ also emanates from veterinary practices.

1.3.1 The veterinary profession advises neutering of companion animals

In the UK, most veterinary practices actively promote the neutering of companion animals, advising the owner accordingly when a new animal is presented to the practice. This approach has led to one author describing veterinary professionals as being “almost indecently keen on spaying and neutering.”⁶¹ Welfare organisations and animal charities promote neutering as a means of reducing the numbers of unwanted animals in the UK, with

⁵⁸ Laurie GT, Harmon SHE, Porter G, ‘The Control of Fertility’ in Mason and McCall Smith’s *Law and Medical Ethics* (10th edn, Oxford University Press 2016) 9.31, 330

⁵⁹ McKenzie B, ‘Evaluating the Benefits and Risks of Neutering Dogs and Cats.’ (2010) 5 CAB Reviews: Perspectives in Agriculture, Veterinary Science, Nutrition and Natural Resources

⁶⁰ See, for example, International Cat Care (formerly Feline Advisory Bureau) webpage ‘Neutering Your Cat’ <<https://icatcare.org/advice/neutering-your-cat>> accessed 4 October 2018, also see RSPCA ‘Neutering Your Pet’ <<https://www.rspca.org.uk/adviceandwelfare/pets/general/neutering>> accessed 4 October 2018

⁶¹ Tony Ellson, ‘Can We Live Without a Dog? Consumption Life Cycles in Dog-Owner Relationships’ (2008) 61 *Journal of Business Research* 565, 570.

some performing neutering at a very early age in both puppies and kittens.⁶² Thus, there is societal pressure to ensure that all companion animals are neutered, with its origins in the attempt to solve the problem of stray animals.⁶³ Indeed, it is this ‘population-based’ utilitarian argument that is fundamentally used to support the view that neutering is a ‘good’ decision to be made by animal owners. In light of this, few argue against the procedure on the basis of interference with the animal’s bodily integrity,⁶⁴ although some authors maintain that the right to bodily integrity precludes the use of any other rights-based argument which supports non-therapeutic neutering.⁶⁵

Together with animal welfare charities, a strong recommendation to neuter companion animals emanates from veterinary organisations. The British Veterinary Association (BVA), in its policy document on neutering dogs and cats, states:

“BVA strongly supports the practice of neutering cats (castration of tom cats and spaying of queens) and dogs (castration of dogs and spaying of bitches) for preventing the birth of unwanted kittens and puppies and the perpetuation of genetic defects. Such surgical intervention removes the problems associated with finding homes or increasing the stray population.

..... BVA acknowledges that neutering is not a trivial procedure but the welfare implications of neutering are outweighed by the benefits.”⁶⁶

A specialist companion animal veterinary organisation, the British Small Animal Veterinary Association (BSAVA) has also produced a position statement on neutering, which is more cautious in its recommendations:

⁶² Anon ‘Neutering: how early is too early?’ (2012) 170 *Veterinary Record* 432

⁶³ See, for example, L Tasker (2007) ‘Stray Animal Control Practices: A report into the strategies for controlling stray dog and cat populations adopted in thirty-one countries.’ World Society for the Protection of Animals and RSPCA International

⁶⁴ For example, see S Wise ‘Legal Personhood and The Nonhuman Rights Project’ (2010) 17 *Animal Law* 1 Wise and other rights campaigners see the right to bodily integrity as a fundamental right

⁶⁵ C Palmer, S Corr, P Sandøe, ‘Inconvenient Desires: Should We Routinely Neuter Companion Animals?’ (2012) 25 *Anthrozoos* 153.

⁶⁶ British Veterinary Association, ‘Neutering of Cats and Dogs’ <<https://www.bva.co.uk/News-campaigns-and-policy/Policy/Companion-animals/Neutering/>> accessed 25 October 2017.

“The BSAVA strongly recommends that the neutering of companion animals *should be considered* for reasons of population control and the prevention of unwanted litters. The decision as to whether to neuter the individual animal for medical or behavioural reasons needs to take into account factors such as species, gender, breed and age of the animal as well as current and future health status. Veterinary advice should always be sought regarding the risks and benefits in individual cases. There are now a number of options regarding the timing and methods of neutering and *these options should be discussed between the owner and veterinary surgeon when making decisions for an individual animal.*”⁶⁷

Not least, when adopting animals from rescue organisations, the adoption agreement usually requires that the animal must be neutered (if not already carried out prior to adoption).⁶⁸

Therefore, in the UK, a large number of neutering procedures take place each day in veterinary practices, which, in turn, means that the larger proportion of small animals visiting veterinary practices are neutered. However, based on data obtained from 526,431 consultations,⁶⁹ a higher percentage of cats (77%) are neutered than dogs (57.1%) or rabbits (45.8%).⁷⁰ In the UK setting, the lack of legal restriction on neutering,⁷¹ together with its active promotion by veterinary organisations, companion animal welfare charities, and veterinary practices, provide more opportunities for carrying out empirical work based on

⁶⁷ British Small Animal Veterinary Association, ‘Neutering’ <<https://www.bsava.com/Resources/Veterinary-resources/Position-statements/Neutering> > accessed 25 October 2017 (my emphasis)

⁶⁸ For example, Dogs Trust advises that “(e)very dog adopted from Dogs Trust is neutered (or comes with a neutering voucher if a puppy)” in ‘Frequently Asked Questions’ <<https://www.dogstrust.org.uk/rehoming/faqs/> > accessed 13 September 2018

⁶⁹ Fernando Sánchez-Vizcaíno and others, ‘Demographics of Dogs, Cats, and Rabbits Attending Veterinary Practices in Great Britain as Recorded in Their Electronic Health Records’ (2017) 13 *BMC Veterinary Research* 218.

⁷⁰ This agrees broadly with data obtained from the United States, where in a larger study, 82% of cats and 64% of dogs were neutered. Rosalie Trevejo, Mingyin Yang and Elizabeth M Lund, ‘Epidemiology of Surgical Castration of Dogs and Cats in the United States’ (2011) 238 *Journal of the American Veterinary Medical Association* 898.

⁷¹ Although there is controversy over whether neutering should be regarded as a ‘veterinary treatment’ – see Chapter 4, Section 4.5.1. The situation is similar in Ireland, where the Animal Health and Welfare Act 2013 does not specifically exclude neutering from its prohibited procedures (S16.1a)

the procedure. It is a surgery that is performed in every companion animal veterinary practice, by most veterinary surgeons, regardless of experience, and is scheduled in operating theatres for most days of the working week. In view of the legal dispensation for the procedure, this setting also provides different angles from which to view the ethical perspective of consent to neutering surgery.

Even more encouragingly, the dearth of previous research into the process of informed consent to routine, non-therapeutic neutering of companion animals leaves a vast area of unexplored practice. Questions such as:

- Should we routinely neuter companion animals?
- How much information should be given to owners about the procedure and its associated risks?
- How does this procedure affect the animal?
- Does the animal patient have any entitlement to rights?

reveal an endless number of potential research areas. I have focused on consent, but inevitably there will be some crossover with wider ethical aspects regarding the performance of non-therapeutic surgery on patients unable to give consent.

1.3.2 Consent for elective surgery

According to Whitney and others,⁷² the requirement for informed consent increases with the level of risk involved in the procedure, which concurs with GMC advice on when written consent is required.⁷³ In attempting to quantify the levels of risk involved in different procedures, and therefore, the level of consent required, I have allocated the levels used in the Whitney paper to various treatments and procedures performed on veterinary patients, to define where consent for non-therapeutic neutering may lie.

⁷² Whitney and others (n51) 56

⁷³ GMC (n5)

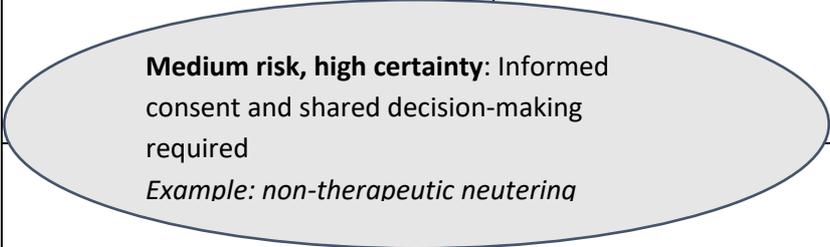
Level of risk 	High risk, high certainty Informed consent required, limited or no shared decision-making <i>Example: puppy requiring emergency surgery to remove a foreign body in stomach</i>	High risk, low certainty Informed consent and shared decision-making required <i>Example: older dog with bone cancer (osteosarcoma) in forelimb</i>
	 Medium risk, high certainty: Informed consent and shared decision-making required <i>Example: non-therapeutic neutering</i>	
	Low risk, high certainty Simple consent required, no shared decision-making <i>Example: altering dose of arthritis drug in older dog depending on response to treatment</i>	Low risk, low certainty Simple consent and shared decision-making required <i>Example: obese cat, several lifestyle and dietary approaches to weight loss</i>
	Level of certainty <i>One option</i>  <i>Several options</i>	

Table 1: Levels of Consent - adapted from Whitney and others⁷⁴

Although it also does not specifically mention non-therapeutic procedures, Whitney’s approach to defining risk versus level of certainty (see Table 1) suggests that elective neutering procedures would fall into a “medium risk, high certainty” domain. The allocation of risk level as “medium” is based on the low, but serious, risk of death associated with the administration of general anaesthesia.⁷⁵ There is a low, but potentially life-threatening, risk

⁷⁴ Whitney and others (n51)

⁷⁵ C Bille and others, ‘Risk of Anaesthetic Mortality in Dogs and Cats: an Observational Cohort Study of 3546 Cases’ (2011) 39 *Veterinary Anaesthesia and Analgesia* 59.

of post-operative haemorrhage following routine neutering of female dogs.⁷⁶ The level of certainty is high because the patient is booked in for a single procedure, without any alternative options for treatment. There is, of course, the possibility that the patient's sex has been mistakenly identified, necessitating a different procedure, while surgical mistakes during routine procedures have been reported.⁷⁷ Nevertheless, I have classified neutering in Whitney's 'high certainty' category, and as one which Passantino would certainly regard as "extra-routine."⁷⁸

The previous table (Table 1) suggests other types of procedure that could have been chosen as a focus for this study. With low risk, high certainty options, although these occur frequently, the requirement for simple consent reduces the content of the discussion between veterinary professional and client. With high risk, high certainty options there are two problems for researchers. First, it is difficult to predict when these scenarios may occur, making observation almost impossible, and second, the high stress involved in decision-making in these circumstances may alter the content and quality of the consent conversation. Turning to low certainty examples, the 'high risk' procedure would again be difficult to predict and observe, with the consent discussion possibly taking place over several consultations. These types of discussion would be rich sources of data for further studies. For low risk, low certainty procedures, the current research focus on client communication and behaviour change to solve the problem of obesity in companion animals may already be investigating this type of decision-making scenario. Therefore, my choice of an elective procedure solved several problems regarding access, availability and standardisation of the discussion. It also removed the influence of client finances on the decision-making process, as discussed in 1.2.2.⁷⁹

⁷⁶ CA Adin, 'Complications of Ovariohysterectomy and Orchiectomy in Companion Animals' (2011) 41 *Veterinary Clinics of NA: Small Animal Practice* 1023, 1024.

⁷⁷ R Mellanby and ME Herrtage 'Survey of Mistakes Made by Recent Veterinary Graduates' (2004) 155 *Veterinary Record* 761.

⁷⁸ Passantino and others (n53) 131

⁷⁹ The cost of non-therapeutic neutering procedures is reasonably standard between veterinary practices, as it is one area, together with procedures such as vaccination, where clients will 'shop around' to compare prices. See, for example, Juliet Stott and Patrick Collinson, 'Vet bills: are they making you as sick as a dog?' *The Guardian* 9 April 2016 <<https://www.theguardian.com/money/2016/apr/09/vet-bills-prices-sick-as-dog>> accessed 27 October 2018

Some authors have suggested that elective procedures should require higher levels of consent. For example, Katz proposes that:

“For elective procedures the fullest disclosures should be stringently enforced and shared decision making should be an absolute requirement.”⁸⁰

If this point of view is applied to the veterinary context, then the consent discussion with owners of animals being admitted for elective neutering surgery should also require full disclosure. I propose an argument supporting greater focus on consent in this context because the patient is a healthy animal, the surgery is not required for therapeutic purposes, the surgical procedure involves interfering with the patient’s bodily integrity, and, not least, there is a risk, albeit small, of death under general anaesthesia.⁸¹ Many owners, however, make the decision to neuter without being fully aware of the risks of the procedure or potential future negative health effects.⁸²

Recognising the tendency to take a rather ‘cavalier’ approach to obtaining consent for this non-therapeutic surgery and acknowledging that many practices give the responsibility for obtaining consent to those without veterinary training, I consider elective neutering an appropriate basis for my research. I will now consider the three participants in the ‘consent for neutering scenario’ in more detail.

1.4 Participants in the consent process for elective neutering

⁸⁰ J Katz, ‘Reflections on Informed Consent: 40 Years After Its Birth’ (1998) 186 *Journal of the American College of Surgeons* 466, 472.

⁸¹ Bille and others (n75)

⁸² I M Reichler, ‘Gonadectomy in Cats and Dogs: a Review of Risks and Benefits’ (2009) 44 *Reproduction in Domestic Animals* 29. See also Kendall E Houlihan, ‘A Literature Review on the Welfare Implications of Gonadectomy of Dogs’ (2017) 250 *Journal of the American Veterinary Medical Association* 1.

As both decision-making processes involve a triadic relationship, the gaining of informed consent to treatment of the animal patient may be considered as having similarities to the situation when the patient is a young child.⁸³ Such a comparison is limited, not least due to the patient's legal status⁸⁴ and entitlement, or lack of entitlement to rights. However, relating the scenario involving the animal patient to its equivalent involving an infant may reveal the "ethical landscape" in which veterinary treatment occurs.⁸⁵ The position of the animal owner, in making decisions on behalf of the animal, invites comparison with the role of parents in making decisions for younger children. Therefore, the veterinary/paediatric comparison will be explored further in Chapter 4.

One important feature of veterinary consent that (arguably) has similarities with paediatric consent is that the triadic relationship involved in the veterinary treatment scenario will always be unequal, both in terms of the legal rights and responsibilities of the participants, and in terms of the power held by each of the human participants in the decision-making process. In the context of veterinary treatment, this triadic relationship can exist in several forms. Rötzmeier-Keuper and others use balance theory to define four distinct types,⁸⁶ which, in turn, depend on the dyadic relationships between owner and animal, owner and service provider (in this case, veterinary professional), and service provider and animal. These definitions of different types of triadic relationship will be revisited in Chapter 8 when making recommendations for consent protocols in practice. Application of the proposed new model of consent to Rötzmeier-Keuper's defined triadic relationships will provide

⁸³ Although there may be similar triadic consent discussions when the patient is an older child, their wishes may be respected in specific situations. Similarly, in the case of an adult patient without capacity, the decision should consider the patient's expressed wishes, and involve multiple opinions, for example, carers, family, and persons with a lasting power of attorney. See Mental Capacity Act 2005, S4.6 - 4.7

⁸⁴ See, for example, Stephen Cretney 'Childrens Legal Status: Legitimate or Illegitimate.' in S. Cretney (ed) *Family Law in the Twentieth Century* (Oxford University Press 2003)

⁸⁵ Kerstin Weich and Herwig Grimm, 'Meeting the Patient's Interest in Veterinary Clinics. Ethical Dimensions of the 21st Century Animal Patient' (2018) *Food Ethics* 1: 259. <https://doi.org/10.1007/s41055-017-0018-0> accessed 22 September 2018

⁸⁶ J Rötzmeier-Keuper and others, 'Triadic Relationships in the Context of Services for Animal Companions' (2018) 85 *Journal of Business Research* 295. Balance theory presumes that individuals seek consistency and reciprocity in their relationships with others, so each dyadic relationship involved in a triad is categorised as positive or negative. Interestingly, 3 positive or 2 negative dyadic relationships can produce a balanced triad, whereas one negative or three negative dyadic relationships will unbalance the triad.

examples of its use in scenarios that involve different power relationships and examples of the human-animal bond. However, in this chapter, it is useful to include a more fundamental description of each of the participants.

1.4.1 The veterinary professional

In discussing this participant first, it is not intended to imply that this person possesses greater power or influence on the consent scenario. However, the veterinary professional can make the decision whether to perform the requested surgery or not.⁸⁷ The veterinary professional is the service provider, but also the 'expert' who brings specialist knowledge of animal disease and its treatment. At this point, it is worth suggesting that a reluctance to share this information with the animal owner could unbalance the relationship between veterinary professional and animal owner.

Veterinary surgery is a restricted practice, under Section 19.1 of the Veterinary Surgeons Act 1966.⁸⁸ The Act defines veterinary surgery as:

- “ (a) the diagnosis of diseases in, and injuries to, animals including tests performed on animals for diagnostic purposes;
- (b) the giving of advice based upon such diagnosis;
- (c) the medical or surgical treatment of animals; and
- (d) the performance of surgical operations on animals.”⁸⁹

⁸⁷ Here, there are parallels with the human medical situation, where a patient can request a procedure or treatment, but the healthcare professional does not have to provide it. See GMC Ethical Guidance 'Personal Beliefs and Medical Practice' para 6 <<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/>> accessed 4 October 2018, which advises that doctors are not obliged “*to provide treatments or procedures that they have assessed as not being clinically appropriate or not of overall benefit to the patient.*”

⁸⁸ There are exemptions under the Veterinary Surgeons Act for veterinary students (s19.3), for animal owners (Schedule 3 Part 1), for agricultural workers and students (Schedule 1 Parts 2 and 5), for anyone, in emergency situations (Schedule 3 Part 3), and for veterinary nursing students (Schedule 3 Part 7). under Schedule 3, Part 6 of the Act, there are provisions for listed Veterinary Nurses to carry out some aspects of veterinary surgery as defined above, provided that the animal is under the care of a veterinary surgeon and the veterinary surgeon has directed the veterinary nurse to carry out the treatment; although, in this case, diagnosis of disease is still limited to veterinary surgeons.

⁸⁹ *ibid*, s27.1

Therefore, although only veterinary surgeons are permitted to perform the surgical procedure on the animal patient, both veterinary surgeons and veterinary nurses may be involved in gaining consent to the treatment.

There has been a significant recent change to veterinary nursing in the United Kingdom. The awarding of professional status by way of a Supplemental Royal Charter in 2015⁹⁰ means that Registered Veterinary Nurses (RVNs) now have their own disciplinary procedures. Prior to the Charter, any misdemeanour by a veterinary nurse was regarded as being the responsibility of the employer, a veterinary surgeon. The achievement of professional status has expanded the job role of many veterinary nurses,⁹¹ and obtaining consent from clients is a routine part of their work.

Codes of Conduct for veterinary surgeons and veterinary nurses contain guidelines for obtaining informed consent. The development of the veterinary nurse's role is recognised in the updated supporting guidance. When advising on who should be responsible for seeking consent, the RCVS states that:

“Ordinarily, it is expected that the veterinary surgeon undertaking a procedure or providing treatment is responsible for discussing this with the client and obtaining the client's consent. If this is not practical, *the veterinary surgeon can delegate the responsibility.....*”⁹²

going on to define a “suitable person” to whom the responsibility can be delegated, which now includes registered and student veterinary nurses (see Chapter 3, Section 3.6.4).

⁹⁰ See RCVS Supplemental Royal Charter, 17 February 2015, Sections 12-17 <<https://www.rcvs.org.uk/document-library/supplemental-royal-charter-2015/>> accessed 16 August 2018

⁹¹ See, for example, Veterinary Nursing Futures Action Group, ‘VN Futures Report’ (2016) <[https://www.vetfutures.org.uk/download/publications/VN%20%20futures%20report\(3\).pdf](https://www.vetfutures.org.uk/download/publications/VN%20%20futures%20report(3).pdf)> accessed 16 August 2018

⁹² RCVS (n11) Section 11.3 (my emphasis)

This thesis, therefore, includes both veterinary surgeons and veterinary nurses in the term “veterinary professionals”, with the recognition that members of both professions are suitably qualified through their knowledge and experience to obtain consent to the treatment of animal patients for most routine procedures, and that both professions regard it as a professional responsibility.

1.4.2 The animal owner

The second person involved in the consent process for animal treatment is the owner of the animal, although the use of the term “owner” is controversial. I will use the term ‘owner’ to convey the position in terms of the legal status of animals. In western cultures, animals have traditionally been regarded as the property of humans. In the UK, this has been reinforced through statute and case law.

*“Domestic animals, like other personal and movable chattels, are the subject of absolute property. The owner can maintain a claim for their detention or conversion, or for trespass to goods in respect of them, and retains his property in them if they stray or are lost.”*⁹³

The UK Animal Welfare Act defines responsibility for an animal, whether this is permanent or temporary,

(2) In this Act, references to being responsible for an animal include being in charge of it.

(3) For the purposes of this Act, a person who owns an animal shall always be regarded as being a person who is responsible for it.⁹⁴

⁹³ Halsbury’s Laws of England, (5th edn, 2017) vol 2, para 2.1.6 (my emphasis)

⁹⁴ Animal Welfare Act (n4), s3

Thus, humans are entitled to “own” animals, although this remains an area of concern for those interested in the concepts of animal rights or animal welfare.⁹⁵ However, Cochrane argues that ownership *per se* neither grants the owner ‘exclusive and absolute’ control over the animal, nor precludes recognition of the animal’s moral status and the owner’s duties towards the animal.⁹⁶ The legal status of animals is considered in more detail in Chapter 4, Section 4.1.

The entitlement to own animals is earned, in some jurisdictions, by a prescribed test of proficiency.⁹⁷ However, in the UK, anyone who has reached the age of sixteen years can legally own an animal, i.e., can purchase an animal and be registered as the owner. The Animal Welfare Act includes the provision that animals cannot be sold or transferred to those under 16 years of age,⁹⁸ stating that “a person shall be treated as responsible for any animal for which a person under the age of 16 years of whom he has actual care and control is responsible.”⁹⁹ The only other qualification for animal ownership in the UK is a negative one, the absence of any “banning orders.” These orders refer to the disqualification from keeping animals for fixed periods of time, or even a lifetime, and are available penalties for breaches of the Animal Welfare Act¹⁰⁰ and the Breeding and Sale of Dogs (Welfare) Act.¹⁰¹ However, if an identical breach occurs when the animal is part of a licensed programme of research, the penalties are limited to those defined in the Animals (Scientific Procedures) Act 1986.¹⁰² These penalties include imprisonment and fines, but do not include a ban on keeping animals, thus illustrating one example of inconsistency in sentencing for causing unnecessary suffering to animals.

⁹⁵ See, for example, Tom Regan (n2) and Maneesha Deckha, ‘Property on the Borderline: A Comparative Analysis of the Legal Status of Animals in Canada and the United States’ (2012) 20 *Cardozo Journal of International & Comparative Law* 313

⁹⁶ Alasdair Cochrane, ‘Ownership and Justice for Animals’ (2009) 21 *Utilitas* 424

⁹⁷ For example, in Switzerland, the Animal Welfare Ordinance 2008 requires dog owners to provide certificates of competence in dog keeping and control (See Animal Welfare Ordinance (TSchV) 2008 455.1 Section 10, Article 68.)

⁹⁸ Animal Welfare Act (n4), s11.1.

⁹⁹ *ibid*, s3.4

¹⁰⁰ *ibid*, s34.

¹⁰¹ Breeding and Sale of Dogs (Welfare) Act 1999 s5.1c.

¹⁰² Animals (Scientific Procedures) Act 1986, s22

The legal limits of owners' treatment of animals are discussed further in Chapter 4, however, the selection of non-therapeutic neutering as the procedure used for this investigation into informed consent raises some important questions about how to define a 'reasonable' and 'responsible' animal owner.¹⁰³ If deciding from the point of view of animal welfare and veterinary organisations, and in order to allow the animal to roam or exercise freely, then the 'responsible' animal owner will have the animal neutered. If deciding from the point of view of the animal's moral status, then the 'responsible' animal owner may decide not to interfere with the animal's bodily integrity, instead taking alternative steps to prevent unwanted reproduction.¹⁰⁴

'Responsibility' is defined in the explanatory notes for the Animal Welfare Act:

Responsibility for an animal is only intended to arise where a person can be said to have assumed responsibility for its day-to-day care or for its care for a specific purpose or by virtue of owning it.¹⁰⁵

Therefore, the "animal owner" may be replaced in the decision-making role by someone providing care for the animal; this individual then becomes the owner's "agent" when considering consent to treatment. In veterinary practice, agency is most likely to include those with whom the animal's owner has a contract for the provision of boarding or training services, for example, kennel or livery stable proprietors, or trainers of sporting animals.¹⁰⁶ The chain of communication can sometimes be quite lengthy and/or convoluted, as in the case of *Glyn v McGarel –Groves*.¹⁰⁷ The animal involved in this case was a sporting horse

¹⁰³ For ideas of what constitutes responsible ownership, see VI Rohlf and others, 'Why Do Even Committed Dog Owners Fail to Comply with Some Responsible Ownership Practices?' (2010) 23 *Anthrozoös* 143

¹⁰⁴ MJ Downes and others, 'Neutering of Cats and Dogs in Ireland; Pet Owner Self-Reported Perceptions of Enabling and Disabling Factors in the Decision to Neuter' (2015) 3 *PeerJ* e1196. Note, however, that many animal rights advocates endorse the routine neutering of companion animals, see L Fusfeld, 'Sterilization in an Animal Rights Paradigm' (2007) 2 *Journal of Animal Law and Ethics* 255

¹⁰⁵ Explanatory notes to the Animal Welfare Act (n4), s3, para 17

¹⁰⁶ Many animal boarding or training contracts include provision for the business owner being authorised to make decisions in the absence of the animal's owner. This also applies to veterinary professionals caring for hospitalised animals.

¹⁰⁷ [2006] EWCA Civ 998

owned by one person, trained by another, treated by an international team veterinary surgeon, but also under the care of the owner's appointed veterinary surgeon. This case is considered in Chapter 3, Section 3.4, where the problems caused by the long chain of responsibility are discussed. Owners' agents have responsibilities to ensure the animal's welfare according to the Animal Welfare Act, while the RCVS offers the following advice on obtaining consent in such situations:

“The client may be the owner of the animal, someone acting with the authority of the owner, or someone with statutory or other appropriate authority ... (....) ...
Practice staff should ensure they are satisfied that the person giving consent has the authority to provide consent.”¹⁰⁸

Thus, practice staff need to verify that the person giving consent is the correct person to do so. The client is the person entering into the contract for services provided by the veterinary practice, whether this is the owner of the animal or not. In most cases, the animal owner will also be the client. For simplicity, therefore, this study will consider the animal owner, rather than an appointed agent, as the other (human) party involved in the decision-making scenario; however, the terms “animal owner”, “owner”, and “client”, may be used interchangeably when referring to those who make treatment decisions for animals.

1.4.3. The animal patient

The animal patient is the individual presented to the veterinary practice for treatment. This study will be based on companion animal patients, chosen because these animals are usually considered to form the closest relationships with humans,¹⁰⁹ because the medical and surgical treatments offered to these patients closely approximate to those offered in human healthcare,¹¹⁰ and also because companion animals, like children, are often regarded as

¹⁰⁸ RCVS (n11) Section 11.2 (my emphasis).

¹⁰⁹ Froma Walsh, ‘Human-Animal Bonds 1: the Relational Significance of Companion Animals’ (2009) 48 *Family Process* 462.

¹¹⁰ Andrew Gardiner, ‘The Animal as Surgical Patient: a Historical Perspective in the 20th Century.’ (2009) 31 *History and Philosophy of the Life Sciences* 355.

family members.¹¹¹ This will allow some correlation and comparison between medical and veterinary approaches to consent, whereas the choice of, for example, food animals would involve a completely different human-animal relationship, with the types of procedure performed on these animals also decided using different criteria.¹¹²

I have made the assumption that the human-companion animal relationship is more easily described than, for example, relationships between horse owners and their animals.¹¹³ Although some horses are regarded as companions, they do not live in such close proximity with their human owners as smaller companion animals, for example, most cats and dogs. However, as discussed earlier in this section, several different types of relationship between owners and companion animals have been identified.

A companion animal is defined as one belonging to “a domestic species that provides humans with social contact, rather than having to produce a product or perform a specific task.”¹¹⁴ The companion animals most commonly presented to ‘small animal’ veterinary practices for treatment are cats and dogs, which make up 64.8% and 30.3% respectively of the total number of animals seen in such practices, with rabbits constituting only 2% of consultations.¹¹⁵ Most consent discussions and decisions regarding neutering in small animal practice will therefore concern these two species, with a smaller proportion of rabbits. The terms ‘small animal’ and ‘companion animal’ may be used interchangeably throughout this thesis.

1.5 Rationale for the study design

¹¹¹ Nickie Charles, ‘Post-Human Families? Dog-Human Relations in the Domestic Sphere’ (2016) 21 *Sociological Research Online* 12 <<https://doi.org/10.5153/sro.3975>> accessed 24 October 2018

¹¹² For example, most decisions are made on either economic or ‘return to productivity’ bases, rather than a ‘best interests’ basis.

¹¹³ For example, CE Scantlebury and others, in ‘Could It Be Colic? Horse-Owner Decision Making and Practices in Response to Equine Colic’ (2014) 10 *BMC Veterinary Research* 51, identified 5 distinct types of horse owner

¹¹⁴ P D McGreevy and P C Bennett, ‘Challenges and Paradoxes in the Companion-Animal Niche’ (2010) 19 (S) *Animal Welfare* 11.

¹¹⁵ Sánchez-Vizcaíno and others (n69)

The study was designed following identification of the perceived differences in ethical foundation between medical and veterinary consent to treatment, the question over the status of the animal patient, and the lack of previous empirical work to investigate how consent to treatment is obtained in veterinary practice. The opportunity to conduct one of the first studies into consent in practice was unmissable; in particular, there was no previous attempt to determine how the consent discussion and consent form combine to form an ethically acceptable consent process, or to construct what the ideal consent process might look like.

However, an important additional factor in study design was the lack of ethical debate regarding the drive to neuter companion animals, who are subjected to a non-therapeutic procedure that poses short- and long-term risks to their health and welfare (see Chapter 4, Section 4.7). Although this thesis will avoid a thorough discussion about animals' moral and legal status, the choice of elective neutering as the focus of the studies requires an initial investigation of the ethical issues underpinning consent to this surgery. The potential influence of the veterinary professional, who regards neutering as beneficial to animal welfare, on the client's decision, which may be made without sufficient information to make an 'informed' choice, adds to the ethical debate surrounding consent in this context.

The design incorporates the essential role of doctrinal research in evaluating the legal direction surrounding informed consent, specifically as a means of respecting the autonomy of the patient. Although legal cases form an important source for any investigation into how well consent is obtained in practice and are certainly important when discussing the implications of failure to obtain consent, the lack of suitable veterinary cases presents a research problem. The notable medical cases available for scrutiny provide a comprehensive view of the progression of the 'risk disclosure' aspect of consent through the analysis of judicial decisions. The study design therefore includes doctrinal legal research based around relevant cases of consent to medical treatment, including consent given by parents on behalf of young children. It incorporates relevant decisions from the few reported cases of veterinary negligence, analysing how these were decided at the time and reflecting on the

different decisions that may be reached if they were heard now. Interwoven with the doctrinal research is analysis of professional guidelines in both medical and veterinary healthcare settings, and their response to legal decisions.

The main aim of this work is to produce findings that are relevant to veterinary professionals, which demands that it is grounded in the practice context. Empirical work is therefore practice-based and consists of three studies, which have the combined aims of capturing and analysing the current approach to consent in veterinary practice and suggesting improvements to the consent process that will prove useful for practitioners.

The findings from the doctrinal and empirical research are synthesised to produce areas of ethical and legal concern, which are worthy of further discussion. Consideration of these areas, and interpretation of examples of best practice from other healthcare professions, are combined to produce a new model of consent for veterinary professionals. This model, together with a redesigned consent form, may be used to facilitate the achievement of an improved and more informed consent to the treatment of animal patients. This improved version aims to recognise the importance of shared decision-making between owners and veterinary professionals when making treatment choices on behalf of animals, and to raise the requirements for informed consent in the context of non-therapeutic neutering.

These aims can be widened to generate issues for debate around the role of professional ethical guidance in matters of consent and communication between clients and veterinary professionals, and the role of the profession in promoting universal neutering of companion animals. Even broader aims relate to the debate around informed consent and human patients. In view of the comparisons drawn with paediatric medicine, there is the opportunity for sharing some of the lessons learned from conducting this study with those responsible for gaining consent from parents of paediatric patients. Specifically, some ideas may be relevant for the consent process for the performance of non-therapeutic interventions in children, such as circumcision of male infants. Additionally, with consideration of the appropriateness of autonomy-based consent for the veterinary context,

there is, perhaps, a wider relevance for consent in medicine, for example, in circumstances where the predominance of autonomy is questioned.

1.6 Summaries of subsequent chapters

Before explaining how the remainder of this thesis will be structured, it is first important to note that the literature review is distributed amongst the various chapters. This approach was selected as each separate review pertains to a specific aspect of either doctrinal or empirical work. Similarly, the details of the methods used for the empirical studies are contained in the corresponding data analysis chapters, as each study utilised different methods of recruitment and data collection. For each of the following chapters, summaries of the main literature reviewed, the principal areas of investigation and the structure of the chapter content are provided.

1.6.1 Chapter 2 summary: Interpretive description as a methodology

Chapter Two outlines the theoretical foundations and methodology for the individual studies, justifying interpretive description¹¹⁶ as the chosen methodology. The chapter begins with the formulation of the research questions, and the contributions of both legal doctrinal and empirical research in answering these. The selection of interpretive description as an underpinning methodology is supported in view of its applicability to practice situations, and its philosophical intention to produce meaningful results for the area of practice investigated. Interpretive description's links to several foundational social science methodologies are outlined. These individual methodologies are explained, with examples of where interpretive description borrows from each of them, and how they are applied to the individual studies in this thesis.

The approach taken to doctrinal research and the analysis of relevant legal cases is explained, accompanied by the rationale for undertaking this research prior to the empirical

¹¹⁶ Sally Thorne, *Interpretive Description* (2nd edn, Routledge 2016)

work. Next, the methods used in each of the three empirical studies are briefly described, with further details provided in each data chapter. The chapter incorporates reflection on my role as the researcher during recruitment and collection of data for each study, discussing the prejudices and preconceptions that are essential considerations while performing and interpreting the analyses.

1.6.2 Chapter 3 summary: Autonomy-based consent and its relevance for consent to veterinary treatment

This chapter comprises an investigation into informed consent in the medico-legal context. Initially, the ethical bases of consent are examined in light of the shift in focus, in terms of medical treatment, from beneficence (paternalism) to respect for patient autonomy. Engaging doctrinal legal research, the current situation in human medicine is examined, with the focus on adult patients with the capacity to consent. The literature examined documents the history of informed consent, the “fall from grace” of beneficence as the underlying principle of medical treatment, and the rise of an autonomy-based consent.

The traditional approach of legal deference to medical professional opinion is illustrated through *Bolam*.¹¹⁷ Threats to this deference are described through, first, *Sidaway*,¹¹⁸ and then *Bolitho*¹¹⁹ and *Pearce*.¹²⁰ Decisions in these cases demonstrate the very gradual shift in the balance between medical professional autonomy and patient autonomy. The more recent case of *Montgomery*,¹²¹ and its aftermath, are investigated from several directions. These include patient autonomy, the definition of risk, and the linking of autonomy with bodily integrity. These areas are additionally investigated through analysis of medical and veterinary professional body guidance.

¹¹⁷ *Bolam v Friern Hospital Management Committee* [1957] 2 All ER

¹¹⁸ *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 871 AC 1

¹¹⁹ *Bolitho v City and Hackney HA* [1997] 232 AC 1

¹²⁰ *Pearce v United Bristol Healthcare NHS Trust* [1999] 167 ECC

¹²¹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11

Cases addressing requirements other than risk disclosure are included to identify some of the essential components of the consent process, and comparisons are made with relevant professional ethical guidance. The investigation moves to consider the few veterinary negligence cases that mention risk disclosure, hypothesising on changes to the decisions if these were heard post-*Montgomery*.

1.6.3 Chapter 4 summary: Giving consent on behalf of others: the use of ‘best interests’ in healthcare decision-making for animals and children

Chapter Four begins with consideration of the legal status of animals. Their current legal status in the United Kingdom is evaluated based on a critical reading of the animal studies literature. Attempts to change this status are explored, occasionally drawing on examples from other parts of the world. Moves to change from “ownership” to “guardianship”, and the possible effects of such a change, are considered in terms of making treatment decisions for companion animals.

Recognising that the legal status of animals and their protection in law impacts on an autonomy-based consent, in this chapter I consider the argument that the closest comparison with the companion animal patient is the paediatric patient. Comparison of the child and animal patient is conducted with reference to the differences in legal status and the available remedies for dealing with disagreement between carers and health professionals.

Relevant case law involving the treatment of very young children is employed to trace the development of the law regarding parental consent for the treatment of children who are unable to consent for themselves. The chapter expands on the consideration of ‘best interests’ in such patients, and the difficulty of calculating best interests in situations where the calculation cannot incorporate the patient’s own wishes. Cases involving infants with life-limiting conditions, while not providing a direct comparison with the medical treatment used for my empirical work, give a useful insight into the dilemma faced by the courts when adjudicating on disagreements between parents and medical professionals. Reference to key

cases involving adults unable to consent for themselves is included to exemplify varying approaches to a 'best interests' calculation.

Finally, the debate surrounding a procedure frequently performed on children, i.e. non-therapeutic circumcision of male infants, is examined. The construction of a 'best interests' calculation for this controversial procedure is attempted, then compared with an equivalent calculation for non-therapeutic neutering in companion animals.

1.6.4 Chapter 5 summary: Evaluating consent forms and their place in the veterinary consent process

Chapter Five commences with a review of prior empirical work concerning analysis of consent forms, and the views of patients and physicians, in medicine, and of the single previous study in veterinary medicine. It continues with a detailed description of the methods used to collect consent forms in the present study, then includes results of the analysis of the language used and the content of consent forms in current use in veterinary practices in the United Kingdom and Ireland.¹²² The analysis of veterinary consent forms initially utilises a grounded theory¹²³ approach to identify themes pertaining to written consent, which are then subjected to further analysis to produce a thematic summary.¹²⁴

Although consent involves much more than the form, this initial study investigates the nature of the document used to record the owner's consent to treatment of the animal patient, seeking to discover how well the consent form documents the consent process while exploring its purpose and its additional functions. In my first empirical study, the balance between client autonomy and paternalism/beneficence is highlighted through analysis of the language used on the forms.

¹²² Forms were submitted from both Northern and Southern Ireland, where there is a similar requirement to obtain informed consent from owners prior to treatment of animals. See Manuel Magalhaes-Sant'Ana and others, 'What Do European Veterinary Codes of Conduct Actually Say and Mean? a Case Study Approach' (2015) 176 *Veterinary Record* 654

¹²³ BG Glaser and AL Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Aldine 1967)

¹²⁴ M Sandelowski and J Barroso, 'Classifying the Findings in Qualitative Studies' (2016) 13 *Qualitative Health Research* 905

1.6.5 Chapter 6 summary: The consent discussion and its role in the consent process

Chapter Six presents an analysis of previous empirical research involving observations of the consent process and its participants, utilising comparative studies from medicine, which are reviewed and evaluated. The protocol for the observational study in veterinary practice is described in detail, which includes the approach to recruitment of practices, the selection of a single practice in which to base the data collection, and the methods used to obtain the resulting data. The observation of consent discussions for elective (non-therapeutic) surgery involves ethnography¹²⁵ as a method of data collection. Transcripts of observed discussions are then thematically analysed to evaluate the consent process that is undertaken in the case study practice.

Subsequently, results and analysis of the observed consent discussions are presented and compared with the documentary approach to consent provided by the analysis of consent forms. The chapter concludes with a critical analysis of the consent process in the case study practice, in view of the prior findings from doctrinal legal research. There is further investigation into the balance between client autonomy and beneficence displayed during these observed consultations.

1.6.6 Chapter 7 summary: The construction of consent – interviews with key participants

Chapter Seven commences with a review of previous empirical work on consent utilising interviews as the principal method. It explains the approach taken to data collection for the interview study by outlining the recruitment of participants. Reasons are given for the selection of key and experienced participants belonging to stakeholder groups. Interviews with key stakeholders are conducted using a symbolic interactionist¹²⁶ approach. These semi-structured interviews with veterinary professionals, clients and representatives from professional bodies provide data for analysis and interpretation. Thus, the views of the different stakeholders are compared and contrasted.

¹²⁵ Martyn Hammersley, Paul Atkinson *Ethnography: Principles in Practice* (3rd edn. Routledge 2007) ProQuest Ebook Central < <https://ebookcentral.proquest.com/lib/bham/detail.action?docID=308687> > accessed 15 January 2017

¹²⁶ H Blumer, *Symbolic Interactionism: Perspective and Method* (University of California Press 1969)

Interview data include various perceptions of an “ideal” consent process and can therefore be used to construct a framework illustrating a normative approach to consent in veterinary practice. This results in the construction of a veterinary consent process incorporating the unique perspectives of those interviewed, albeit through my interpretation of their views. Opinions regarding client autonomy, veterinary professional autonomy, timing and content of the consent process reflect the perceptions of these participants. Analysis of these data is taken to the level of conceptual description, through the use of a hermeneutics¹²⁷ approach to the analysis. The influence of the prior research, including doctrinal legal study, is acknowledged when presenting the resulting analysis.

1.6.7 Chapter 8 summary: Towards a new model of consent for veterinary practice

The final chapter begins with a re-evaluation of the consent procedure for treatment of animal patients, particularly the relationship between informed consent and recognised models of medical and veterinary decision-making. The resulting discussion revisits the autonomy versus beneficence debate, but this time from the perspective of findings from the empirical studies, which are used to underpin proposed changes to the consent process in veterinary practice. These suggestions include a clearer definition of material risks, the offering of alternatives to surgical neutering, better sharing of information on the risks and benefits of neutering for the individual animal patient, methods of respecting client financial autonomy, and the place for beneficence in veterinary decision-making. The place of the consent form is re-evaluated, with suggestions for improvements to the recording of consent in practice. A sample consent form is redesigned in light of the findings.

A proposed model for consent to veterinary treatment of animal patients is presented, with reasons for its design that incorporate synthesis of the research findings from all the studies that were undertaken. Although intended as a conceptual model, it can also be translated into a consent protocol for practice. To give examples of its practical application, the

¹²⁷ Hans-Georg Gadamer, *Truth and Method* (Joel Weinsheimer and Donald G Marshall trs, Sheed and Ward 1989)

proposed model is applied to differing forms of the triadic relationship between veterinary professional, client and patient.

The chapter concludes with a description of the limitations of the studies conducted, in terms of what was possible within a limited time frame, the narrow focus on companion animals rather than all species treated as animal patients, and the concentration on one procedure, i.e., neutering. This section includes a critical evaluation of the chosen methodology, with further reflection on the researcher's influences and consideration of whether veterinary medicine should follow in medicine's footsteps. Additionally, it identifies potential areas for future research.

1.7 Conclusion

This introductory chapter has provided some essential information that prepares the way for the subsequent doctrinal and empirical research. The vast gap in knowledge regarding the veterinary informed consent process, its purpose, ethical foundations and practical application, has inspired the design of an inter-disciplinary and mixed methods study that aims to capture the essence of consent in veterinary practice, then analyse it from a combination of ethical, social and legal perspectives. The use of the novel (for veterinary research) methodological approach of interpretive description has been introduced, with an explanation of how it triangulates three discrete empirical studies and analyses them thematically, while incorporating the horizon of doctrinal legal research.

The meaning of informed consent as transmitted through veterinary professional ethical guidance has been explored, demonstrating some differences in normative advice between medicine and veterinary medicine. The unique emphasis on the requirement to disclose financial information in the veterinary setting has also required some initial consideration of the nature of the contract between veterinary practice and client.

The usual approach to obtaining consent in veterinary practice, from the researcher's own experience and from the normative guidance provided by the Royal College of Veterinary

Surgeons, has provided justification for undertaking this study. Reasons have been given for choosing the procedure of non-therapeutic neutering as the focus of the empirical studies, requiring evaluation of the different levels of consent that may apply to veterinary treatment procedures more generally, while also introducing an ethical perspective regarding the decision to interfere with the animal's bodily integrity, and societal pressure on clients to request this procedure on behalf of their companion animals.

Introduction of the three usual participants in the veterinary consent scenario, with explanations of their roles and status, has allowed initial exploration of the meaning of the triadic relationship in this context, preparing the way for a more thorough exploration of the relationship and how this might affect consent in Chapter 8.

Finally, the rationale for conducting a study into consent in the veterinary setting has been given; justification has been provided for limiting the study to one type of practice setting, to companion animals and to one procedure. Brief summaries of subsequent chapters have been included to define the content of each and explain the location of specific reviews of the relevant literature.

This initial chapter has explored the value of what can be achieved using this study design, while introducing additional areas for discussion in the remainder of the thesis. It has explained where decisions have been taken to include or to omit particular topics, indicating where further exploration of ideas will take place.

Overall, the area of consent to the treatment of animals is ripe for investigation, with numerous compelling associated issues. Some of these tangential ideas will be discussed throughout the remainder of this thesis, while some will inevitably have to wait for future research. I have introduced the possible relevance of the findings of this study to consent in the wider medical context, signposting its specific application to parental consent on behalf of young children. However, consent to the treatment of animals is sufficiently fascinating in its own right to warrant this comprehensive investigation. The approach that I take to this

investigation is interdisciplinary, combining legal research with empirical studies conducted using social science methodology. The principles underlying this approach, and the consequences for study design, are explored in the next chapter.

CHAPTER TWO: INTERPRETIVE DESCRIPTION AS A METHODOLOGY

2.0 Introduction

As introduced in Chapter 1, the approach taken to this study is interdisciplinary, combining law, ethics and the social sciences. This requires the methodology used to investigate the nature and application of informed consent to veterinary treatment to be appropriate for such an interdisciplinary approach.¹ In this chapter I will explain how the research questions were formulated, outline the philosophical basis of the chosen methodology, and briefly describe the methods used.

First, the traditional doctrinal approach was used to analyse relevant legal cases that have shaped medico-legal thinking on informed consent. I used legal analysis to consider how the term 'informed consent', and its components, have been interpreted through judicial reasoning in cases involving medical or veterinary negligence. Much of this research utilised cases involving human patients, as more of these were pertinent, and available, compared with their veterinary equivalent; this rationale will be described in detail, together with the method used, in Chapter 3.

The analysis of relevant cases provided a foundation and indicated analytic themes for the subsequent series of empirical studies. These three studies utilised multiple social science research methods to investigate how the informed consent doctrine is employed in veterinary practice, and to provide suggestions for improvement of the process. Thus, the empirical component aimed to describe and evaluate current approaches to consent in

¹ I agree with Williams' assertion that the humanities, particularly moral philosophy, and in this case, ethics, have a place in this type of research. See Melanie Williams 'Socio-legal studies and the humanities – law, interdisciplinarity and integrity' (2009) 5 *International Journal of Law in Context* 243

veterinary practice, through analysis of the consent forms used, observation of consent discussions and interviews with those involved.

This chapter sets out the methodological foundations for the doctrinal and empirical research. It briefly describes the approach taken for the legal research, together with the methods used for each of the three discrete empirical studies and explains why these were selected. Finally, it explains the approach to the analysis of the four sets of data. Detailed descriptions of the methods used for the doctrinal research and the three complementary empirical studies accompany the analyses of the resulting data in Chapters 3, 4, 5, 6 and 7.

First, I will describe the formulation of the research questions.

2.1 The research questions

Previous research on informed consent in the veterinary context has either focused on consent forms and clients' perceptions of their meaning,² or has examined an ethical approach to consent in the veterinary context.³ Several authors have proposed a normative direction for consent to the treatment of animal patients, both in the clinical⁴ and in the research setting.⁵ However, there is a dearth of empirical studies that analyse the nature of consent in veterinary clinical practice.

² Whiting MC and others, 'Survey of Veterinary Clients' Perceptions of Informed Consent at a Referral Hospital' (2017) 180 *Veterinary Record* 20

³ Ashall V, Millar KM, Hobson-West P, 'Informed Consent in Veterinary Medicine: Ethical Implications for the Profession and the Animal "Patient"' (2018) 1 *Food Ethics* 247

⁴ See, for example, Fettman MJ and Rollin BE, 'Modern Elements of Informed Consent for General Veterinary Practitioners' (2002) 221 *Journal of the American Veterinary Medical Association* 1386; Flemming DD, Scott JF, 'The Informed Consent Doctrine: What Veterinarians Should Tell Their Clients' (2004) 224 *Journal of the American Veterinary Medical Association* 1436; Passantino A, Quartarone V, Russo M, 'Informed Consent in Veterinary Medicine: Legal and Medical Perspectives in Italy' (2011) 01 *Open Journal of Animal Sciences* 128 and M Stanford, 'Claims, Complaints and Consent in the Small Animal Dispensary' (2016) 21 *Companion Animal* 43.

⁵ For example, see LM Russow and P Theran, 'Ethical Issues Concerning Animal Research Outside the Laboratory' (2003) 44 *International Laboratory Animal Research Journal* 187, and PJ Pascoe and KW Clarke, 'Informed Owner Consent - How Informed?' (2012) 39 *Veterinary Anaesthesia and Analgesia* 321.

I considered it essential to investigate the approach to consent in the real-world practice context before making any normative suggestions for the 'ideal' approach to informed consent in veterinary practice. Therefore, the broad aims of this research were to capture the essence of consent to the treatment of companion animals in the context of planned elective surgery (see Chapter 1, Sections 1.3.4 and 1.4, for more details on the selection of these criteria), to analyse the current approach to consent and to suggest ways to improve the process that are useful for practitioners.

These aims required an approach that investigated how the consent form and consent discussion together produce an 'informed' consent, how selected key participants view the process and how experienced practitioners might describe the 'ideal' consent process.

Studies investigating consent in medicine have used:

- direct observation and recording of consent discussions⁶
- analysis of the language used on consent forms⁷
- interviews with participants following the consent process⁸
- measurement of patient recall via the use of questionnaires⁹
- reverse simulation scenarios¹⁰
- response to hypothetical vignettes¹¹

⁶ C H Braddock and others, 'How Doctors and Patients Discuss Routine Clinical Decisions: Informed Decision-Making in the Outpatient Setting' (1997) 12 *Journal of General Internal Medicine* 339

⁷ JML Williamson and A G Martin, 'Assessing the Readability Statistics of National Consent Forms in the UK' (2010) 64 *International Journal of Clinical Practice* 322

⁸ S V Arnold and others, 'Converting the Informed Consent From a Perfunctory Process to an Evidence-Based Foundation for Patient Decision Making' (2008) 1 *Circulation: Cardiovascular Quality and Outcomes* 21; F Wood and others, 'Doctors' Perspectives of Informed Consent for Non-Emergency Surgical Procedures: a Qualitative Interview Study' (2014) 19 *Health Expectations* 751

⁹ AW Barritt and others, 'Assessing the Adequacy of Procedure-Specific Consent Forms in Orthopaedic Surgery Against Current Methods of Operative Consent' (2010) 92 *The Annals of The Royal College of Surgeons of England* 246; J Wong and others, 'Audit on Surgical Patients' Understanding of Their Informed Consent' (2015) 19 *Surgical Practice* 48

¹⁰ E Goldfarb and others, 'Enhancing Informed Consent Best Practices: Gaining Patient, Family and Provider Perspectives Using Reverse Simulation' (2012) 38 *Journal of Medical Ethics* 546

¹¹ E Donovan-Kicken and others, 'Sources of Patient Uncertainty When Reviewing Medical Disclosure and Consent Documentation' (2013) 90 *Patient Education and Counseling* 253

- focus group discussions¹²

to categorise the essential elements of the consent process and evaluate the level of understanding achieved. Reviews of relevant studies will be included in chapters 5, 6 and 7. Before considering potential designs for my study, it was important to define the research questions.

Recognising the important role of the form in documenting the consent process and providing evidence of consent, the first research questions pertained to the consent form. Although the research investigates consent for a single procedure (non-therapeutic neutering), most forms are generic and designed for use for consent to multiple surgical procedures. Through analysis of these forms, my first empirical study sought to answer the following questions:

RQ1 Which topics are included in the text of consent forms used in veterinary practice?

RQ2 What part does the consent form play in the process of informed consent?

Addressing RQ1 involved accessing a selection of consent forms in current use in UK veterinary practices, then analysing of the topics covered and the language used.

Addressing RQ2 involved investigating how the consent form is used in the practice setting, how it enables documentation of the process, and how it is integrated with consent discussions. This was achieved through observation of the consent process in practice.

¹² J Olumide Olufowote, 'A Structural Analysis of Informed Consent to Treatment: (Re)Productions of Contradictory Sociohistorical Structures in Practitioners' Interpretive Schemes' (2009) 19 *Qualitative Health Research* 802; A Fenety and others, 'Informed Consent Practices of Physiotherapists in the Treatment of Low Back Pain' (2009) 14 *Manual Therapy* 654

The importance of consent as a process rather than an event is reiterated in relevant guidelines¹³ and research papers.¹⁴ Investigating the relative contribution of the discussion and the form to this process was essential, leading to the next set of research questions:

RQ3 Which topics are covered during discussions between veterinary professionals and clients regarding consent for non-therapeutic neutering?

RQ4 How do these consent discussions expand on the topics included on consent forms?

The combined contribution of form and discussion could then be assessed and compared with the ethical obligations outlined in the RCVS Code of Professional Conduct's Supporting Guidance on communication and consent, updated in March 2018.¹⁵

The final empirical study utilised data from interviews with experienced participants in the consent process. Selection of suitable interviewees required that they had knowledge and experience of consent in practice, through being responsible for obtaining it, being asked to give it on behalf of an animal patient or advising the profession on issues associated with consent. The research questions for the interview study were:

RQ5 How would participants define informed consent, its purpose and how it should be obtained, specifically regarding consent to non-therapeutic neutering?

RQ6 How would participants describe the ideal consent protocol?

¹³ See, for example, General Medical Council, 'Consent: Patients and Doctors Making Decisions Together' <<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent>> and the Royal College of Surgeons of England 'Consent: Supported Decision Making - a guide to good practice' (2016) <<https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/>> accessed 24 September 2018. Also see S M Yentis and others, 'AAGBI: Consent for Anaesthesia 2017' (2016) 72 *Anaesthesia* 93

¹⁴ For example, Berry MG and others, 'A Comparison of the Views of Patients and Medical Staff in Relation to the Process of Informed Consent' (2007) 89 *The Annals of The Royal College of Surgeons of England* 368

¹⁵ Royal College of Veterinary Surgeons, 'Supporting Guidance' <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/>>

Thus, the current approach and the 'ideal' approach could be compared and contrasted. Analysis of doctrinal research provided a legal framework on which to base analysis of the veterinary consent process, despite major differences between the medical and veterinary settings, and their bases for consent. These differences will be highlighted briefly in the results and analyses chapters (Chapters 3-7), with more detailed explanation in the discussion chapter (Chapter 8). Having formulated the research questions, I will now introduce the chosen methodological approach.

2.2 Interpretive Description

When selecting a methodological approach, the aim of producing knowledge that is relevant and easily translated for use in practice directed me towards 'interpretive description',¹⁶ which seemed to fulfil the requirements for the primary objectives of the research; namely, increased understanding of consent in a specific context, with findings that can be utilised by veterinary professionals to inform their everyday practice.

Interpretive description was developed by Sally Thorne, a healthcare professional from a nursing background. Observing fundamental differences in approaches to research design between social scientists and researchers in applied disciplines, due to the "messiness" of those disciplines where care is combined with clinical and scientific medicine, she developed interpretive description to cater for the health professions' specific requirements for knowledge.¹⁷

First described as a methodology in 1997,¹⁸ it has principally been used for healthcare research, but has also been employed in sport and exercise science¹⁹ and in women's

¹⁶ Thorne S, *Interpretive Description* (2nd edn, Routledge 2016)

¹⁷ *Ibid*, 25-29

¹⁸ S Thorne, S R Kirkham, J MacDonald-Emes, 'Interpretive Description: a Noncategorical Qualitative Alternative for Developing Nursing Knowledge' (1997) 20 *Research in Nursing and Health* 169

¹⁹ M I Clark, J C Spence, N L Holt, 'In the Shoes of Young Adolescent Girls: Understanding Physical Activity Experiences Through Interpretive Description' (2011) 3 *Qualitative Research in Sport, Exercise and Health* 193

studies,²⁰ amongst other fields. It is designed to combine the “coherence and integrity” provided by the theoretical approach with the variations on design required by the “context, situation and intent”²¹ of the disciplinary setting to produce “useable” knowledge.²² This methodology seeks to combine “... factual material and social construction to build meaningful and relevant understandings of the ideas that are of central importance to the applied disciplines...,”²³ thus aligning with a social constructionist epistemology. Interpretive description borrows from several of social science’s foundational methodologies, such as ethnography, grounded theory and phenomenology. While it imports methods for data collection and aspects of data analysis from each, it avoids strict adherence to their philosophical traditions, or the wholesale adoption of the theoretical drivers used for most social science research.

Other donor methodologies have been added to Thorne’s list. For example, Carolyn Oliver suggests that symbolic interactionism’s purpose of “understanding how individuals and groups make meaning and act in situations in which automatic responses are inadequate”²⁴ matches the world of practice problems that led to interpretive description’s creation. Oliver posits that the use of key practitioners, as described by Thorne,²⁵ has parallels with Herbert Blumer’s description of the deliberate recruitment of participants who are active and informed.²⁶ Blumer proposed that:

“One should sedulously seek participants in the sphere of life who are acute observers and who are well-informed. One such person is worth a hundred others who are merely unobservant participants.”²⁷

²⁰ E A Utley, ‘Rethinking the Other Woman: Exploring Power in Intimate Heterosexual Triangular Relationships’ (2016) 39 *Women's Studies in Communication* 177

²¹ Thorne (n16) 30

²² *ibid*, 13

²³ *ibid*, 11

²⁴ C Oliver, ‘The Relationship Between Symbolic Interactionism and Interpretive Description’ (2011) 22 *Qualitative Health Research* 409, 411

²⁵ Thorne (n16) refers to these key participants as “*thoughtful practitioners*,” 92-93

²⁶ Oliver (n24) 412.

²⁷ Blumer H, *Symbolic Interactionism: Perspective and Method* (University of California Press 1969) 41

Thorne advises that the use of the “thoughtful practitioner” is important for triangulation, meaning that any conclusions can be drawn more confidently, through “the multiple lenses of different actors and observers of the phenomenon”²⁸ being studied. When consolidating my definition of interpretive description, I therefore added symbolic interactionism to my list of donor methodologies.

Both symbolic interactionism and interpretive description have links with pragmatism.²⁹ Interpretive description employs a pragmatic approach to choosing methods and to defining the end-point of the study (when the practical question has been satisfactorily answered). As Thorne remarks, applied health sciences view the end-point of research as its application, not as a sole source of evidence, but in conjunction with other sources of knowledge such as “shared clinical wisdom, pattern recognition, established practice and ethical knowledge.”³⁰ It requires the researcher to attempt to push beyond mere description, to produce better understanding and, in turn, to apply this to practice with the goal of improving lives or services.³¹

Interpretive description therefore requires that its user has defined “a real-world research question; an understanding of what we know, and what is missing, from prior empirical work, and an appreciation of the context and the target audience,”³² with the results obtained adding to the evidence base for the specific practice context in which the research is situated.

²⁸ Thorne (n16) 94

²⁹ However, there are many forms of pragmatism. Classical pragmatism is defined as having a starting point of “*experience as actually encountered*” by J L Webb, ‘Pragmatism (Plural) Part I: Classical Pragmatism and Some Implications for Empirical Inquiry.’ (2007) 41 *Journal Of Economic Issues* 1063, 1069

³⁰ Thorne (n16) 28-29.

³¹ *Ibid*, 36

³² *ibid*, 40.

Thorne is careful to point out that the use of collateral data sources, such as policy documents (or in my study, legal cases), does not require separate methodological consideration, but does require deliberation regarding how the perspectives obtained from their analysis will be used to inform other sources of data.³³ For my research, a key consideration was to ensure that the analysis of medico-legal cases informed the analysis of empirical data. Interpretive description methodology lends itself to applied and interdisciplinary research, and therefore provides a suitable methodological basis for this work.³⁴ However, in addition to choosing a suitable methodology, it is also important to elucidate the philosophical foundations of this approach to research.

2.3 Philosophical assumptions

In view of the interdisciplinary approach adopted for this study, the philosophical basis of research in both disciplines (law and social sciences) provided a useful foundation. As John Clarke has noted, law is variable according to context, such as time and place,³⁵ with the study of law made more “meaningful, productive and ... (...) ... interesting” through its “encounters with the social.”³⁶ Thus, findings from empirical studies on informed consent could be combined with findings from legal research to produce results that are translatable and practically useful for colleagues in practice.

However, the nature of socio-legal studies also requires that empirical work fits within the chosen research ‘paradigm’. Although informed consent is grounded in legal and ethical frameworks, it is nevertheless primarily constructed via communication between the parties

³³ Ibid, 92

³⁴ I gave a presentation on the potential contribution of this methodology to socio-legal methods at the Socio-Legal Studies Association conference in 2018. C Gray, ‘Interpretive Description as a Methodology of Socio-Legal Studies’ *Book of Abstracts* (SLSA 2018) 161<https://docs.wixstatic.com/ugd/af48eb_1b24410b4e934b96b50b0b7eb934f86f.pdf> accessed 7 October 2018

³⁵ John Clarke, ‘The Contested Social’ in Dermot Feenan (ed) *Exploring the ‘Socio’ of Socio-Legal Studies*. (Palgrave MacMillan 2013) 38

³⁶ Ibid, 38

involved. The concept of “an observable, independent reality”³⁷ was therefore inappropriate, with the relationship between the researcher and the research context characterised as “fluid and reciprocal, with influences in both directions.”³⁸ This realisation provided an early warning that I could not consider myself as an independent observer, and would need to consider how my experience and values might influence the approach taken to the study.

Michael Crotty, from a background in education and research studies, defines the theoretical perspective as the “philosophical stance lying behind a methodology.”³⁹ The decision to use an *interpretivist* perspective involved the search for understanding rather than explanation or causality. The ideas underpinning this perspective originate from Kant’s theory of knowledge. In his *Critique of Pure Reason*, Kant endeavoured to prove the validity of knowledge, and thus provide an antidote to the positivist empiricism of Hume. In maintaining that knowledge is more than just sense impressions of objects, but includes judgments based on experience,⁴⁰ Kant proposed that our own interpretations of what our senses tell us, together with thinking about our experiences, lead to ‘practical reason.’⁴¹ Kant’s ideas were subsequently developed and applied by, amongst others, Wilhelm Dilthey. Dilthey stressed the importance of people’s “lived experiences,” stating that “Verstehen” (understanding) is gained through interpreting the expressions of the minds of others, in the form of, for example, language and gestures.⁴² Dilthey maintained that understanding required empathy with the actor, i.e. the ability to get inside the other person’s head to understand the values and beliefs underpinning actions.⁴³ Dilthey’s views were combined with those of Max Weber, who emphasised the importance of culture in lending meaning to

³⁷ Virginia Braun and Victoria Clarke, *Successful Qualitative Research* (Sage 2013) 7

³⁸ *ibid.*, 8.

³⁹ Michael Crotty, *The Foundations of Social Research* (SAGE 1998) 66.

⁴⁰ Justus Hartnack, *Kant’s Theory of Knowledge* (Hackett Publishing Company 2001) 4-12

⁴¹ Jane Ritchie and Jane Lewis, *Qualitative Research Practice: A Guide for Social Science Students and Researchers* (Sage 2003) 6-7

⁴² Richard H Brown, ‘Dilthey, Wilhelm’ in *Encyclopedia of Social Theory* (SAGE Publications, 2005) 1

⁴³ Thomas A Schwandt, ‘Three Epistemological Stances for Qualitative Inquiry: Interpretivism, Hermeneutics and Social Constructivism’, in Norman K Denzin, Yvonna S Lincoln (eds), *Handbook of Qualitative Research* (2nd edn, Sage 2000) 192

the world,⁴⁴ resulting in interpretivism. Many social scientists would regard interpretivism as integral to the qualitative tradition.⁴⁵

In both medical and veterinary settings, the information required for valid consent depends on the language used by the person giving the information, and how it is interpreted by the receiver. Interpretation, in turn, depends on previous experiences in similar and contrasting situations. The choice of an interpretivist approach was appropriate in describing the participants' interpretation of the conversation, both in the clinical setting and in interviews, and, subsequently, my interpretation of their words as the researcher.

2.3.1 Epistemology and ontology

The choice of interpretivism as the theoretical approach for this research required careful consideration of the epistemology and ontology underpinning it. Epistemology is defined as the way of obtaining knowledge about something. Any claim to knowledge must be based on transparency about how that knowledge is obtained. In selecting social constructionism as my epistemological approach, I subscribe to the belief that meaning is “constructed in and out of interaction between human beings and their world.”⁴⁶ This approach acknowledges the existence of multiple realities depending on:

- the individuals involved
- the context of the phenomenon being investigated
- the analysis that is undertaken, and
- the researcher's own involvement in the process.

Michael Crotty is careful to define “constructionism” as a collective approach to the generation of meaning, whereas he considers “constructivism” as meaning constructed by an individual mind.⁴⁷ Although my role as the researcher required me to construct my own

⁴⁴ Sam Whimster, 'Weber, Max' in *Encyclopedia of Social Theory* (SAGE Publications 2005) 1

⁴⁵ Ritchie and Lewis (n41) 7

⁴⁶ Crotty (n39) 42

⁴⁷ *ibid*, 58

meaning from the data, analysis involved more than just my own view of the subject. As the data were derived from a social setting, I considered 'constructionism' to be more suitable as an epistemological basis. I therefore assumed that knowledge would be created through the process of research, through how I studied the phenomenon, through interpretation of 'informed consent' by key participants, and through attempts to discover its meaning via its documents, events and activities.

Ontology is understood as the nature of reality, and is often separated into *realist* (realities exist, whether humans know about them or not) and *relativist* (realities only exist when humans give meaning to them) perspectives.⁴⁸ Initially, a realist view seemed to align with some aspects of my legal research. The law exists, and has an objective reality, although it is subject to change and revision. Laws are "material and concrete phenomena,"⁴⁹ however, they are also part of the "signs used to navigate through life,"⁵⁰ requiring interpretation. Therefore, my legal study contained a strong relativist component, supported by the argument that interpretation of legal rules is subjective.⁵¹ Crotty proposes that both realism and relativism can apply to a constructionist approach,⁵² which seemed appropriate for my research. In other words, if we assert that reality is "socially constructed" we can also say that it is real.

Further justification for taking both realist and relativist positions is provided when considering how consent to treatment is achieved in practice. The RCVS requires informed consent to be obtained before any treatment or procedure is carried out on an animal, enshrining a normative approach to consent in the supporting guidance to the Code of Conduct.⁵³ This requires consent forms to be used in specific situations and provides

⁴⁸ Braun and Clarke (n37)28

⁴⁹ Susan Silbey, 'What Makes a Social Science of Law? Doubling the Social in Socio-Legal Studies,' in Dermot Feenan, ed, *Exploring the 'Socio' of Socio-Legal Studies*. (Palgrave MacMillan 2013) 25

⁵⁰ Ibid

⁵¹ T Hutchinson and N Duncan, 'Defining and Describing What We Do: Doctrinal Legal Research' (2012) 17 *Deakin Law Review* 83

⁵² Crotty (n39) 63-64

⁵³ Royal College of Veterinary Surgeons (n15) S11

'specimen' forms of consent for use in practice.⁵⁴ Thus, there is a professional ethical reality to consent. The professional guidance and forms exist as 'real' objects, i.e., they can be considered as providing a realist ontology to the term 'consent'. However, consent in practice involves communication between a veterinary professional and a client about proposed treatment, which the client can then choose or decline. This suggests a relativist ontology, as meaning is only given to the object (consent) by the participants. The term 'informed consent' only exists when the participants are involved in a discussion in the appropriate context. The combination of professional ethical obligation, consent form, and consent discussion unite to construct an object that is founded on both realism and relativism.

I considered a third ontology, materialism, which seemed a promising alternative. One version of materialism involves a relational approach that regards human bodies, inanimate material and abstract entities as interrelated, with each one requiring all the others for ontological integrity.⁵⁵ However, this approach involves a research design that focuses less on the human participants and places more emphasis on the system of which they are part, i.e. a form of social production. Materialism, or certainly this version of it, perhaps reduces the importance of language and meaning, in order to facilitate the exploration of object, materials and processes.⁵⁶ My view of informed consent as being socially constructed led me to reject this version of materialism as a potential ontology.⁵⁷ I prioritised language and the interpretation of its meaning over the production of consent via objects such as the form and institutional processes.

⁵⁴ Ibid, S11.11-11.12; RCVS 'Specimen Form of Consent for Anaesthesia and Surgical Procedures' <<https://www.rcvs.org.uk/document-library/specimen-form-of-consent-for-anaesthesia-and-surgical-procedures/>> accessed 1 September 2018

⁵⁵ N J Fox and P Alldred, 'New Materialist Social Inquiry: Designs, Methods and the Research-Assemblage' (2014) 18 *International Journal of Social Research Methodology* 399

⁵⁶ R Price-Robertson and C Duff, 'Realism, Materialism, and the Assemblage: Thinking Psychologically with Manuel DeLanda' (2016) 26 *Theory & Psychology* 58

⁵⁷ I also considered neo-materialism, or embodied materialism, as espoused by Rosi Braidotti, in, for example, *The Posthuman* (Polity Press 2013). However, this would have involved a comprehensive rethink on the human-animal relationship, so is perhaps an ontology for a future piece of work.

I therefore based my research on a social constructionist and interpretivist philosophy, underpinned with an ontology that is both realist and relativist. I will now apply these philosophical assumptions to doctrinal research.

2.4 Doctrinal legal research

I will begin by trying to define the methodology of doctrinal legal research. Doctrine refers to knowledge or instruction, but in legal terms also stipulates rules and sets precedent.⁵⁸ According to Paul Chynoweth, doctrinal research is “concerned with the formulation of legal ‘doctrines’ through the analysis of legal rules.”⁵⁹ This approach utilises research questions such as ‘What is the law in this particular area?’, involves textual analysis and is independent of empirical research, although it may be complementary. Its findings are classed as positivist or descriptive.⁶⁰ Indeed, as Jan Smits observes, the legal doctrinal approach has been regarded as synonymous with “descriptive legal science.”⁶¹ However, Smits also refers to a ‘normative’ legal science, which involves asking what the law *ought* to be and how it *ought* to be interpreted, while being careful to point out that this may not explain how humans actually behave.⁶²

It is often difficult for non-lawyers to grasp the methods employed, as doctrinal legal researchers seldom explain their methodology, either in research articles or in dissertations.⁶³ According to Hutchinson and Duncan,⁶⁴ this may be because these scholars regard the legal method as “tacit” and “implicit” to their field, and so do not feel the need to

⁵⁸ Hutchinson and Duncan (n51) 84-85

⁵⁹ Paul Chynoweth, ‘Legal Research’ in Andrew Knight and Les Ruddock, eds, *Advanced Research Methods in the Built Environment* (Wiley-Blackwell 2008) 29

⁶⁰ Although Susan Bartie, in ‘The Lingering Core of Legal Scholarship’ (2010) 30 *Legal Studies* 345, 349 refers to the treatment of this type of research as positivist as “*out of vogue*.” See also Matyas Bodig, ‘Legal Doctrinal Scholarship and Interdisciplinary Engagement’ (2015) 8 *Erasmus Law Review* 43, who refers to legal scholarship as being normative and interpretive.

⁶¹ Jan Smits, *The Mind and Method of the Legal Academic* (Edward Elgar 2012) 11

⁶² *Ibid*, 61-62.

⁶³ T Hutchinson, ‘The Doctrinal Method: Incorporating Interdisciplinary Methods in Reforming the Law’ (2015) 3 *Erasmus Law Review* 130

⁶⁴ Hutchinson and Duncan (n51) 99

explicitly describe the method, but may also arise because the techniques used are identical to those employed by practitioners (lawyers and judges) when carrying out their work. The impression given is that there is no need to describe what legal practitioners do every day. As a non-lawyer, uncovering this tacit knowledge of how to undertake legal research required that I learn how to access legal cases and how to read them, before attempting to interpret the decisions.

The choice of a social constructionist epistemology (see 2.3.1) to inform my research placed greater reliance on the interpretive aspect of legal research, through my interpretation of the judicial decisions in relevant cases. However, as will be explained in Chapter 3, the majority of cases that were suitable for analysis involved human patients and their medical treatment. In turn, some cases involved consulting the medical profession's guidance on consent. Attempting to relate these cases and their underpinning principles to the veterinary context required an interpretivist understanding of how the findings may translate into practice. The empirical work provided the contextual interpretation of consent and its underpinning principles, but the contribution from doctrinal research was invaluable for analysis of the resulting data.

2.4.1 Methods used for legal research

A doctrinal research approach utilises analysis of primary legal sources including statutes and cases. When examining informed consent to medical treatment, much of the case law is generated through medical negligence cases. Actions in battery are normally reserved for grievous breaches of autonomy, such as fraud or deception, where there is a criminal act involved, and where the basic premise of the patient's right to bodily integrity has been breached.⁶⁵ This leaves the majority of medical consent cases as negligence cases, with my research focusing on those cases where there has been a failure to disclose relevant

⁶⁵ Maclean A, *Autonomy, Informed Consent and Medical Law* (Cambridge University Press 2009)
192

information to the patient.⁶⁶ Similarly, most cases in veterinary medicine will turn on negligence. Exceptions include cases in trespass, which require proof that the procedure carried out on the animal patient was unrelated to the one to which the owner gave consent.⁶⁷

A strategy was formulated to search for relevant cases. Baude and others⁶⁸ suggest that legal researchers could learn from the structure and methods of systematic reviews to make case selection transparent. In following their recommendations for making doctrinal work more rigorous, in Chapter 3.2.2 I will outline the search strategy employed, listing the search terms used to identify suitable cases from both human and veterinary medicine.

2.5 Empirical research

Prior to describing the methods used for my empirical studies, it is useful to provide an overview of how knowledge is created through research into veterinary medicine. Following a brief explanation of the methods chosen, I will then investigate how my position as researcher may have affected the collection and analysis of data, and how I will address this potential influence.

2.5.1 How knowledge is created in veterinary research

Exploration of the epistemological positioning, that is, how knowledge is produced in the discipline, helps to provide a rationale for the selection of methods for empirical work. In veterinary medicine, as in many science-based disciplines, the requirement for practice to be 'evidence-based' leads to the perception that evidence obtained through objective enquiry is superior to that gained through subjective enquiry. Several previous studies of veterinary

⁶⁶ McHale JV, 'Consent to Treatment: the Competent Patient' in Judith Laing and Jean V McHale (eds), *Principles of Medical Law* (4th edn, Oxford University Press 2017) 8.71, 443-444

⁶⁷ See, for example, C Foster 'The price of animal suffering' (1993) 143 *New Law Journal* 123, although the only cases of trespass cited are from the USA.

⁶⁸ W Baude, A Chilton, A Malani 'Making Doctrinal Work More Rigorous: Lessons from Systematic Reviews' (2017) 84 *The University of Chicago Law Review* 37

communication-related topics have used positivist, objective approaches with some success. Techniques such as careful coding, measuring and quantifying of video transcripts of veterinary consultations have produced meaningful results.⁶⁹ While acknowledging the usefulness of such an approach, my research questions required eliciting participants' beliefs and values; for example, what *should* be in a consent discussion? The participants' own experience of the consent process was, therefore, fundamental to the answer.

Previous qualitative studies in the veterinary context have yielded valuable and influential results. Amongst the overwhelming predominance of quantitatively designed studies in veterinary research, an increasing number of papers have reported the use of qualitative methodology. Sometimes, however, reporting is limited to the methods used, with little or no methodological explanation. A major contributor to qualitative studies has been the field of veterinary medical education, which has followed its medical counterpart in recognising the valuable contribution of qualitatively designed studies to research in this context. For example, in the *Journal of Veterinary Medical Education*, 70 of 222 articles published between 2015 and 2017 reported using a qualitative study design. One example is a paper by Langebaek and others, which investigates the methods students use when learning how to perform surgical procedures on animals.⁷⁰

The remainder of the veterinary research world has been slower to adopt qualitative methodology, but the signs are encouraging. Increasingly, qualitative methods are utilised to investigate such areas as veterinary surgeon's prescribing habits,⁷¹ veterinarians' ideas of

⁶⁹ See, for example, J R Shaw and others, 'Use of the Roter Interaction Analysis System to Analyze Veterinarian-Client-Patient Communication in Companion Animal Practice' (2004) 225 *Journal of the American Veterinary Medical Association* 222, also J R Shaw and others, 'Veterinarian-Client-Patient Communication Patterns Used During Clinical Appointments in Companion Animal Practice' (2006) 228 *Journal of the American Veterinary Medical Association* 714, and J B Coe, C L Adams, B N Bonnett, 'Prevalence and Nature of Cost Discussions During Clinical Appointments in Companion Animal Practice' (2009) 234 *Journal of the American Veterinary Medical Association* 1418, all of which used the Roter system of numerical coding of each segment of video-recorded interaction.

⁷⁰ R Langebaek, L Tanggaard, M Berendt, 'Veterinary Students' Recollection Methods for Surgical Procedures: a Qualitative Study' (2016) 43 *Journal of Veterinary Medical Education* 64

⁷¹ For example, A L.P. Mateus and others, 'Qualitative Study of Factors Associated with Antimicrobial Usage in Seven Small Animal Veterinary Practices in the UK' (2014) 117 *Preventive Veterinary Medicine* 68, and L A Coyne and others, 'Understanding the Culture of Antimicrobial Prescribing in Agriculture: a Qualitative Study of UK Pig Veterinary Surgeons' (2016) 71 *Journal of Antimicrobial Chemotherapy* 3300

the consequences of “convenience euthanasia” of companion animals,⁷² responses by horse owners to signs of colic in their animals,⁷³ farm animal veterinary surgeons’ visions regarding the future of their sector,⁷⁴ how veterinary professionals and animal owners view long-term therapy for arthritis in pets,⁷⁵ animal owners’ perceptions of their veterinarians’ role in end-of-life decision-making,⁷⁶ and evaluation of the performance of veterinary students by workplace supervisors.⁷⁷ The studies cited to this point used interviews to collect data, apart from one study which also used focus groups.⁷⁸ One common approach utilises a qualitative method (for example, interviews) to provide information for a subsequent quantitative study, such as a questionnaire.⁷⁹

It is less common to find ethnographic methods such as non-participant or participant observation, or case studies, but these have been used for investigating such areas as the giving of behavioural advice during consultations,⁸⁰ the relationship between errors in practice and teamwork,⁸¹ and communications training interventions for veterinary surgeons.⁸² The increasing use of qualitative methods in veterinary research demonstrates greater acceptance of qualitative methodology in practice-based research and justifies the choice of interpretive description methodology for this study.

⁷² D Rathwell-Deault and others, ‘Expected Consequences of Convenience Euthanasia Perceived by Veterinarians in Quebec’ (2017) 58 *Canadian Veterinary Journal* 723

⁷³ Scantlebury CE and others, ‘Could It Be Colic? Horse-Owner Decision Making and Practices in Response to Equine Colic’ (2014) 10 *BMC Veterinary Research* 51

⁷⁴ A Ruston and others, ‘Challenges Facing the Farm Animal Veterinary Profession in England: a Qualitative Study of Veterinarians’ Perceptions and Responses’ (2016) 127 *Preventive Veterinary Medicine* 84

⁷⁵ Z Belshaw, L Asher, RS Dean, ‘The Attitudes of Owners and Veterinary Professionals in the United Kingdom to the Risk of Adverse Events Associated with Using Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) to Treat Dogs with Osteoarthritis’ (2016) 131 *Preventive Veterinary Medicine* 121

⁷⁶ S B Christiansen and others, ‘Veterinarians’ Role in Clients’ Decision-Making Regarding Seriously Ill Companion Animal Patients’ (2016) 58 *Acta Veterinaria Scandinavica* 30

⁷⁷ E J Norman, ‘Supervisor Descriptions of Veterinary Student Performance in the Clinical Workplace: a Qualitative Interview Study’ (2017) 180 *Veterinary Record* 570

⁷⁸ Belshaw (n75)

⁷⁹ See Scantlebury and others (n73)

⁸⁰ A L Roshier and E A McBride, ‘Canine Behaviour Problems: Discussions Between Veterinarians and Dog Owners During Annual Booster Consultations’ (2013) 172 *Veterinary Record* 235

⁸¹ T Kinnison, D Guile, S A May, ‘Errors in Veterinary Practice: Preliminary Lessons for Building Better Veterinary Teams’ (2015) 177 *Veterinary Record* 492

⁸² A M Bard and others, ‘The Future of Veterinary Communication: Partnership or Persuasion? a Qualitative Investigation of Veterinary Communication in the Pursuit of Client Behaviour Change’ (2017) 12 *PLoS ONE* e0171380

2.5.2 Methods used for empirical studies

When deciding on the approach to data collection for empirical studies, I chose a combination of qualitative research methods to produce a 'mixed methods', rather than a 'mixed methodologies' study. This approach to mixed methods research is termed "triangulation of sources."⁸³ Triangulation can be regarded as either a means of increasing the validity of the data, or a way of broadening the understanding of the topic.⁸⁴ Here, triangulation was used to achieve the latter purpose, through "the use of multiple perspectives or different types of 'readings'."⁸⁵ This fulfilled the aim of using an interpretive description methodology to increase the understanding of the topic (informed consent) in a specific practice setting (consent to non-therapeutic neutering of companion animals). Three discrete empirical studies utilised documentary analysis (consent forms), participant observation (consent discussions) and interviews (key participants and stakeholders). The findings from each study could be triangulated with the others to produce the multiple perspectives required to broaden the understanding of informed consent in the veterinary context. Each method will now be briefly introduced, together with the rationale for choosing such an approach.

2.5.3 Study 1: Documentary analysis of consent forms

The first study involved analysis of the language used on consent forms from a selection of UK veterinary practices. Analysis of these documents was important because of their role as evidence of the consent discussion. For example, the RCVS advises that they "may be used to record agreement to carry out specific procedures."⁸⁶ They can also be used as 'aide-memoires' by those taking consent, with the RCVS advising that "(c)onsent forms should be viewed as an aid to consent, in conjunction with a discussion with the client."⁸⁷

⁸³ Ritchie and Lewis (n41) 276

⁸⁴ *ibid*, 275

⁸⁵ *ibid*, 44

⁸⁶ RCVS (n15) S11.9

⁸⁷ *ibid*, S11.6

During the initial planning of this research, a brief search of practice websites revealed that some practices have pre-printed consent forms, which are available for clients to download prior to visiting the practice. The consent form in this context plays an important role. It helps to prepare the client for the discussion about treatment of the animal patient by providing information and guidance on the content of this discussion. Consent forms thus comprised the first set of data for the study.

In practice, the forms are not used in isolation during the consent process. It was therefore important to investigate how they might be used in conjunction with the accompanying discussions. My second empirical study therefore involved accessing these discussions.

2.5.4 Study 2: Observation of consent conversations

A review of similar studies in medicine, particularly in clinical research, revealed a range of qualitative methods used to improve the understanding of informed consent. However, most studies revealed issues with study design.⁸⁸ For example, the use of hypothetical scenarios may not replicate real decisions, surveys and interviews are subject to errors of recall and social desirability bias and audio- or video-recorded consent discussions may cause altered participant behaviour.⁸⁹

Initially, I deliberated using a questionnaire with veterinary professionals and clients. This plan offered several potential advantages. For example, it would have enabled reaching more participants, resulting in an increased number of respondents. However, the quality of data obtained then depends on participants' ability to recall the content of specific consent discussions, and previous research with medical patients has revealed their recall of specific information to be poor.⁹⁰ Therefore, I decided it would be more useful to directly observe discussions in the practice setting. This approach would allow me to investigate how consent

⁸⁸ G A Sachs and others, 'Conducting Empirical Research on Informed Consent: Challenges and Questions' (2003) 25 *IRB Ethics and Human Research* 54

⁸⁹ *Ibid*

⁹⁰ For example, parental recall of risks was less than 60% in the study by DP Nadeau and others, 'Informed Consent in Pediatric Surgery' (2010) 136 *Archives of Otolaryngeal Head and Neck Surgery* 265

is actually communicated and enable analysis of that communication in terms of the requirements for a valid consent.

This second study was designed using participant observation, which borrows heavily from ethnography. An ethnographic approach to fieldwork allowed investigation into the roles of the client (usually the animal's owner) and the veterinary surgeon, and their respective relationships with the animal, when making decisions regarding elective surgery. These three key participants form a triadic relationship,⁹¹ which is developed and maintained during consent discussions. Observing natural consultations allowed examination of this interaction, through thematic analysis of the resulting data.

During observation of these conversations, my presence throughout the interaction meant that I could not be considered a neutral observer. This position, of being present in the room while the interaction takes place, is often labelled as "observer-as-participant."⁹² Although not forming an integral part of the interaction between veterinary professional and client, I was marginally involved, through being in the consulting room and able to ask questions (prior to, and following, the observation). Unlike Gold's definition above, Yin reserves the term "participant observer"⁹³ for those who work in the organisation where the research is being conducted and would classify my role as "passive observer." However, acknowledging that I brought previous experience, prior knowledge and pre-judgments into the room with me, and appreciating that clients and veterinary surgeons could talk to me before, during or after the discussion, the description as 'participant observer' seems appropriate.

Observation of discussions gave insight into how the consent procedure was conducted in practice, although it did not include the perspectives of the participants involved.

Recognising that their perspectives were essential to achieving the aims of the study, a third method was required to attempt to capture these aspects of consent.

⁹¹ V Ashall and P Hobson-West, "Doing Good by Proxy": Human-Animal Kinship and the 'Donation' of Canine Blood' (2017) 39 *Sociology of health & illness* 908, 913

⁹² R L Gold, 'Roles in Sociological Field Observations' (1958) 36 *Social Forces* 221

⁹³ Robert K Yin, *Case Study Research: Design and Methods* (5th edn, SAGE 2014)

2.5.5 Study 3: Interviews with key participants

The perspective of participants in the consent process provided the data for my third empirical study. As with the observational study in 2.5.4 above, I needed to choose between interview and questionnaire-based research. Interviews are more suitable than questionnaires in situations where participants create meaning during and after the interaction. Gillham⁹⁴ lists several reasons for selecting interviews as a method, for example, where the research involves small numbers, employs open questions requiring extended responses, regards every participant as “key”, seeks depth of meaning rather than typicality, and has aims that require insight and understanding. These criteria applied to my study of participants’ perspectives of consent. Therefore interviews, which borrow from a symbolic interactionist methodology, were selected as the method of eliciting views from “key” participants. Those interviewed either had recent experience of obtaining or giving informed consent or routinely provided normative guidance to practitioners. Such participants fit with Blumer’s description of active and involved participants, with several interviewees also fitting Thorne’s category of “thoughtful practitioners” (see 2.2).

At this point, the decision *not* to interview those individuals involved in the observed consent discussions requires explanation. The reasons for excluding such participants were chiefly ethical. During an interview, if an animal owner had realised that a recent consent discussion was less than perfect, this may have affected the future veterinary surgeon-client relationship. Similarly, if a veterinary surgeon had realised during an interview that a key element of consent was omitted from a recent discussion, this may have caused stress and anxiety. I therefore took an early decision to interview a novel population of consent participants.

The experiences, beliefs and opinions of those interviewed constituted the data for this study. For analysis of these data, I borrowed an approach from phenomenology, particularly

⁹⁴ B Gillham, *The Research Interview* (Continuum 2000) 10-11

hermeneutics, to provide an interpretive framework. This approach incorporated the “perspective of others” and the influence of cultural and social shaping.⁹⁵ However, the analysis was undoubtedly influenced by ‘pre-understanding’ and my previous research. The interpretive version of hermeneutics requires the researcher to access the world of participants by “dwelling in their language.”⁹⁶ Thematic analysis is used inductively to reveal both explicit and implied meanings, while also challenging any ‘taken-for-granted’ thinking.⁹⁷

Data from forms and observed conversations therefore gave an ‘*etic*’ perspective of consent, with analysis of data related to theoretical and abstract concepts.⁹⁸ Data from interviews revealed the ‘*emic*’ perspective,⁹⁹ i.e., the ‘first person’ experiences and opinions of key participants in consent discussions, and of key stakeholders from the veterinary profession. Prioritising the aim of producing relevant and practically useful findings, I considered that the ‘*emic*’ perspective was essential in providing another horizon from which to view the construction of informed consent.

2.6 Methodological approach to data analysis

Interpretive description borrows data analysis techniques from other methodologies, principally grounded theory and thematic analysis. With grounded theory, knowledge is “inductively generated from within the data.”¹⁰⁰ Interpretive description methodology borrows from constant comparative analysis, a highly prescriptive approach to data analysis which is closely associated with grounded theory. However, interpretive description does not adhere to the rigid format required by the grounded theory version.¹⁰¹

⁹⁵ Thorne (n16) 55

⁹⁶ KHM Ho, VCL Chiang, D Leung, ‘Hermeneutic phenomenological analysis: the ‘possibility’ beyond ‘actuality’ in thematic analysis’ (2017) 73 *Journal of Advanced Nursing* 1757, 1758

⁹⁷ *Ibid*, 1760

⁹⁸ I Holloway and S Wheeler, *Qualitative Research in Nursing and Healthcare* (3rd edn, Wiley 2013) 7

⁹⁹ *ibid*, 6

¹⁰⁰ Thorne (n16) 109

¹⁰¹ *ibid*, 168

Thematic analysis provides a way of “identifying and describing implicit and explicit ideas within the data.”¹⁰² It is used for comparative analysis, for comparing and contrasting themes between two distinct sets of data, or in an applied version for examining themes arising from data in a “transparent and credible” way.¹⁰³ Although this method can be used for quantitative research (e.g., through word frequency counts and ‘key word in context’ phrase identification), it has become accepted as a main method of interpreting texts in qualitative studies. I chose thematic analysis as the method for analysing data from consent forms, transcriptions of observed consultations, and interviews. Not only is it recognised as a key method in interpretive description, it could be used for analysis of text from all three sources of data.

Coding data using interpretive description requires ‘broad-based’ coding (rather than line-by-line) and experimentation with different “angles of vision.”¹⁰⁴ Transforming the data requires asking increasingly complex questions about their meaning, with the aim of “capturing the important elements (...) in a manner that can be readily grasped, appreciated and remembered in the applied practice context.”¹⁰⁵ However, for the findings to be useable, they must also reach a level of analysis beyond mere description. There is some controversy about whether data analysis is a “neutral, mechanical and decontextualized” venture.¹⁰⁶ Mauthner and Doucet argue that, despite software programmes for data analysis attempting to ‘model’ the neutral researcher, all data analysis methods involve assumptions (of those who developed them and those who use them) so cannot be regarded as ‘neutral techniques’. As will be shown in later chapters, although initially employing qualitative analysis software for handling data, I eventually coded manually, utilising hard copies of transcribed conversations.

¹⁰² Greg Guest, Kathleen M MacQueen and Emily E Namey, *Applied Thematic Analysis* (Sage 2012), 10

¹⁰³ *ibid*, 15

¹⁰⁴ Thorne (n16) 161

¹⁰⁵ *ibid*, 188

¹⁰⁶ NS Mauthner and A Doucet, ‘Reflexive Accounts and Accounts of Reflexivity in Qualitative Data Analysis’ (2003) 37 *Sociology* 413, 415

2.6.1 Levels of Analysis

Sandelowski and Barroso propose four distinct levels of data analysis, thus providing guidance on where particular analyses may be located. The level reached is dependent on how far the analysis is removed from the original data. The levels achieved by broad-based coding will usually sit somewhere between a “thematic survey” and a “conceptual or thematic description,”¹⁰⁷ depending on the degree of transformation and abstraction of the data patterns. The different levels are explained in Table 2.

Level of analysis	Description
Topical survey	<i>Reduction of data in ways that remain close to the original data</i>
Thematic survey	<i>Conveyance of underlying patterns discerned in data</i>
Conceptual/thematic description	<i>Transformation of data using situated or imported themes or concepts to reframe data or convey latent pattern</i>
Interpretive explanation	<i>Re-presenting the target phenomenon as a coherent model, specifically addressing causality or essence</i>

Table 2: Levels of Analysis, adapted from Sandelowski and Barroso¹⁰⁸

Initially, I aimed for conceptual or thematic description in each of the empirical analyses. I realised that the most difficult challenge to achieving this level would be provided by the documentary analysis of consent forms, which would remain closer to the original data. However, after reviewing the data analysis from each empirical study, I will consider which level has been reached.

2.6.2 Reflexivity and data collection

Utilising a qualitative and interpretivist approach to this study requires that I follow good practice in these traditions by reflecting on my own position as the researcher, and how this

¹⁰⁷ Sandelowski M and Barroso J, ‘Classifying the Findings in Qualitative Studies’ (2016) 13 *Qualitative Health Research* 905-914

¹⁰⁸ *ibid*, 910-914

may have influenced data collection and analysis.¹⁰⁹ My interest in consent and the part that communication plays in the consent process stems from my background as a veterinary practitioner and lecturer in veterinary communication skills. Realising that many communication dilemmas concern a failure to obtain informed consent, I discovered a dearth of previous research into consent in the veterinary context.

The first difficulty that faced me was letting go of my scientific training. A positivistic background in veterinary science, both in practice, where 'evidence-based medicine' was recognised as the basis for treatment decisions, and in veterinary education, where the value of qualitative methods was just starting to be recognised, meant that I had to open my mind to new approaches. At the start of this journey, I felt as if I was caught between two intellectual paradigms, initially considering that I should be an objective and invisible observer to lend more credence to my findings. Discovering interpretive description provided the framework that was needed to embrace qualitative research in a practice setting.

However, with a veterinary practice background, I approached the research with some ingrained prejudices about the subject I was investigating. I examine the legal status of animals in Chapter 4, but I believe that animals deserve more than their current status as 'property' and perceive the relationship between a companion animal and her owner to differ from other human-animal relationships. My perception of what constitutes a healthy human-companion animal relationship, and what it means to be a 'responsible' animal owner,¹¹⁰ may have altered the way that I asked questions or interpreted data.

¹⁰⁹ Braun and Clarke (n37) at 303-304

¹¹⁰ For definitions of responsible dog ownership, see Rohlf VI and others, 'Why Do Even Committed Dog Owners Fail to Comply with Some Responsible Ownership Practices?' (2010) 23 *Anthrozoos: A Multidisciplinary Journal of The Interactions of People & Animals* 143. Rohlf defines responsible owner behaviour as confining the dog unless on a walk, identifying via microchip, neutering, training and socialization. This gives a fairly narrow view of 'responsible' dog ownership, with most criteria concerning the dog's impact on human society.

Regarding data collection, my previous experience as a veterinary surgeon was documented on the participant information sheet for each study, and thus may have moderated participants' responses to interview questions, or their behaviour during consultations. Rather than fighting or attempting to abolish prejudices, these need to be written into the study,¹¹¹ through consideration during analysis of the data. The underpinning philosophical research paradigm of interpretivism involves a presumption that research "can never be bias-free,"¹¹² and requires the researcher to reflect on how prior experiences and opinions may influence observations and data recording. I therefore discuss my approach to observation, interviewing and data analysis in the relevant results chapters.

As one of the contributing methodologies to interpretive description, phenomenology incorporates a fuller consideration of the researcher's prejudice. For example, Gadamer provides a positive view of 'fore-understanding', recognising that "all understanding inevitably involves some prejudice."¹¹³ He regards all interpretation as necessarily pre-judgmental, involving a dialogue encompassing both self-understanding and understanding of the object of investigation, suggesting that neutrality involves "not the extinction of one's self, but the foregrounding and appropriation of one's own foremeanings and prejudices."¹¹⁴

Interpretive description incorporates many aspects of the approach to analysis described for phenomenological hermeneutics (see 2.5.5); however, it requires that, instead of 'bracketing' any prior knowledge, beliefs and opinions, as would happen with a purely phenomenological methodology, the "forestructure of meaning"¹¹⁵ must be clarified. This involves locating my disciplinary orientation as a veterinary surgeon, and as someone with an interest in communication between veterinary professionals and clients. It also requires consideration of the setting for the research.

¹¹¹ L A Mazzei, 'Materialist Mappings of Knowing in Being: Researchers Constituted in the Production of Knowledge' (2013) 25 *Gender and Education* 776

¹¹² S Bunniss and DR Kelly, 'Research paradigms in medical education research' (2010) 44 *Medical Education* 358, 363

¹¹³ Gadamer H-G, *Truth and Method* (Joel Weinsheimer and Donald G Marshall trs, Sheed and Ward 1989) 270

¹¹⁴ *ibid*, 269

¹¹⁵ F J Mootz, 'The Ontological Basis of Legal Hermeneutics: A proposed Model of Inquiry Based on the Work of Gadamer, Habermas and Ricoeur' (1988) 68 *Boston University Law Review* 523, 534

2.7 Preparation for data collection: the research setting

The research setting was confined to the United Kingdom,¹¹⁶ principally because of the difficulty and scale of incorporating different legal and professional regulatory systems,¹¹⁷ but also for reasons of practicality regarding access to participants for the empirical studies.

The approach to consent may be similar in other European countries,¹¹⁸ however, I was aware of the enormity of the task in analysing medico-legal cases from more than one jurisdiction, and in view of time limits, this precluded extension beyond the UK. Second, in realising the importance of conducting empirical research in this field, there were limits in terms of available time and finances to the scope of these individual studies. Third, familiarity with the landscape of such a study can be key to its success, in facilitating access to research sites, i.e., veterinary practices. This is especially true when following the selected methodology of interpretive description, which requires ‘inside’ knowledge of the context of the proposed research, and its locations. And finally, some authors regard the UK as having high standards in animal welfare research and legislation,¹¹⁹ so in geographical terms, this was an interesting location for researching informed consent with respect to the treatment of animals.

The selected consent scenario involved a companion animal, the owner or guardian of this animal, and a ‘small animal’ veterinary surgeon. The focus of the research centred on

¹¹⁶ Although, as noted earlier in Chapter 1, section 1.6.4, some consent forms from Ireland were included in the analysis for this study.

¹¹⁷ J Bomhoff, ‘Comparing Legal Argument’ in M Adams and J Bomhoff (eds.) *Practice and Theory in Comparative Law* (Cambridge University Press 2012) 74

¹¹⁸ The requirement for informed consent is documented in the FVE (Federation of Veterinarians of Europe) European Veterinary Code, in the Portuguese and Irish versions of professional ethical codes for veterinary surgeons, see Magalhaes-Sant’Ana M and others, ‘What Do European Veterinary Codes of Conduct Actually Say and Mean? a Case Study Approach’ (2015) 176 *Veterinary Record* 654 and in the Italian Ethical Code for veterinarians, see Passantino and others (n4)

¹¹⁹ See, for example, F Lundmark and others, ‘Intentions and Values in Animal Welfare Legislation and Standards’ (2014) 27 *Journal of Agricultural and Environmental Ethics* 991, which compares standards in several EU countries, and LJ Keeling and others, ‘Designing Animal Welfare Policies and Monitoring Progress’ (2012) 21 *Animal Welfare* 95. Both articles rate the UK’s welfare policies highly, and refer to the UK’s tradition in promoting animal welfare

elective, non-therapeutic neutering surgery, Reasons for choosing these participants and procedure were provided in Chapter 1. The narrow context of the setting, the participants and the procedure must be borne in mind, however, such an approach fitted with the applied, context-sensitive requirements of interpretive description.

2.7.1 Preparation for data collection: ethics review

Prior to the commencement of data collection, application for ethics approval was submitted to the University of Birmingham Humanities and Social Sciences Ethical Review Committee. Initial approval was granted for the collection of consent forms and observation of consultations in February 2016 (*reference number: ERN_16-0077*), with additional ethical review and approval to include the addition of interviews in September 2016 (*reference number: ERN_16-1138*).

2.8 Conclusion

This chapter has introduced the research questions that this work was designed to answer, in response to the lack of previous research into consent in the veterinary setting. It has sought to explain the philosophical basis of interpretivism that, in turn, underpins the choice of a social constructionist epistemology and an ontology combining realism and relativism.

Exploration of the epistemological basis for the creation of knowledge in the veterinary context included documenting the rise in qualitative methodology for studies in veterinary medicine. This trend has paved the way for the choice of a novel methodology (for the veterinary field) of interpretive description. This methodology has been evaluated with reference to its usefulness in research that involves applied and highly context-specific settings and its incorporation of several foundational social science methodologies. These allowed the use of different methods to collect data, and triangulation of these different methods to enhance understanding through providing several different perspectives.

Conceptual and practical justification has been provided for the narrow context of veterinary practice, type of animal patient and procedure selected for these studies, in light of the

methodological requirements of interpretive description. This chapter included brief explanations of the methods used for doctrinal legal research and empirical studies, which will be described more fully in the subsequent chapters. The approach taken to the analysis of empirical data has been explained, with an outline of the levels of analysis that these studies sought to achieve and how this will be evaluated.

My own prejudices, originating from my background within the discipline being studied, have been recognised. I have proposed a plan for making these prejudices explicit by considering them during each chapter of data analysis.

The next chapter will consider the approach taken to the doctrinal legal research, which was undertaken prior to the empirical work. The benefits of conducting this research prior to working with data collected from practice include the ability to utilise knowledge of the ethical and legal frameworks of consent in the medical setting to provide an additional horizon when analysing veterinary consent data, and the possibility of measuring the influence that medical consent has had on its veterinary equivalent.

CHAPTER THREE: AUTONOMY-BASED CONSENT AND ITS RELEVANCE FOR CONSENT TO VETERINARY TREATMENT

3.0 Introduction

The interdisciplinary and mixed methods approach described in Chapter 2 required analysis of relevant legal cases in human and veterinary medicine to inform the subsequent interpretation of empirically-derived data. Although this thesis examines consent for a specific procedure, i.e., non-therapeutic neutering of companion animals, it is important to examine the wider aspects of consent to medical treatment. Primarily, there is a need to investigate the interrelationship between the principle of respect for patient autonomy, and the requirement for consent, which is the legal means by which the patient's wishes are respected.

Non-therapeutic sterilisation of human patients for contraceptive purposes proceeds with informed patient consent. It involves a procedure that may be reversible¹ and often does not involve the removal of reproductive organs, instead involving the ligation or severing of tubes.² In contrast, the sterilisation of humans who are unable to consent requires reference to the courts³ and involves decisions regarding the capacity and best interests of a non-competent patient, rather than the consent of a competent patient. Therefore, consideration of such examples is delayed until Chapter 4, where the use of 'best interests' as a basis for decision-making in the medico-legal context is explored.

¹ Or conversely, may be unsuccessful. For more on wrongful pregnancy claims, see JK Mason, 'Unsuccessful Sterilisation' In *The Troubled Pregnancy: Legal Wrongs and Rights in Reproduction* (Cambridge University Press 2007)

² P Benn and M Lupton, 'Sterilisation of young, competent, and childless adults.' (2005) 330 *Br Med J* 1323

³ If done for non-therapeutic reasons, or if the patient is a minor. See Neil Allen, 'Care and Treatment of Those Lacking Decision-Making Capacity' in J. Laing and J. McHale (eds), *Principles of Medical Law* (4th edition, Oxford University Press 2017) 10.160, 538

In this chapter, I will concentrate on the information requirements for consent involving a competent adult patient, which are now based on respect for the patient's autonomy. I will trace the development from a consent based on what the physician decided that the patient should be told, to one based on what the patient wishes to know. This change will be illustrated through the shift in the ethical basis of consent from beneficence to autonomy, and through relevant case law.

Doctrinal legal research involves analysis of primary legal sources, such as cases and statutes. However, in addition to analysing relevant case material, I include analysis of professional ethical guidance, sometimes referred to as 'soft law'.⁴ Selection of appropriate case law from human and veterinary medicine allows comparison between the two contexts with respect to the development of a consent based on autonomy. This comparison requires the selection of key medico-legal cases that turn on the validity of consent as the basis of a claim in negligence. In the UK, once a patient is informed in broad terms of the proposed procedure, their consent prevents a claim in battery (trespass).⁵ As Bristow J states in *Chatterton v Gerson*,

once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass.⁶

In view of the nexus between risk disclosure and consent, and with the requirements for risk disclosure now being based on respect for the patient's autonomy, my main focus is on this criterion. However, I also include a brief examination of the other requirements for a valid

⁴ U Mörth, 'Soft Law' in Bertrand Badie, Dirk Berg-Schlosser and Leonardo Morlino (eds), *International Journal of Political Science* (SAGE Publications, 2018) 2463

⁵ See for example, the difference between claims in battery and claims in negligence in 'Consent to Treatment' in Laurie GT, Harmon SHE, Porter G, *Mason and McCall Smith's Law and Medical Ethics*. (10th edn, Oxford University Press 2016) 4.101-4.105, 110-111

⁶ *Chatterton v Gerson* 1981 QBD 432 per Bristow J at 443A

consent. Relevant professional ethical guidance on informed consent is examined for alignment with current legal thinking, for areas where it may lead the way, or where it lags behind. Finally, I consider the appropriateness of a consent based on respect for autonomy in situations where the decision-maker is someone other than the patient. In summary, the chapter will outline the path to a consent based on respect for autonomy and examine the requirements for a valid consent. It will introduce the argument that a consent based on respect for autonomy cannot be applied wholesale to consent in the context of veterinary treatment.

3.1 The ethical foundations of consent to treatment

Increasingly, consent to medical treatment is based on a model of patient autonomy, although many regard this as an unachievable goal, particularly as healthcare becomes more standardised and instrumental.⁷ Autonomy has been variously defined as liberty, dignity, free will, independence and critical reflection.⁸ For the purposes of informed consent, Maclean suggests that it is important to differentiate between the autonomous *person*, who may not always make autonomous decisions, and the autonomous *act*.⁹ The philosophical underpinnings of autonomy derive from either deontological (via Kant) or utilitarian (via Mill)¹⁰ traditions.

3.1.1 Kantian autonomy as a basis for consent

The Kantian version regards autonomy and morality as inseparable. According to Kantian principles, all rational people have the capacity to act autonomously, but only those who act morally do so. Donnelly interprets Kantian autonomy as being “not about free choice, but

⁷ See, for example, J Molina-Mula and others, ‘Instrumentalisation of the health system: An examination of the impact on nursing practice and patient autonomy’ (2018) 25 *Nursing Inquiry*: e12201 <<https://doi.org/10.1111/nin.12201>> accessed 13 September 2018

⁸ Maclean A, *Autonomy, Informed Consent and Medical Law* (Cambridge University Press 2009) 10

⁹ *ibid*, 12.

¹⁰ Mary Donnelly, ‘Autonomy: Variations on a Principle’ in *Healthcare Decision-making and The Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2009) 16

about the drive to appropriate or moral action.”¹¹ Moreover, according to Maclean, Kantian autonomy is essentially relational (see 3.1.3) and cannot fail to consider the impact of a decision on others, particularly those in close relationships.¹² Thus, the ‘Kantian’ autonomous agent makes decisions based on what *ought* to be done, taking into account the views of others affected by the decision.

Thus, this view of autonomy necessarily involves a degree of heteronomy, or the idea that “as soon as the Kantian subject becomes an ethical agent, he or she ought to do something.”¹³ Indeed, there is not necessarily a tension between moral freedom and compulsion, provided that the compulsion is morally derived.¹⁴ Thus, a Kantian version of autonomy may be appropriate when humans are making decisions about the treatment of animals. If we regard animals as worthy of moral respect, there will be a morally ‘right’ choice to make regarding treatment decisions.

3.1.2 Millian autonomy as a basis for consent

The Kantian basis for autonomy is contrasted with the utilitarian version derived from the views of Hume and Mill, which allows no room for rationality.¹⁵ Individual liberty is the key, as only the individual knows what is best for that individual. When considering consent to medical treatment, the Millian interpretation of autonomy is often regarded as more suitable than the Kantian interpretation, as it is based on self-interest and self-knowledge, with the only reason for overruling this personal freedom being prevention of harm to others.¹⁶ However, rather than promoting idiosyncratic choices, Mill’s version also promotes reflection on, and analysis of, these choices.¹⁷

¹¹ *ibid*, 19

¹² Maclean (n8) 21.

¹³ I Devisch, ‘Oughtonomy in Healthcare. a Deconstructive Reading of Kantian Autonomy’ (2010) 13 *Medicine, Health Care and Philosophy* 309

¹⁴ I Brassington, ‘The Concept of Autonomy and Its Role in Kantian Ethics’ (2012) 21 *Cambridge Quarterly of Healthcare Ethics* 174

¹⁵ Maclean (n8) 18-20, 30

¹⁶ Donnelly (n10) 21

¹⁷ Onora O’Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press 2002) 31

The normative view of autonomy in healthcare upholds the right of a human patient to make decisions about their own treatment, but also gives it a value that is worth protecting. Some authors claim that it is a value rather than a right,¹⁸ while others suggest that consent could be reframed to protect an autonomy based in human rights.¹⁹

The freedom to make decisions that may cause harm to the decision-maker, but avoid causing harm to others, indicate that a utilitarian interpretation of autonomy could be appropriate for owners making decisions on behalf of animals. Such a view requires that we consider the animal as only being entitled to protection from harm. However, I propose that the Kantian version is more appropriate in the veterinary consent process, as the animal patient is entitled to more than just protection from harm. Consideration of the animal's positive interests will be discussed further in Chapter 4, Section 4.3.1. This proposal does, of course, require that the animal owner is motivated to make a beneficent decision on behalf of the animal.

3.1.3 Relational autonomy as a basis for consent

As indicated above, the selection of Kantian autonomy as the basis for consent in the veterinary context depends on the animal owner making the 'correct' (according to normative ethical guidance) decision for the animal patient. Achieving this ideal may be difficult for every potential treatment scenario found in practice. A more achievable alternative may be relational autonomy. This version of autonomy refigures traditional autonomy in light of feminist critiques, viewing every individual as being socially embedded, and rejecting the ideal of the individualist, (male), rational autonomous agent.²⁰ Social relationships, race, class, gender and ethnicity affect identity formation. In turn, it is important to recognise these influences on the choices available and the values and beliefs

¹⁸ M Sjostrand and others, 'Paternalism in the Name of Autonomy' (2013) 38 *Journal of Medicine and Philosophy* 710

¹⁹ JV McHale, 'Innovation, Informed Consent, Health Research and the Supreme Court: *Montgomery v Lanarkshire* - a Brave New World?' (2017) 12 *Health Economics, Policy, and Law* 435

²⁰ C Mackenzie and N Stoljar, 'Introduction: Autonomy Refigured' in Catriona Mackenzie and Natalie Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (Oxford University Press 2000), 4

of the agent.²¹ In healthcare settings, the influences of social location and experience may limit options available to patients; two examples being economic circumstances and “group-specific constraints.”²² Relational autonomy recognises that “not everyone has equal opportunities for autonomous decision-making and action.”²³ It requires working out how the “structures and policies of clinical settings”²⁴ operate to support or limit autonomy.

In the current study, client autonomy *may* be affected by societal views that encourage the neutering of all companion animals, views that are reinforced by most UK veterinary professionals. However, the achievement of patient-centred care, which is strengthened by a relational autonomy approach,²⁵ requires shared decision-making between veterinary professional and client. Importantly, this decision-making should incorporate the client’s wishes, values and beliefs.

Autonomy, in any of its forms, has only emerged as the basis for consent relatively recently.²⁶ There is continuing debate over, firstly, its appropriateness as the underpinning principle, and secondly, its predominance over other bioethical principles such as beneficence and justice.²⁷ When considering the treatment of animals, I agree with the proponents of this view, and therefore now consider a model for consent that is based on beneficence.²⁸

3.1.4 Beneficence-based consent

²¹ *ibid*, 22

²² S Sherwin and M Winsby, ‘A Relational Perspective on Autonomy for Older Adults Residing in Nursing Homes’ (2010) 14 *Health Expectations* 182, 185

²³ E Durocher and others, ‘Contradictions in Client-Centred Discharge Planning: Through the Lens of Relational Autonomy’ (2015) 22 *Scandinavian Journal of Occupational Therapy* 293, 297

²⁴ C Ells, MR Hunt, J Chambers-Evans, ‘Relational Autonomy as an Essential Component of Patient-Centered Care’ (2011) 4 *International Journal of Feminist Approaches to Bioethics* 79, 96-7

²⁵ *Ibid*, 90

²⁶ For example, Margot Brazier, in ‘Do No Harm - Do Patients Have Responsibilities Too?’ (2006) 65 *The Cambridge Law Journal* 397, at 398 refers to the past two decades as having ‘*over-corrected the balance*’ between patient autonomy and physician paternalism

²⁷ *Ibid*, 399

²⁸ I have concentrated on beneficence because the principle of justice is very difficult to apply to veterinary medicine, where the treatment given to an individual animal is heavily dependent on the owner’s ability to pay.

If there are problems with some aspects of an autonomy-based model for consent, then a more promising ethical principle may be beneficence, defined as “acts of mercy, kindness, friendship, charity etc. action intended to benefit other persons.”²⁹ For the purposes of this study, I will include animals in the definition of ‘other persons,’ although I acknowledge that this terminology clashes with the perception that they are the property of their owners. In selecting companion animals as the focus of this work and recognising that they are often regarded as family members,³⁰ I propose that their inclusion as ‘persons’ is valid. Beauchamp and Childress describe two types of beneficence. *Positive beneficence* obliges agents to provide benefits in all circumstances, whereas *utility* obliges agents to balance benefits and drawbacks to produce the best overall results.³¹ However, as patient autonomy has risen to predominance in matters of consent in human medicine, beneficence has fallen from favour.

In medicine, beneficence has become synonymous with paternalism, defined as the “intentional over-riding of one person’s known preferences or actions by another person.”³² The intention of the paternalistic intervention is to prevent harm to, or to benefit, the decision-maker. Two types of paternalism have been described.³³ ‘Hard’ paternalism applies when the person making the decision has no deficiency in decision-making ability, and ‘soft’ paternalism applies when the person’s ability to make decisions is compromised. Hard paternalism is considered as antithetical to autonomy. It is more difficult to see how ‘soft’ paternalism thwarts autonomy, unless the patient has fluctuating capacity to make autonomous decisions. When considering whether paternalism could apply to the veterinary context, it is necessary to separate the decision-maker (client) from the patient (animal). Over-riding the client’s wishes would be regarded as hard paternalism if the client were the patient, but as the patient does not have the ability to make decisions, then at most it could be regarded as soft paternalism. However, I regard paternalism as unsuitable terminology

²⁹ TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (7th edn, Oxford University Press 2013) 202-203.

³⁰ Charles N and Davies CA, ‘My Family and Other Animals: Pets as Kin’ (2008) 13 *Sociological Research Online* 1 <<https://doi.org/10.5153/sro.1798>> accessed 29 October 2018

³¹ Beauchamp and Childress (n29) 202.

³² *ibid*, 215.

³³ *ibid*, 216-7

for veterinary decision-making, as the person making the decision is not the patient. I therefore propose reclaiming 'beneficence' as the term applied to consent to veterinary treatment.

Prior to its association with paternalism, the traditional medical beneficence model derived from the Hippocratic tradition that physicians were ethically obliged to act for the benefit of patients, because only physicians had the requisite knowledge and skills to decide what *would* benefit patients. The model was based on maximum physician discretion (or physician autonomy), with minimal patient involvement, and predominated until the end of the 19th Century. The shift to an autonomy-based model commenced at the turn of the 20th Century.³⁴

Beneficence incorporated "benevolent deception," which encouraged, or even obliged, doctors to withhold from patients any information that would be detrimental to patient health. The traditional thinking was that *any* information could be detrimental to patient health, even the true nature of their illness. As medicine developed, there was a shift in thinking to allow limited disclosure to patients, either to raise the patient's opinion of the physician (by demonstrating medical knowledge), or to increase patient compliance with treatment.³⁵

Gradually this view was replaced by an increased focus on autonomy and informed consent, which required greater involvement of the patient in decision-making, through full information disclosure, the presentation of options for treatment, and the removal of coercion on the part of the physician. Thus, the beneficence-based model, with its limited disclosure to patients, received a 'bad press' through its association with paternalism, or 'doctor knows best'. The autonomy-based model has grown to dominate the medical ethical field through the late 20th and into the 21st Century.

³⁴ JF Will, 'A Brief Historical and Theoretical Perspective on Patient Autonomy and Medical Decision Making' (2011) 139 *Chest* 669

³⁵ *ibid.*

3.1.5 Balancing autonomy and beneficence in consent scenarios

Recently, there has been a revival of interest in using the beneficence model as the basis for clinical treatment. For example, Sheehan describes a developing “anti-autonomy” lobby,³⁶ which highlights the healthcare professional’s duty to challenge patients when they make poor decisions. This view considers that humans may need help to achieve their most treasured goals, and ‘coercive paternalism’ can be used to help them to achieve what is most valued. Opponents of this stance question the assumption that everyone values good health above all else, an argument that resurfaces when considering ‘best interests’ as a basis for decision-making for others.³⁷ Shared decision-making has become the perceived gold standard of medical treatment decision-making,³⁸ through encouraging the active participation of the patient in treatment decisions, rather than “passive acquiescence”³⁹ in the doctor’s decision. However, Moulton and others see it instead as a way to balance autonomy and beneficence, with both patient and physician as contributors to the decision, the physician providing beneficent guidance.⁴⁰ In considering beneficence as a possible foundation for veterinary treatment decisions, I reject the ‘limited disclosure’ approach of paternalism. The version of beneficence that I will use in this thesis therefore includes the obligation to share information with the client.

Given the negative connotations of paternalism, and to incorporate increasing public health initiatives that involve influencing individual choice, modern versions of paternalistic influence are sometimes labelled as ‘nudging’. This renaming reflects a greater emphasis on educating patients, rather than just making decisions on their behalf. Cohen describes nudging as “steering individual decision-making so as to make the chooser better off,

³⁶ M Sheehan, ‘Reining in Patient and Individual Choice’ (2014) 40 *Journal of Medical Ethics* 291

³⁷ *ibid.*

³⁸ See, for example, G Elwyn and others, ‘Shared Decision Making: a Model for Clinical Practice’ (2012) 27 *Journal of General Internal Medicine* 1361. Elwyn promotes shared decision-making as a means of respecting patient autonomy.

³⁹ B Moulton and others, ‘From informed consent to informed request: do we need a new gold standard?’ (2013) 106 *Journal of the Royal Society of Medicine* 391, 393

⁴⁰ *ibid.*

without breaching free choice.”⁴¹ Nudging presents information in a way that may influence the decision. For example, risks can be presented using success rate rather than failure rate, an approach known as “framing.”⁴² Whether nudging should be considered as genuinely different from paternalism remains, however, a subject for debate, and in view of its continued association with paternalism, I suggest that beneficence remains a better term for ethical influence in veterinary treatment decisions.

In concluding this section on the ethical bases of consent, it is essential to return to the autonomy/ beneficence debate. When considering which version of autonomy might seem more appropriate for consent in the context of veterinary treatment, it seems that the Kantian version may appear more suitable for a form of consent where the decision-maker is not the patient, and where there exists a normative view of what the decision-maker *should* do. However, I propose that a key contribution from relational autonomy involves recognition of constraints on the client’s autonomy.

Conversely, there are two types of beneficence, one of which (utility) seems more appropriate for decision-making on behalf of an animal, where risks and costs are involved. One aim of this study is, therefore, to question which, if any, of (Kantian) autonomy or utility beneficence offers a more suitable basis for owner consent to veterinary treatment, and to investigate implications for non-therapeutic neutering. First, it is necessary to investigate how autonomy’s rise to predominance in the regulation of human medicine, and the legal endorsement of this vision. I will utilise cases where alleged medical or veterinary negligence turns on the failure to disclose risks to patients or clients. I will start by describing the search strategy employed to find such cases.

⁴¹ S Cohen, ‘Nudging and Informed Consent’ (2013) 13 *The American Journal of Bioethics* 3. See also SD Gelfand, ‘The Meta-Nudge - a Response to the Claim That the Use of Nudges During the Informed Consent Process Is Unavoidable’ (2016) 30 *Bioethics* 601. Gelfand argues that patients should be informed when nudges are used. For more on the use of nudges for public health purposes, see LA Reisch and CR Sunstein, ‘Do Europeans Like Nudges?’ (2016) 11 *Judgment and Decision Making* 310

⁴² RJ Gordon-Lubitz, ‘Risk Communication: Problems of Presentation and Understanding’ (2003) 289 *JAMA* 95

3.2 Methods used for legal research

My doctrinal research approach focused on analysis of cases. The case law surrounding informed consent to treatment is generated through cases involving alleged negligence, specifically the failure to disclose risks on the part of the healthcare professional. A search strategy was therefore developed to gather relevant cases. Reporting on this strategy follows Baude and others' recommendations for making doctrinal work more rigorous.⁴³ These authors suggest that legal researchers could learn from the structure and methods of systematic reviews to make case selection explicit to readers. I have followed their advice, finding it helpful to document my reasons for case selection.

3.2.1 Search strategy

All searches were limited to cases heard in UK courts since 1950. I knew that a key medical case was heard in 1957, so limiting the search to cases heard in this decade seemed sensible. Although it was important to perform a comprehensive review, a more detailed historical narrative of veterinary and medical treatment cases was not required. Specific searches were carried out in July 2016 using the on-line legal libraries of Westlaw⁴⁴ and Lexis Library.⁴⁵ Search terms were defined as follows:

Search 1: "Veterinary" AND (medicine OR treatment) AND "informed consent."

This search yielded 10 cases from Westlaw and 17 cases from Lexis Library, of which only one and two cases, respectively, contained specific reference to consent. The search was therefore widened to incorporate the terms 'Veterinary' AND 'negligence', then refined through further reading to leave 6 cases (Westlaw) and 8 cases (Lexis Library) deemed relevant for further analysis. Transcripts of selected cases were then analysed in more detail. However, it was found that none of the cases turned on informed consent, or failure to

⁴³ Baude W, Chilton A, Malani A, 'Making Doctrinal Work More Rigorous: Lessons from Systematic Reviews' (2017) 84 *The University of Chicago Law Review* 37

⁴⁴ Westlaw UK <<https://legalresearch.westlaw.co.uk>> accessed 3 March 2018

⁴⁵ Lexis Library UK <<https://www.lexisnexis.com/uk/legal/>> accessed 3 March 2018

obtain consent. This necessitated refocusing the search on human medical negligence case law to see if decisions in these cases could be applied to veterinary practice.

Search 2: “Medical AND treatment” AND “informed consent”.

The second search yielded 274 cases (Westlaw) and 446 cases (Lexis Library) respectively. The results were refined by reading the cases in more detail, then selecting those that addressed consent or risk disclosure as a main topic. After duplicates were removed, 27 cases remained from the Westlaw search, and 14 from the Lexis Library search. Cases that were deemed as significant (in confirming or distinguishing decisions in preceding case law) were studied in detail. Additional cases cited in works by legal scholars were added to the results, together with new cases flagged by regular email alerts from legal databases and journals.

3.2.2 Analysis of cases and professional guidance

Judgments were carefully scrutinised. Key passages referring to the meaning and components of informed consent were carefully analysed. Thematic analysis, utilised as part of an interpretive description methodology (see Chapter 2, Section 2.2), identified the gradual legal move from a physician-centred to a patient-centred approach. Although this move focused primarily on the information required for consent to be ‘informed’, thematic analysis also identified other components deemed necessary for a valid consent.

Professional codes of conduct and guidelines, although often referred to as ‘soft law’,⁴⁶ are not legally binding, and have no legal sanction in cases of non-compliance. They are sometimes used as guidance in court. In view of their use in medical negligence cases, not least in *Montgomery* in 2015,⁴⁷ the most recent versions of the medical professional guidelines were analysed. I focused on guidance produced by medical registration and

⁴⁶ Mörth (n4)

⁴⁷ Medical professional guidance has also been consulted in previous cases, for example, in *W v Egdeell and others* [1989] 1 All ER 1089 where Scott J consulted the GMC’s ‘Advice on Standards of Professional Conduct and of Medical Ethics’ for guidance on the duty of confidentiality owed by the consultant psychiatrist in this case to his patient.

licensing bodies, for example, the GMC and the Royal Colleges, together with the supporting guidance on communication and consent produced by the RCVS for veterinary professionals, updated in 2018.

Although it may seem strange in a veterinary-focused study, the medical cases are reported first. This decision was taken for three main reasons; first, the dearth of specific veterinary cases involving informed consent; second, the reliance of the veterinary cases on previous medical jurisprudence,⁴⁸ and third, the influence of medico-legal cases on the language used in veterinary professional codes. The veterinary cases are, therefore, analysed after the medical cases. Then, the advice from professional bodies is evaluated, together with the impact of medical negligence decisions on consent in the veterinary context. I therefore begin with the leading medical negligence cases that involve a failure to disclose risks.

3.3 Risk disclosure and informed consent

Judicial decisions in cases of medical negligence involving risk disclosure demonstrate a gradual move from a doctor-based ‘paternalistic’ basis for consent, towards respect for patient autonomy. Therefore, a ‘doctor-centred’ approach to risk disclosure is evident in earlier cases, which correlates with the ethical basis of doctor-patient relationships at that time (see 3.1). To illustrate the progression of the legal interpretation of doctor-patient decision-making, the cases will be presented sequentially to convey the timeline for progressive change, starting with the 1950s.

The prevalent doctor-centred basis for risk disclosure, and therefore informed consent, was confirmed in 1957 via *Bolam v Friern Hospital Management Committee*. This case concerned alleged negligence in relation to both the administration of treatment (electro-convulsive

⁴⁸ As in, for example, *De Maynard v Streatham Hill Veterinary Surgery* [2001] EWCA Civ 1728, and *Calver v Westwood Veterinary Group* [2000] All ER (D) 1973

therapy), and the failure to warn the patient of the risks involved. In a direction to the jury, later expressly approved by the House of Lords, McNair J ruled that a doctor was:

... not guilty of negligence if he has acted in accordance with a practice accepted as proper by *a responsible body of medical men* skilled in that particular art.⁴⁹

The question posed to the jury regarding risk disclosure was:

Having considered the evidence on this point, you have to make up your minds whether it has been proved to your satisfaction that when the defendants adopted the practice they did (namely, the practice of saying very little and waiting for questions from the patient), they were falling below a proper standard of competent professional opinion on this question of whether or not it is right to warn.⁵⁰

However, McNair J also emphasised the link to causation, provided via a further question for the jury:

If you do come to the conclusion that proper practice requires some warning to be given, the second question which you have to decide is: If a warning had been given, *would it have made any difference?*.....⁵¹

Therefore, it was not surprising that the jury found for the defendants, the hospital management, thus ensuring that the “reasonable physician” standard was taken to apply to both treatment and to the disclosure of associated risks. A doctor-centred standard was therefore the accepted normative basis for risk disclosure at this time. Additionally, *Bolam* reinforced the principle that there must be a link between (failure of) risk disclosure and causation of harm for a claim in negligence to be successful.

⁴⁹ *Bolam v Friern Hospital Management Committee* [1957] 2 All ER, at 587 (my emphasis)

⁵⁰ *ibid*, at 590

⁵¹ *Ibid*, at 590 (my emphasis)

The situation regarding consent and risk disclosure remained fundamentally unchanged until 1985, when the case of *Sidaway v Board of Governors of the Bethlem Royal Hospital* raised the possibility of an alternative to a doctor-centred norm. This case centred on a surgeon's failure to warn a patient of a <1% chance of spinal damage. Again, it was unanimously decided in favour of the surgeon involved, but with a noteworthy dissenting judgment from Lord Scarman on the issue of the standard to be applied for disclosure of risk. On this issue, he stated that *Bolam* did not apply to risk disclosure, as opposed to diagnosis and treatment. Since there was no question of lack of skill or care in the treatment given by the surgeon involved, he ruled that the question was whether the surgeon:

.... gave consideration, which the law requires him to give, to the right of the patient to make up her own mind, in the light of the relevant information, whether or not she will accept the treatment which he proposes.⁵²

Lord Scarman proposed that the UK should consider adopting the doctrine of informed consent, as was applied at the time in the United States and Canada. He advocated a "prudent patient" test, which required a patient-centred approach, rather than the doctor-oriented test used in *Bolam*. Lord Scarman's judgment therefore highlighted the potential for a decisive shift in the jurisprudence on consent, illustrated through his definition of the materiality of risks involved:

..... I have indicated I think that English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing ... (....)
The (....) ... duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that *a reasonable person in the patient's position would be likely to attach significance to the risk.*⁵³

⁵² *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 871 AC 1, at 876H

⁵³ *Ibid*, at 889H (my emphasis)

However, despite his progressive opinions on patient autonomy, Lord Scarman dismissed the appeal on the grounds of lack of evidence for the failure to warn. In this, he agreed with his fellow judges, who relied more heavily on *Bolam* in their reasoning. Nevertheless, Lord Scarman's judgment was later to prove influential on judicial thinking.

The next significant challenge to *Bolam* came in 1997, via *Bolitho v City and Hackney HA*. This case involved a failure to act; a doctor failed to attend and intubate a child in respiratory failure, resulting in the child's cardiac arrest and brain damage. The main argument concerned disagreement amongst the experts regarding what was a reasonable course of action. Although finding in favour of the health authority, the court stated that there had to be a logical basis for the medical experts' opinion, with Lord Browne-Wilkinson determining that:

..... in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence.⁵⁴

However, he specifically excluded risk disclosure from this statement, thus leaving *Bolam* as the prevailing, doctor-centred basis for disclosure and, therefore, for consent.

*Pearce v United Bristol Healthcare NHS Trust*⁵⁵ confirmed the right of a doctor to withhold information on risk from a patient, if the risk was deemed insignificant. Lord Woolf cited Lord Bridge in *Sidaway* as describing a significant risk to be a risk of something in the region of 10%.⁵⁶ The risk of stillbirth (as happened in this case) due to delay in induction or Caesarean section was estimated as 0.1 to 0.2%. The patient had requested a Caesarean section, but the doctor insisted on waiting for nature to take its course. The patient was not

⁵⁴ *Bolitho v City and Hackney HA* [1997] 232 AC 1, at 243A

⁵⁵ *Pearce v United Bristol Healthcare NHS Trust* [1999] 167 ECC

⁵⁶ Per Lord Bridge in *Sidaway* (n52) at 663C.

informed of the risk of stillbirth, and Lord Woolf agreed that the risk was not significant, and therefore did not require warning. Therefore, fundamentally, the *Bolam* test was again applied to risk disclosure, and the *status quo* was maintained. However, the decision in *Pearce* held that it was necessary to disclose a significant risk.

... it seems to me to be the law ... (...) ..., that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.⁵⁷

Thus, according to these *dicta*, if the risk had been deemed significant, then the doctor would have had a duty to disclose it. *Pearce* therefore demonstrates a move towards a 'reasonable patient' basis for risk disclosure, albeit one that is still grounded on what a doctor would consider as a significant risk.

Pearce can also be considered to have prepared the way for the decision in *Chester v Afshar*⁵⁸ in 2004, when the House of Lords found in favour of the patient. This decision was surprising, in view of the previous cases, in that it prioritised the autonomy of the patient. In this case, the risk of cauda equine syndrome resulting from spinal surgery was estimated to be 0.9%, some way below the previously suggested threshold of 10% for risk disclosure. Lord Steyn prefaced his decision with a robust statement regarding patient autonomy:

The starting point is that *every individual of adult years and sound mind has a right to decide* what may or may not be done with his or her body. Individuals have a right to make important medical decisions affecting their lives for themselves: they have the right to make decisions which doctors regard as ill advised.⁵⁹

⁵⁷ Per Lord Woolf in *Pearce* (n55) at 21.

⁵⁸ [2005] 1 AC 134

⁵⁹ *Ibid*, per Lord Steyn at para 14 (my emphasis)

Although perhaps more notable for the dissociation of causation from the failure to warn the patient of possible risks, the decision in *Chester* effectively awarded damages to the patient for loss of autonomy. Lord Steyn observed that “... medical paternalism no longer rules.....”⁶⁰ and stressed that the court, rather than the medical profession, was “the final arbiter of what constitutes informed consent.”⁶¹ However, a more radical decision would have been to award damages for the breach of autonomy, therefore grounding consent in the patient’s right to autonomy.⁶²

Montgomery v Lanarkshire Health Board may be regarded as the culmination of this gradual move towards respect for patient autonomy in medical negligence cases. In 2015 the UK Supreme Court reversed the original ruling of the Inner House of the Court of Session⁶³ that the plaintiff was not entitled to damages as a result of injuries received by her child during labour. The Supreme Court upheld the plaintiff’s claim that she should have been warned of the risk of shoulder dystocia and offered a Caesarean delivery.

In their speeches, Lord Kerr and Lord Reed considered the main preceding cases, particularly *Sidaway* and its interpretation of *Bolam*, together with advice from the General Medical Council, and stated that patients are now legally regarded as:

persons holding rights, rather than as the passive recipients of the care of the medical profession ... [and are] also widely treated as *consumers exercising choices*.⁶⁴

⁶⁰ *Ibid*, at 16

⁶¹ *Ibid*, at 14

⁶² Indeed, McHale (n19) suggests, when referring to the *Montgomery* decision, that it would have been more groundbreaking to “entirely reframe consent through the prism of autonomy-based human rights...” 450.

⁶³ The case started in Scotland

⁶⁴ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, at 74G-H (my emphasis)

In *Montgomery*, the definition of a ‘material risk’ was taken some distance from the previous incarnation, which relied on percentages and statistics, and was firmly grounded in a ‘particular patient’ basis. The test of materiality was now described as:

..... whether a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.⁶⁵

This decision confirmed the removal of a numerical cut-off point for a risk to be deemed significant, and instead mandated a ‘reasonable patient’ or, in some cases, a ‘particular patient’ basis to the test for materiality of that risk.

Additionally, Baroness Hale’s judgment specifically aligned autonomy with bodily integrity, noting that

the interest which the law of negligence protects is a person’s interest in their own *physical and psychiatric integrity*, an important feature of which is their autonomy.⁶⁶

However, it must be pointed out that the link between autonomy and protection of bodily integrity can only be considered to apply to those with capacity to consent, thus excluding young children and animals, whose bodily integrity is not protected in this way (see Chapter 4, section 4.5.1 for further discussion on bodily integrity and those unable to consent).

Montgomery makes an important contribution to the informed consent debate in human healthcare. It grounds informed consent in respect for the autonomy of the patient; it promotes a “reasonable patient” rather than a “reasonable doctor” approach to risk disclosure; it removes the numerical basis for evaluating the materiality of risks involved,

⁶⁵ Ibid, at 87C

⁶⁶ Ibid, per Baroness Hale at 108C (my emphasis)

and it explicitly links autonomy with bodily integrity. It has subsequently been applied in many cases involving failure to obtain consent through failure to disclose risks, including *Webster (A Child) v Burton Hospitals NHS Foundation Trust*,⁶⁷ *Hassell v Hillingdon Hospitals NHS Foundation Trust*,⁶⁸ and *Duce v Worcestershire Acute Hospitals NHS Trust*,⁶⁹ with its application extending to non-medical cases.⁷⁰ It may, indeed, be regarded as having “(vanquished) all trace of the Bolam test from informed consent.”⁷¹ Nevertheless, there have been cases that have considered *Montgomery* where the courts have found in favour of the medical professionals.⁷²

However, the judgment is not without its critics. As Jonathan Montgomery⁷³ points out, the suggested separation of medical and non-medical decisions may prove unworkable, specifically indicating that as medical training includes communication skills, these should be judged in the same way as clinical skills. Montgomery maintains that the image painted of the doctor-patient relationship, in which the patient knows nothing, and the doctor provides the information, ignores the increased agency of patients in general, and the specific characteristics of Nadine Montgomery in this case.⁷⁴ His critique builds on an earlier paper, in which he suggests that the decision ‘infantilised’ the patient, and ignored the “complexities of clinical judgments.”⁷⁵ Additionally, Heywood and Miola identify several unanswered questions left by *Montgomery*, including its lack of detail regarding disclosure of alternative treatments, and its failure to recommend that doctors must ensure patient understanding.⁷⁶

⁶⁷ [2017] EWCA Civ 62

⁶⁸ [2018] EWHC 164 (QB)

⁶⁹ [2018] EWCA Civ 1307

⁷⁰ For example, in *O’Hare v Couetts & Co* [2016] EWHC 2224, where it was applied to a financial case

⁷¹ J-P Swoboda, ‘Bolam: going, going, gone....’ (2018) 1 *Journal of Personal Injury Law* 9

⁷² See, for example, *Holdsworth v Luton and Dunstable NHS Health Trust* [2016] EWHC 3347 (QB), In this case, the judge preferred the evidence of the surgeon to that of the claimant regarding the adequacy of consent.

⁷³ J Montgomery, ‘Patient No Longer? What Next in Healthcare Law?’ (2017) 70 *Current Legal Problems* 73

⁷⁴ *Ibid*, 93

⁷⁵ J Montgomery and E Montgomery, ‘Montgomery on Informed Consent: an Inexpert Decision?’ (2016) 42 *Journal of Medical Ethics* 89

⁷⁶ R Heywood and J Miola, ‘The changing face of pre-operative medical disclosure: placing the patient at the heart of the matter’ (2017) 133 *Law Quarterly Review* 296

Finally, the judgment in *Montgomery*, rather than being considered as ground-breaking, may be viewed as merely closing the gap between the law and professional medical guidance.⁷⁷ Indeed, some authors worry that the gap is now too small, and that professional ethics should strive to remain ahead of the law in this area.⁷⁸ Having considered the situation in medicine, I now turn to examine its veterinary counterpart.

3.4 Veterinary negligence and informed consent

In contrast to the many cases of risk disclosure available for analysis in medicine, fewer veterinary cases are available in general, with even less involving a failure to disclose risks. A single veterinary case, concerning an application for permission to appeal, involves risk disclosure as a major factor. *De Maynard v Streatham Hill Veterinary Surgery* was heard in 2001, therefore prior to *Chester* and *Montgomery*, in the Court of Appeal (Civil Division). The lower Court's decision had found for the defendant veterinary surgeon. The plaintiff sought damages for the loss of his dog, who died following an illness several months after receiving a second vaccination at the defendant's surgery. The claim was based on the veterinary surgeon's failure to warn the plaintiff (the dog's owner) of the risks of over-vaccination.

There were several problems in interpreting this case, not least that the reason for the dog's illness and death had not been confirmed. However, the main reference to risk disclosure cited the application of *Bolam* in *Sidaway*, and thus the plaintiff was refused permission to appeal. The presiding judge, Sir Anthony Evans, highlighted these cases in his decision:

.....as regards the failure to inform, the court has to apply the law as stated by the House of Lords in the case of *Sidaway* (....).... the question whether the

⁷⁷ See, for example, A Farrell, M Brazier 'Not so new directions in the law of consent? Examining *Montgomery v Lanarkshire Health Board*' (2016) 42 *Journal of Medical Ethics* 85. See also J Herring and others, 'Elbow Room for Best Practice? *Montgomery*, Patients' Values, and Balanced Decision-Making in Person-Centred Clinical Care' (2017) 25 *Medical Law Review* 582

⁷⁸ Heywood and Miola (n76)

professional was negligent in failing to explain the risks inherent in the operation or vaccination has to be determined by the application of the *Bolam* (...) test itself.(....).....Mr Hill could only be said to have been negligent in failing to explain the risks if either Dr De Maynard could show on the evidence that there is no body of reputable veterinary opinion or practice which would have failed to explain the risks, or if, secondly, he can say that the court should hold that it was clearly unreasonable for Mr Hill to fail to do so on this occasion.

As regards the first of those ways, it is quite clear on the evidence that there is indeed *a substantial body of expert opinion and practice* – it may be the general, indeed the overwhelming, body of opinion and practice – to the effect that *the risks are not explained before vaccinations of this sort are given.*⁷⁹

The *De Maynard* case confirms the alignment between decisions in medical and veterinary negligence cases at that time. In view of the judge's acceptance that it was perfectly valid to rely on medical case law as precedent, which was neither questioned nor qualified in the judgment, it is interesting to hypothesise how *De Maynard* might be decided now. Post-*Montgomery*, if relying on medical case law to the same extent as in 2001, and I would agree that this would be sensible for many reasons,⁸⁰ then in my opinion, the judge would be bound to find for the plaintiff and allow the appeal based on a failure to disclose risks.

A second veterinary case that mentions risk, although this time in a minor role, is the High Court decision in the case of *Glyn v McGarel-Groves*.⁸¹ Two veterinary surgeons were sued in negligence by the owner of a valuable dressage mare. The French dressage team's veterinary surgeon had administered an overdose of a steroid drug, causing the horse to

⁷⁹ *De Maynard* (n48) at 32-33 (my emphasis)

⁸⁰ The principal reason would be the lack of veterinary negligence case law, but another reason would be the similarity of the two professions regarding treatment offered.

⁸¹ *Glyn v McGarel –Groves* [2006] EWCA Civ 998

develop a chronic and incurable condition (laminitis) that led to her death.⁸² In the Queen’s Bench decision, the reference to risk disclosure supported the finding that the defendant, the home-based (English) veterinary surgeon, had a duty of care to the horse and to her owner. In defence, he claimed that he was attending in order to merely “observe” the treatment administered by the French dressage team’s veterinary surgeon.

As Forbes J noted,

..... his treatment was ...(…)... in breach of the duty of care that he owed to Mrs McGarel-Groves and was negligent(.....)..... It was also common ground that Mrs McGarel-Groves should have been warned of the risk of laminitis if it was proposed to administer any such treatment to Anna.⁸³

going on to state that:

.....Mr Glyn knew perfectly well that two different cortico-steroids were to be used, that Anna's back and each of her hocks were to be injected at the same time and that a “high” dose of cortico-steroids *would involve a sufficient risk* of laminitis to make it necessary to warn (in effect) Mrs McGarel-Groves.⁸⁴

By again applying *Montgomery*, and also by referring to the updated RCVS guidance,⁸⁵ the decision that the veterinary surgeon involved was negligent in not disclosing the risks of laminitis would be upheld if this case was decided now. These deliberations also reveal the complicated ownership/agency relationship involved in this case. The decision-maker was

⁸² Laminitis is a painful condition of the feet in horses, sometimes acquired following a severe infection, or the administration of steroids. This case subsequently went to the Court of Appeal and was decided in favour of the plaintiff, with the English veterinary surgeon sharing liability for the owner’s losses due to a breach of duty of care to observe the treatment and intervene as necessary. Damages were split 85:15 between the French and English vets.

⁸³ *Glyn* (n81) at 64

⁸⁴ *Ibid* at 65 (my emphasis)

⁸⁵ RCVS ‘Supporting Guidance’ <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/>> Which now refers to the requirement to disclose ‘common or serious risks’

the French team rider and trainer of the horse, the veterinary surgeon administering the treatment was the French team's veterinary surgeon, and the owner's veterinary surgeon was present only in a "monitoring" role.

A third veterinary case makes passing reference to risk disclosure, through giving a horse owner the option of having prophylactic antibiotic treatment administered to a mare following an abortion in order to prevent laminitis.⁸⁶ *Calver v Westwood Veterinary Group* is notable chiefly for the differing opinions expressed by experts for the opposing sides. Citing *Bolitho*, Brown LJ rejected the contention of the respondent's barrister that the case rested on a failure to disclose risks, rather than negligent diagnosis and treatment:

..... In a sentence, the argument is that Mr Hughes was obliged to consult the mare's owner (if only notionally), and to discuss with him the comparative risks and benefits of administering antibiotics (....) I would unhesitatingly reject this argument. In my judgment this case has nothing whatever to do with disclosure of risk and everything to do with diagnosis and treatment. It must be judged by reference to the *Bolitho* principle and by that principle it fails.⁸⁷

By holding that risk disclosure was not central to the case, Brown LJ did not need to address the issue of whether he agreed with Lord Browne-Wilkinson's exclusion of risk disclosure from the test in *Bolitho*. If the case was heard now, with the application of *Montgomery* and RCVS guidance, I consider that the case may be decided in favour of the horse owner, if the emphasis shifted to the disclosure of alternative treatments.

Analysis of the small number of veterinary cases reveals their reliance on the profession-centred approach to consent in medicine, based on *Bolam* and *Bolitho*, which considers that the type and level of risk disclosure can be measured by referring to a body of reasonable practitioners. If these cases had been heard post-*Montgomery*, it could be postulated that

⁸⁶ The development of laminitis can be linked to metritis, an infection of the uterus, which can follow an abortion or difficult foaling. Metritis could be prevented by the administration of antibiotic treatment.

⁸⁷ *Calver* (n48) at 36.

the outcome in at least two would have been different. *De Maynard* may have required the veterinary surgeon involved to have disclosed the risks of vaccination to the dog's owner, and *Glyn* may have been decided on the failure to disclose the material risk (of death) to the owner of a valuable horse. However, if professional guidelines are an indicator of intent (see 3.6.3), the veterinary profession seems reluctant to abandon *Bolam* just yet. Nevertheless, when both veterinary clients and modern medical patients can be considered as "consumers exercising choices,"⁸⁸ it seems that it will only be a matter of time before *Montgomery* is cited as the standard for risk disclosure in veterinary consent.

Consent involves more than just risk disclosure. Although many cases of medical negligence focus on risk disclosure as the primary requirement for the patient's informed consent, there are many other components of consent that combine to create a valid and informed consent, as was discussed in Chapter 1, Sections 1.0 and 1.2. I will now consider the factors beyond risk disclosure that have been key in relevant medical cases.

3.5 Medical negligence and the consent process

If informed consent in medicine is underpinned by respect for the autonomy of the patient, the next task is to consider how this can be operationalised in everyday medical and veterinary practice. This requires the analysis of cases that refer to the consent process beyond risk disclosure. Again, the cases analysed emanate from human medicine. For example, *Birch v UCL Hospital NHS Health Trust*⁸⁹ includes consideration of the components of an informed consent, specifically the offering of alternative treatments. Citing Lord Woolf in *Pearce*, Cranston J stated that, for the patient in this case:

...the duty to inform a patient of the significant risks will not be discharged unless she is made aware that fewer, or no risks, are associated with another procedure. In

⁸⁸ *Montgomery* (n64)

⁸⁹ [2008] EWHC 2237 (QB)

other words, unless the patient is informed of the comparative risks of different procedures she will not be in a position to give her fully informed consent to one procedure rather than another.⁹⁰

The *Montgomery* judgment reinforces the requirement to offer options, with Baroness Hale emphasising that:

..... it is not possible to consider a particular medical procedure in isolation from its alternatives.⁹¹

The offering of alternatives to surgical sterilisation is pertinent to both medical and veterinary contexts. In *Gold v Haringey Health Authority*,⁹² a case of failed sterilisation, the alternative that should have been offered was surgical sterilisation of the male partner rather than the female partner, for whom there was a higher risk of failure of the procedure. In *Blyth v Bloomsbury Health Authority*,⁹³ the plaintiff's successful claim in negligence for a failure to warn of the side-effects of a long-acting contraceptive injection was overturned in the Court of Appeal. For competent adults who are childless, doctors are reluctant to perform surgical sterilisation, primarily for the reason that the patient may regret the decision in the future (the chance of a successful reversal is less than 50%).⁹⁴ Therefore, with a multitude of options for effective contraception for human patients, it would be unusual for options not to be offered.

The situation is different for animal patients. Alternatives to surgery do exist, such as those available as long-term implants for male dogs to induce 'chemical castration', however,

⁹⁰ *Ibid*, at 74

⁹¹ *Montgomery* (n64) at 109E

⁹² [1988] QB 481. The case was originally found for the plaintiff, but was overturned on appeal, where a *Bolam*-based standard of disclosure of alternative treatments was applied to non-therapeutic procedures.

⁹³ [1993] 4 Med. L.R. 151. In this case, again, a *Bolam*-based standard of information disclosure was adopted, and it was decided that the plaintiff had been given information about alternatives.

⁹⁴ *Benn and Lupton* (n2) at 1324. However, these authors consider that the reluctance of doctors to perform sterilisation in these circumstances amounts to a paternalistic decision on their part.

clients are rarely offered alternatives to surgical sterilisation for their companion animals.⁹⁵ This may be for several reasons. First, the client is often the party who requests the procedure, so the veterinary professional may view the suggestion of alternatives as overly 'paternalistic'. Second, the use of long-term hormonal therapy may produce side-effects.⁹⁶ Finally, repeated use of chemical implants works out more expensive than surgery, which is often priced as a "loss leader," (see Chapter 4, Section 4.5), so veterinary professionals may make the decision on financial grounds, without involving the client. As will be discussed in Chapter 7, Section 7.6.4, it is doing the client a disservice if the veterinary professional decides what she may or may not be prepared to pay, limiting the discussion of alternatives based on financial constraints.⁹⁷

Regarding the timing and voluntariness of consent, the 2014 County Court judgment in *Holloway v DMC Optical Ltd. and another* found for the plaintiff on the basis of lack of informed consent. The case involved eye surgery, which led to post-operative complications. Bailey J referred to professional guidelines in his decision:

.....both experts are agreed that *the information documents and consent form should be presented to the patient at least 24 hours prior to surgery*. They agreed that any failure to do that is in contravention of the GMC Guidelines on Good Medical Practice and the Standards for Laser Refractive Surgery of the Royal College of Ophthalmologists. As for the claimant's assertion that she had no sight of the consent form except for minutes prior to the procedure, an assertion which I accept to be true, Mr. Watson says that this would constitute a material breach of duty of care.⁹⁸

⁹⁵ V Adams 'Attitudes to and Opinions of Dog Castration – Vet Survey Results' [2016] *Veterinary Times* (Peterborough, 21st November 2016) Adams found that only 52% of vets offered alternatives to surgical neutering to clients, although 61% of vets were aware of, and considered, alternatives.

⁹⁶ M Kutzler, A Wood, 'Non-Surgical Methods of Contraception and Sterilization' (2006) 66 *Theriogenology* 514 discuss side-effects to long-term hormonal therapy in both sexes.

⁹⁷ I propose that the client should be offered all reasonable alternatives, and it is up to the client to decide whether finances limit these choices. This proposal will be evaluated further in Chapter 8, Section 8.2.4

⁹⁸ *Holloway v DMC Optical Ltd. and another* (Central London County Court, 26 September 2014) at 80 (my emphasis)

A second recent case has reinforced the importance of appropriate timing of the consent process, while also introducing a requirement to ensure that named personnel are involved in carrying out the proposed treatment, if the patient indicates that this is important. *Jones v Royal Devon and Exeter NHS Foundation Trust*⁹⁹ was decided for the plaintiff, who suffered complications as a result of spinal surgery. The procedure was carried out by a surgeon other than the consultant whom the patient believed would be responsible for the surgery. In finding for the plaintiff, reference was made to *Chester v Afshar* by explaining that it was

an infringement of her right to make an informed choice as to whether, and if so when, and by whom to be operated on.¹⁰⁰

The change of surgeon was conveyed to the patient on the morning of the surgery. It was not clearly explained, and she was not given adequate time to consider the implications:

In the circumstances I consider that her decision to allow the operation to go ahead (and thus her consent to it) was not freely taken, and I find that the Defendant was in breach of its duty of care to her.¹⁰¹

Thus, medical case law has provided direction on the timing of the consent process, the offering of alternative treatments and the identification of particular personnel if deemed important by the patient. The right of the patient to indicate her choice of surgeon in *Jones* is endorsed by the NHS's move to make surgeon success rates available to patients.¹⁰² Originally devised as a means of improving patient safety, and providing increased patient choice,¹⁰³ there have been some unintended outcomes. For example, in the US healthcare system, surgeons with low risk-adjusted mortality rates may charge higher prices, and it is

⁹⁹ *Jones v Royal Devon and Exeter NHS Foundation Trust* (Exeter County Court, 22 September 2015)

¹⁰⁰ *Ibid*, at 70

¹⁰¹ *Ibid*, at 38

¹⁰² See, for example, RCSE 'Patient Care' <<https://www.rcseng.ac.uk/patient-care/surgical-staff-and-regulation/surgical-outcomes/>> accessed 9 September 2018

¹⁰³ Although in one study, 41% of patients would rather leave the choice of surgeon to their physician. See R Harris and J Mayberry, 'The impact of surgeon specific outcome data on patient choice.' (2014) 63 *Gut* A166

reported that higher risk patients with cardiac conditions receive conservative treatment rather than surgery.¹⁰⁴ As yet, there is no move to publish similar data in veterinary medicine, and in the absence of professional requirement, it is difficult to see what might incentivise individual practices to do this. The notion of charging more for lower mortality rates only applies to procedures that have high mortality rates (thus excluding elective procedures). Moreover, the profession has yet to fully embrace the correct protocol for clinical audit, with most reported audits judged to be of poor quality.¹⁰⁵ I therefore propose that choice of surgeon is, perhaps, not as important in the veterinary medical context, but that knowing who will perform the procedure may affect trust between the client and the veterinary professional, as will be discussed in Chapter 7, section 7.5.3.

3.6 Professional ethical guidance and consent

The sparse body of case law on veterinary negligence results in scant legal reference to consent, including risk disclosure, in the veterinary context. Thus, greater responsibility falls on the profession's regulatory body to guide veterinary professionals on how best to ensure that they obtain informed consent from clients.

An important difference between medicine (in the United Kingdom) and veterinary medicine is the contract-based, commercial aspects of the latter, a difference highlighted by the sparse references to financial obligations in the GMC and RCSE guidelines. For example, the GMC includes "any bills they will have to pay"¹⁰⁶ in the list of information that doctors must give patients, the only reference to payment in their consent guidance. The RCSE limits such information to those paying for private healthcare, advising that, "for private patients, costs

¹⁰⁴ E Burns and others 'Understanding the strengths and weaknesses of public reporting of surgeon-specific outcome data' (2016) 35 *Health Affairs* 415

¹⁰⁵ N Rose, L Toews, DSJ Pang, 'A systematic review of clinical audit in companion animal veterinary medicine,' (2016) 12 *BMC Veterinary Research* 40

¹⁰⁶ General Medical Council, 'Consent: Patients and Doctors Making Decisions Together' <<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent>> at 9J, p10

of treatment and potential future costs in the event of complications,”¹⁰⁷ should be discussed.

Conversely, the RCVS guidance devotes a whole section to fees.¹⁰⁸ The link between financial disclosure and consent is exemplified by the advice that “(c)lients should be furnished with sufficient information about the fees associated with treatment to be in a position to give informed consent to treatment.”¹⁰⁹

The College specifically links consent and contract in a later section on informed consent, using the phrase “Informed consent, which is an essential part of any contract....”¹¹⁰ Thus, the importance of fee discussion as part of the consent process is emphasised in several places in the veterinary code, and the College advises that estimated fees should be written on the consent form. When considering whether the contractual basis to treatment in veterinary medicine makes a substantial difference to claims involving a failure to obtain consent, compared with claims in negligence, it seems that similar standards are implied into the contract regarding the ‘duty of care’ towards the patient. In practice, therefore, the veterinary professional is required to use reasonable care and skill and has a duty to advise and disclose relevant information to the client.¹¹¹

3.6.1 Professional guidelines and the components of the consent discussion

To illustrate the latest advice from three professional bodies, the following table (Figure 3) compares the required components for consent listed by the GMC, the RCSE (post-*Montgomery*) and the RCVS. The reasons for choosing these organisations were explained in 3.0, with selection of the RCSE specifically because their guidance was updated as a reaction to the *Montgomery* judgment.

¹⁰⁷ RCSE ‘Consent: Supported Decision Making - a guide to good practice’ (2016) <<https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/>> at 4.1, p12

¹⁰⁸ RCVS (n85) S9.5 – 9.26

¹⁰⁹ Ibid, S9.8

¹¹⁰ Ibid, S11.2

¹¹¹ See Mulheron R, ‘Duties in Contract and Tort’, in Judith Laing and Jean V McHale (eds) *Principles of Medical Law* (4th edn, Oxford University Press 2017) 104-121.

When advising on the components of the consent discussion, the updated RCVS guidance has expanded the topics to be covered from four (treatment options, estimated fees, escalation of costs, and risks) in the previous guidance,¹¹² to a list that bears more similarity to that provided by the GMC. The comparative table below (Table 3) demonstrates the similarities and differences.

Component of consent	GMC 2008¹¹³	RCSE 2016¹¹⁴	RCVS 2018¹¹⁵
<i>Diagnosis/prognosis</i>	✓	✓	
<i>Options for treatment</i>	✓	✓	✓
<i>Nature and purpose of proposed investigation/treatment</i>	✓	✓	✓
<i>Potential benefits of treatment</i>	✓	✓	✓
<i>Risks of treatment</i>	✓	✓ material	✓ common/ serious
<i>The likelihood of success</i>		✓	11.2e*
<i>Personnel involved in care, and if any students involved</i>	✓	✓	11.1g*
<i>Right to refuse to take part in teaching or research</i>	✓		11.19*, 11.20* (research only)
<i>Right to seek a second opinion</i>	✓		✓ 9.3*
<i>Financial liabilities</i>	✓	✓	✓
<i>Conflicts of interest</i>	✓		✓ 2.2*
<i>Potentially beneficial treatments available elsewhere</i>	✓		✓
<i>Respect for patient/client autonomy</i>	✓	✓	
<i>Advice on lifestyle that may moderate the disease process</i>		✓	
<i>Potential follow-up treatment</i>		✓	

¹¹² RCVS (n85) S11.2 f-i

¹¹³ GMC (n106) at 9, 10

¹¹⁴ RCSE (n107)

¹¹⁵ RCVS (n85) S11.2 a-h

<i>Inviting questions, checking for concerns re diagnosis, treatment and costs</i>			✓
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*Table 3: Comparing the consent guidance produced by professional associations; here, the advice produced by the General Medical Council, the Royal College of Surgeons of England, and the Royal College of Veterinary Surgeons. *For the last-named, some of the guidance is not in the main “consent” section, so the exact location in the College’s Supporting Guidance is provided.*

Thus, from the table it can be seen that, although the updated RCVS guidance demonstrates some progress towards a more comprehensive approach to consent, together with some alignment with the guidance in medicine, there remains a gulf between medical and veterinary approaches to consent, particularly in the area of respect for the autonomy of the decision-maker.

3.6.2 The requirement to respect the autonomy of the patient/client

While the legal landscape of patient rights and an associated autonomy-based consent was taking shape in medicine, the move towards patient autonomy was already being promoted via the medical profession’s regulatory body and professional association guidelines. Indeed, the *Montgomery* judgment includes reference to the General Medical Council’s 2008 publication *Consent: patients and doctors making decisions together*. The GMC guidance firmly grounds the basis of consent in patient autonomy, requiring doctors to “respect patients’ decisions.”¹¹⁶ The use of the phrase, ‘You must’ before this requirement indicates that the GMC regards it as an overriding duty. The requirement is restated in the context of treatment refusal:

“You must respect a patient’s decision to refuse an investigation or treatment, even if you think their decision is wrong or irrational.”¹¹⁷

¹¹⁶ GMC (n106) at para 2.e, p6.

¹¹⁷ *ibid*, at para 43, p19

The GMC's consent guidelines specify the amount and type of information to be given to patients, requiring the doctor to cover these topics through the use of "you must."

In 2016 the RCSE updated its guidelines for surgeons, with the principal areas updated in light of *Montgomery* being the definition of material risks, and the move from doctor-centred to patient-centred decision-making. On giving patients choices, the guidelines present the case unambiguously:

"The *Montgomery* case has changed the focus of the consent process from one in which the surgeon would explain the procedure to the patient and obtain their consent to proceed, to one in which the surgeon sets out the treatment options and allows the patient to decide."¹¹⁸

There is also guidance on who should obtain consent and when the consent discussion should take place.

A further post-*Montgomery* set of guidelines was produced by the Association of Anaesthetists in Great Britain and Ireland (AAGBI) in January 2017.¹¹⁹ These guidelines incorporate the 'particular patient' standard for information disclosure:

"The amount and the nature of information that should be provided to the patient should be determined by the question: 'What would this particular patient regard as relevant when coming to a decision about which of the available options to accept?'"¹²⁰

¹¹⁸ RCSE (n107) at S4.6, 15

¹¹⁹ Yentis SM and others, 'AAGBI: Consent for Anaesthesia 2017' (2016) 72 *Anaesthesia* 93

¹²⁰ *ibid*, Recommendation 3, p2

Although suggesting the type of information that should broadly be given to patients during the consenting process, additional advice states that “the anaesthetist should be guided by what each particular patient wants to know, rather than a proforma list...”¹²¹

Thus, professional medical guidelines require similar areas for discussion to those suggested by the *Birch*, *Holloway*, *Jones*, *Chester* and *Montgomery* cases described previously in this chapter. They demonstrate a respect for patient autonomy that extends to respecting patients’ decisions that seem irrational.

The RCVS updated its guidance on “Communication and Consent” in March 2018.¹²² In several places, there is implicit reference to client autonomy, although without the use of such specific terminology. For example, in the Supporting Guidance on Veterinary Care, the veterinary professional is reminded to:

“...ensure that a range of reasonable treatment options are offered and explained, including prognoses and possible side effects; [and] ... recognise the need, in some cases, to balance what treatment might be necessary, appropriate or possible against the circumstances, wishes and financial considerations of the client.”¹²³

The requirement to consider the wishes of the client is stated more forcefully in a later section on qualified consent:

“... veterinary surgeons and veterinary nurses must accept that their own preference for a certain course of action cannot override the client's specific wishes, other than on exceptional welfare grounds.”¹²⁴

Thus, although the wishes of the client must be respected, these must be balanced with animal welfare and financial considerations. The RCVS guidance does not incorporate the

¹²¹ *ibid*, Table 2, p8

¹²² RCVS (n85). The updated supporting guidance on consent was launched on 29 March 2018 <<https://www.rcvs.org.uk/news-and-views/news/communication-and-consent-guidance-refined/>> accessed 15 May 2018.

¹²³ RCVS (n85) S2.2 b-d.

¹²⁴ *ibid*, S11.17

overriding message that the autonomy of the person giving consent must be respected, as is conveyed throughout both the GMC and RCSE guidelines. In comparison with those, I suggest that the RCVS's equivalent perhaps demonstrates, at most, a respect for client financial autonomy, as indicated in 3.5.

3.6.3 Requirements for risk disclosure

In considering risk disclosure, I will start with the RCSE guidelines, which have adopted the definition of a "material risk" from the *Montgomery* judgment. These guidelines emphasise the individuality of risks to each patient:

"What constitutes a material risk will vary from patient to patient. Therefore consent has to be patient-specific."¹²⁵

However, the RCVS adopts a more *Bolam*-based approach to risk disclosure, requiring that the person obtaining consent gives:

"..... a clear indication of both common and serious risks presented in a way that the client understands (e.g. explain any clinical terms)."¹²⁶

Despite producing their updated consent guidance post-*Montgomery*, the RCVS has avoided the use of the term 'material risks' and has instead used the phrase *common or serious risks*. It seems that the College's determination of what is regarded as a 'common or serious risk' for veterinary procedures would most likely rely on a *Bolam*-derived standard, and would therefore be based on a reasonable body of professional opinion.¹²⁷ This approach, in my opinion, is short-sighted, does not incorporate the latest medical thinking, and suggests that

¹²⁵ RCSE (n107) para 4.3, 14

¹²⁶ RCVS (n85) S11.2b

¹²⁷ I base this hypothesis on the RCVS's previous reliance on the *Bolam* standard for its disciplinary hearings. See also the RCVS's 'A Note on Negligence', which refers to an alleged breach of a duty of care being considered against 'the standards of the profession at that time' <<https://www.rcvs.org.uk/document-library/a-note-on-negligence/>> accessed 25th September 2018. Also note the judges' distinct separation of clinical and risk disclosure standards in *Montgomery* (n120).

the RCVS does not wish to completely align itself with equivalent medical professional guidance. If a case of alleged veterinary negligence based on a failure to disclose risks was decided in the courts, I would expect *Montgomery* to be applied. Therefore, I argue that the RCVS should have anticipated such a move, by changing its guidance to include reference to a 'reasonable client' basis for risk disclosure, and by referring to 'material risks'. I will return to the discussion of "material risks" in the context of non-therapeutic neutering in Chapters 7 and 8.

3.6.4 Personnel involved in obtaining consent

The frequency with which veterinary nurses are given the responsibility for admission of patients for procedures¹²⁸ invites reflection on their suitability for this role. Updated guidance from the RCVS addresses the delegation of responsibility for obtaining consent:

"... the veterinary surgeon can delegate the responsibility to someone else, provided the veterinary surgeon is satisfied that the person they delegate to:

- a. Is suitably trained, and
- b. Has sufficient knowledge of the proposed procedure or treatment, and understands the risks involved."¹²⁹

As mentioned in Chapter 1.1, the RCVS lists those to whom the delegation would be appropriate, from veterinary surgeons, through veterinary nurses to student veterinary nurses, subject to the provisos above.

In contrast, the RCSE's guidelines on surgical consent require that care is taken when delegating the responsibility for discussing options with the patient,

¹²⁸ For example, one large corporate practice, Vets4Pets, advises clients that "our vet nurses will often admit pets for investigations or surgery. During this appointment, they will walk you through the procedure and deal with any questions or concerns you might have." <<https://www.vets4pets.com/pet-health-advice/our-vet-nurses/>> accessed 28 August 2018

¹²⁹ RCVS (n85), at 11.3

“..... the discussion about options lies with the surgeon responsible for the patient’s care or, if this is not practical, with an experienced member of the surgical team who has the time and skill to gain sufficient understanding of the patient’s views and wishes and sufficient knowledge of the associated risks and complications.....”¹³⁰

Thus, the surgeons’ guidelines demand that the person taking consent has the experience, time and skill to ensure understanding. These requirements are more demanding than those for veterinary surgeons, or, indeed, for medical GPs. The GMC’s guidelines, on which the RCVS advice is based, state that consent can be delegated to those with suitable training and qualifications, provided that they have sufficient knowledge of the procedure and risks involved, and an understanding of the guidelines themselves.¹³¹

My interpretation of the RCVS guidance concludes that either veterinary surgeons or veterinary nurses would be regarded as suitable personnel to obtain consent for ‘routine’ treatment, such as elective (non-therapeutic) neutering procedures. However, the inclusion of student veterinary nurses is a concern. As students, these members of staff are not professionally registered, and therefore do not assume professional responsibility for their behaviour. I propose that, ideally, in practice, only registered (i.e. qualified) veterinary professionals should undertake the obtaining of consent from clients. However, I realise that in some practice settings, this will prove difficult. I acknowledge that student veterinary nurses who have received training in informed consent are more suitable personnel for obtaining consent than reception staff, to whom the responsibility is sometimes given (see Chapter 1.1).

3.6.5 The timing of the consent discussion

¹³⁰ RCSE (n107) at para 4.6, 15

¹³¹ GMC (n106) 15

With reference to the timing of consent discussions, the GMC guidelines state that doctors should:

“... share information in a way that the patient can understand and, whenever possible, in a place and at a time when they are best able to understand and retain it.”¹³²

However, the guidance for surgeons is more prescriptive regarding the timing of consent discussions, stipulating that patients should be:

“... given enough time to make an informed decision regarding their treatment ... (....)This may require that the discussion takes place over more than one session ... (....)... The process of consent should begin well in advance of the treatment....”¹³³

In both sets of guidelines, it is important to note that the use of the term “*should*” refers to principles that may not apply to every situation or set of circumstances.¹³⁴

The updated RCVS guidance contains a statement addressing the timing of consent, recommending that “for non-urgent procedures, the consent discussion should take place in advance of the day of the treatment/procedure where possible.”¹³⁵

Thus, both medical and veterinary guidance on the timing of consent indicate a preference for holding the discussion in advance of the procedure. Such advice is relevant for elective procedures, where there is no requirement to perform the procedure on a particular day. The issue of timing of the consent process for non-therapeutic neutering in veterinary practice will be addressed in Chapter 6.

¹³² *ibid*, at para 18a, p12

¹³³ RCSE (n107) at para 4.8, p17

¹³⁴ GMC (n106) 5

¹³⁵ RCVS (n85), S11.2

3.7 Comparison of veterinary and medical guidance on consent

Medical case law has seen the courts gradually move towards a recognition of patient autonomy similar to that evident in professional medical guidelines. Indeed, as Farrell and Brazier observe, the *Montgomery* decision may provide a “clear roadmap” for doctors to identify legal requirements for risk disclosure, complemented by ethical and professional requirements in the GMC guidelines.¹³⁶

However, as indicated in 3.3, there is a body of opinion that what *Montgomery* has achieved is simply an alignment of the law with existing professional guidance. As Heywood notes, “the ethics of the medical profession overtook the law some time ago.”¹³⁷ If this is the case, then medical professional guidance prepared the way for the legal requirement to respect patient autonomy.

A similar move in the veterinary context seems a remote possibility. The RCVS’s recently revised guidance on communication and consent fails to specifically address client autonomy, and it seems unlikely that change will be instigated via veterinary negligence case law. A sudden surge in veterinary negligence cases is improbable for several reasons. First, there is no incentive offered by the significantly lower awards (confined to the economic value of the animal only) for breach of the duty of care to an animal patient, coupled with the costs involved in bringing such a case to court.¹³⁸ Second, many cases have traditionally been settled out of court via professional indemnity insurers.¹³⁹ Finally, the successful introduction of a mediation and arbitration service by the RCVS in 2016 has led to an extension of the trial of the Veterinary Client Mediation Service, leading to even more cases being settled out of court.¹⁴⁰ If these alternative remedies to court actions result in

¹³⁶ Farrell and Brazier (n77) 85

¹³⁷ R Heywood, ‘R.I.P. Sidaway: patient-oriented disclosure - a standard worth waiting for? *Montgomery v Lanarkshire Health Board* 2015 UKSC 11’ (2015) 23 *Medical Law Review* 455, 466

¹³⁸ M Fox ‘Veterinary Ethics and Law’, in CM Wathes and others (eds) *Veterinary & Animal Ethics: Proceedings of the First International Conference on Veterinary and Animal Ethics*, September 2011 (Blackwell Publishing 2012)

¹³⁹ In 2015, the largest of these insurers dealt with approximately 1400 civil claims and regulator enquiries. Veterinary Defence Society, email to author, 29 October 2016

¹⁴⁰ Veterinary Client Mediation Service <<https://www.vetmediation.co.uk>> accessed 22 August 2018. In 2017-18, according to RCVS June 2018 Council papers, the VCMS was dealing with approximately 130 enquiries per month. Section 7e,

acceptable awards to those bringing claims (usually the animal owner), these act as a further disincentive to bring such claims to court. For *Montgomery* to have an impact on veterinary practice, it would require an owner to pursue a claim in court where a lack of respect for client autonomy was pivotal, and a monetary award regarded as insufficient recompense. As I have indicated in 3.6.3, I think that the courts in this situation would apply *Montgomery*, which would then require the RCVS to update their professional guidance. Thus, it seems that the veterinary profession is innately more conservative than its medical counterpart, with the 'leading role' of the GMC not being mirrored by the RCVS, which seems rather more reactive than proactive.

3.8 Is autonomy an appropriate basis for consent to veterinary treatment?

The lack of focus on respect for client autonomy in veterinary professional guidelines invites the question of whether autonomy is relevant when considering informed consent to the treatment of the animal patient. UK case law on patient autonomy and the doctrine of informed consent has developed within the context of a straightforward dyadic relationship between doctor (or health professional) and patient, who are increasingly represented as equal partners in the consent process. This contrasts with the triadic relationship existing between the veterinary professional, the owner and the animal patient. This, as Ashall and Hobson-West observe, "makes veterinary medicine ethically complex, especially when the welfare needs of the animal and the wishes of the owner come into conflict."¹⁴¹

This triadic relationship does not necessarily impact on the criteria which must be met for valid consent to be given. As Ashall and others¹⁴² have argued, consent in both human and

Preliminary Investigation Committee minutes 12 April 2018, p5, points 21-25 <<https://www.rcvs.org.uk/document-library/14-june-2018-unclassified-council-papers/>> accessed 22 August 2018

¹⁴¹ Ashall V, Hobson-West P, 'Doing Good by Proxy: Human-Animal Kinship and the 'Donation' of Canine Blood' (2017) 39 *Sociology of Health & Illness* 908, 913

¹⁴² Ashall V, Millar KM, Hobson-West P, 'Informed Consent in Veterinary Medicine: Ethical Implications for the Profession and the Animal "Patient"' (2018) 1 *Food Ethics* 247

veterinary medicine demands that treatment is freely chosen on the basis of appropriate information disclosure and adequate understanding. However, the objective of informed consent is different in each professional setting, since, as Ashall and others point out:

“Whilst medical consent protects a patient’s rights to make autonomous decisions concerning their own body, veterinary informed consent aims to protect an owner’s right to make autonomous decisions concerning their legal property.”¹⁴³

Although the owner could be considered as a “consumer exercising choices,” as described by the Supreme Court in *Montgomery*,¹⁴⁴ any obligation to respect the owner’s wishes is constrained by the veterinary surgeon’s paramount professional duty to provide treatment in the best interests of the animal. This duty is reemphasised in the section on ‘Veterinary Care’ in the RCVS Code of Professional Conduct, which advises that veterinary professionals should “.....make decisions on treatment regimes based first and foremost on animal health and welfare considerations....”¹⁴⁵ Additionally, the diversity of animal patients, as regards species,¹⁴⁶ use, and perceived value to their owners, may influence the ability or willingness of the animal owner to pay for veterinary treatment. And, finally, of course, virtually all veterinary treatment will be delivered as part of a commercial contract, paid for by the owner or their insurance company.¹⁴⁷ These financial considerations may, in turn, affect the relationships between veterinary professional, client and animal(s).

Restrictions placed on animal owners regarding the treatment of their ‘animal property’ will be discussed further in Chapter 4, Section 4.1, however failure to seek appropriate

¹⁴³ *ibid*, 255

¹⁴⁴ *Montgomery* (n64) at 75H.

¹⁴⁵ Royal College of Veterinary Surgeons, ‘RCVS Code of Professional Conduct’ <<http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/>> at 2.2c.

¹⁴⁶ Although human patients differ in terms of, for example, age, capacity and ethnicity, there is a more obvious “speciesism” in the world of animal treatment. We give different levels of legal protection to different species, and to different members of the same species. Rats can be killed in apparently inhumane ways for pest control, but their deaths are strictly regulated if they are used for research, and there are higher levels of justification required for using certain species of animal, such as primates, dogs and cats, in research. See Animals (Scientific Procedures) Act 1986.

¹⁴⁷ The only exception is treatment provided by a clinic run by one of the charities, such as the PDSA, Blue Cross or the RSPCA

treatment for an animal could result in the owner being prosecuted under the Animal Welfare Act.¹⁴⁸ Therefore, although the RCVS requires veterinary professionals to prioritise welfare, this needs to be balanced against the client's financial and other considerations. Thus, if animal owners are entitled to have their autonomous decisions respected, it is at best a 'constrained autonomy', with constraints being applied by welfare, finances, and the very nature of the veterinary surgeon-client-patient relationship.

3.9 Conclusion

Examination of the ethical foundations of a consent based on respect for the autonomy of the competent patient raised questions regarding the suitability of direct application to its veterinary counterpart, notwithstanding the use of precedent from cases of medical negligence in veterinary cases. Having compared the professional guidance given to doctors and to veterinary surgeons, it is clear that there is increasing alignment between the advice given to members of both professions regarding the content of consent discussions, the selection of personnel to be involved in obtaining consent, and the timing of the consent process. However, the emphasis on respect for patient autonomy in medical ethical guidance is not currently reflected in its veterinary counterpart. In addition to ethical constraints, the constraints on the autonomy of animal owners discussed in 3.8 may lead to the conclusion that it is not an appropriate basis for consent in the veterinary setting.

I will now address the use of beneficence as a basis for decision-making in other settings. Previous authors have underlined the similarity between decision-making for animals and paediatric decision-making.¹⁴⁹ Others have viewed our understanding of the role of the veterinary professional as a choice between paediatrician (where the animal patient is regarded as a member of the family) or garage mechanic (where the animal patient is

¹⁴⁸ Animal Welfare Act 2006

¹⁴⁹ See, for example, JR Shaw, CL Adams, BN Bonnett, 'What can veterinarians learn from studies of physician-patient communication about veterinarian-client-patient communication?' (2004) 224 *J Am Vet Med Assoc* 676; see also Ashall and others (n142)

regarded as the owner's property).¹⁵⁰ In order to consider an alternative to autonomy based on the approach taken in the paediatric setting, it is necessary to compare the contexts in which decisions are made for children and animals. From this point forward, I will replace the term 'beneficence' with its legal counterpart, 'best interests.'

In the next chapter, the fundamental differences between these patients' moral and legal status will be considered. Cases of medical decision-making for infants that involve disputes between parents, or between parents and professionals, will be examined. The reliance on 'best interests' as a basis for judicial decisions in these circumstances will be critically evaluated, with the aim of defining a 'best interests' approach suitable for use in the veterinary context, and specifically in the area of non-therapeutic neutering.

¹⁵⁰ Bernard Rollin (1999). *An Introduction to Veterinary Medical Ethics: Theory and Cases*. (2nd edn, Blackwell Publishing 1999) 27

CHAPTER FOUR: GIVING CONSENT ON BEHALF OF OTHERS - THE USE OF 'BEST INTERESTS' IN HEALTHCARE DECISION-MAKING FOR ANIMALS AND CHILDREN

4.0 Introduction

The previous chapter ended by questioning the place of autonomy in the context of consent to veterinary treatment. This chapter draws on comparisons made by other authors between veterinary surgeons and paediatricians,¹ examining whether a similar approach to consent to medical treatment for their patients is appropriate. Initially, I will consider the legal status of companion animals, comparing protection of rights with protection of interests. Examination of parental consent for the treatment of children will include an analysis of relevant case law. Cases where parental decision-making has been questioned, and has required resolution in the courts, illustrate the 'best interests' standard used when making healthcare decisions for young children. The tension between owner or parent autonomy and the best interests of the patient will be exemplified using non-therapeutic surgical procedures, with particular focus on their interference with bodily integrity.² Finally, the potential for using 'best interests' as a basis for decision-making on behalf of animals will be investigated, with specific application to the elective neutering of companion animals. I will argue that there is a place for balancing client autonomy with the best interests of the animal patient within the context of consent to veterinary treatment.

4.1 The legal status of the animal patient

Comparing medical treatment of animals and young children entails comparison of their legal status. Before considering the current status of animals that are owned by humans, it is useful to view this from a historical perspective.

¹See, for example, Bernard Rollin in *An Introduction to Veterinary Medical Ethics: Theory and Cases* (2nd edn, Blackwell Publishing 1999)

² The link between autonomy and bodily integrity was reinforced by Baroness Hale in *Montgomery v Lanarkshire Health Board* at 108C

Initially, only food or draught animals had status in law, in terms of being the subjects of theft or abuse. The value of an animal was decided solely in terms of the financial value to its owner. As only food or draught animals had financial value, these were the animals given legal protection against cruelty and ill-treatment via Martin's Act in 1822.³

Although societal views regarding which species deserve protection may have changed since the early days of animal protection legislation, it can be argued that priority is still given to the extrinsic value of an animal to its owner, rather than its intrinsic value as a moral being.⁴ This is perhaps most evident in cases of negligence involving animals, where the calculation of damages awarded is based mainly on the animal's extrinsic current value, or potential value, to its legal owner. Despite the existence of individual cases in other jurisdictions, especially the USA, in which additional damages were awarded for losses such as 'loss of companionship',⁵ such an approach does not seem to have spread, and indeed is not consistently applied in the United States.⁶ Even if additional damages are awarded, it is still the owner who benefits from the claim.

Notwithstanding the negative connotations of having only extrinsic value in the eyes of the courts, it could be posited that owned animals gain some advantages through being owned, despite their legal status as property. For example, animals owned by humans were given the legal protection against cruelty and abuse that was not afforded to their un-owned counterparts until 1996, through the introduction of the Wild Mammals Protection Act.⁷ More recently, the focus of the UK legislation that protects domestic animals from cruelty or

³ Mike Radford, 'The Nature of Animal Welfare' in *Animal Welfare Law in Britain: Regulation and Responsibility* (Oxford University Press 2001) 262-288

⁴ G Francione 'Taking Sentience Seriously' (2006) 1 *Journal of Animal Law and Ethics* 1, 7

⁵ See, for example, *Laporte v Associated Independents Ltd.* 163 So.2d 267 (Fla. 1964), *Knowles Animal Hospital v Wills* 360 So.2d 37 (Fla.App.,1978)

⁶ As discussed by Maneesha Deckha in 'Property on the Borderline: A Comparative Analysis of the Legal Status of Animals in Canada and the United States' (2012) 20 *Cardozo Journal of International & Comparative Law* 313

⁷ Wild Mammals Protection Act 1996. Prior to this legislation, although section 9 of the Wildlife and Countryside Act 1981 had prevented those species listed in Schedule 5 from being killed or injured, and the Badgers Act 1992 had given specific protection to badgers, there was no blanket anti-cruelty legislation in place for wild animals.

neglect has changed, from a negative approach (what an owner *cannot do* to an animal) to a more positive one (what an owner *must do* or *must provide* for an animal). This change has been enacted through incorporation of the fundamental requirements for animal welfare into Section 9.2 of the Animal Welfare Act 2006. Ownership of an animal now involves specific duties to provide for the animal’s basic needs, based on similar principles to the “Five Freedoms.”⁸ The Five Freedoms have been modified to describe the minimum standards of care for all owned animals in the Act; these are explained in Table 4 below.

Original Freedoms (as described by the Farm Animal Welfare Council)⁹	<i>Interpretation of needs in the Animal Welfare Act</i>
Freedom from Hunger and Thirst	<i>Need for a suitable diet</i>
Freedom from Discomfort	<i>Need for a suitable environment</i>
Freedom from Pain, Injury or Disease	<i>Need to be protected from pain, injury and disease</i>
Freedom to Express Normal Behaviour	<i>Need to be able to exhibit normal behaviour patterns</i>
Freedom from Fear and Distress	<i>Need to be protected from suffering, including (the) need to be housed with, or apart from, other animals</i>

Table 4: A comparison of the Five Freedoms with the welfare needs outlined in the Animal Welfare Act.

The provisions of the Act focus on the avoidance of negative welfare states, and provide principally for basic survival needs, a focus probably arising from their origins in standards of welfare for farmed animals. In seeking to extend the principles of the Five Freedoms to the provision of positive experiences, Mellor proposes that owners should seek to give animals “a range of opportunities to experience comfort, pleasure, interest, confidence and a sense of control.”¹⁰

⁸ These criteria were originally referred to in the report by the Brambell Committee, set up by the UK Government in 1965 to investigate farm animal welfare following the publication of Ruth Harrison’s book, *Animal Machines* (Vincent Stuart Publishers, 1964).

⁹ The earliest reference to the Five Freedoms is contained in a Press Release from the Farm Animal Welfare Council in December 1979, available at <<http://webarchive.nationalarchives.gov.uk/20121010012427/http://www.fawc.org.uk/freedoms.htm>> accessed 06 August 2018

¹⁰ DJ Mellor (2016) ‘Updating animal welfare thinking: moving beyond the “Five Freedoms” towards “A Life Worth Living.”’ *6 Animals* 21 <www.mdpi.com/journal/animals> doi:10.3390/ani6030021 accessed 01 August 2018

Although many ‘animal rights’ advocates regard ownership as a negative state for animals, it could be argued that the legal obligations placed on owners to provide for the Five Freedoms do offer owned animals some welfare advantages over un-owned animals. For example, wild animals may not always have access to sufficient food, or they may contract injuries or diseases that remain untreated and therefore cause suffering.¹¹ The obligations placed on animal owners via the Act should, at least, ensure that animals have adequate nutrition and shelter, and treatment for illnesses or injuries.¹² Animals face risks if found as injured strays. For example, treatment may be delayed while owners are sought, or decisions for euthanasia may be taken rather more hastily. The RCVS advises that “lost or stray animals presented to a veterinary practice may be (...) ill or injured and require first aid and pain relief, which could include euthanasia.”¹³ Interestingly, it urges caution in undertaking “significant procedures with lasting effects, e.g. neutering.”¹⁴ Therefore, neutering *stray* animals requires careful thought, but only because the animal may have an owner.¹⁵

The Animal Welfare Act requires owners to provide veterinary treatment, and to ensure that the animal is “protected from pain, suffering, injury and disease.”¹⁶ However, there is no mechanism to require owners to comply with veterinary advice. In similar situations involving children, the Children Act 1989 requires parental compliance through civil court orders.¹⁷

¹¹ See, for example, David De Grazia, *Taking Animals Seriously: Mental Life and Moral Status* (Cambridge University Press, 1996) 295. De Grazia regards competent veterinary care, leading to longer life for animals in zoos, as a benefit, but balances this with psychological harms.

¹² *ibid*, 274. De Grazia regards special relationships that humans have with animals as the basis of positive obligations, such as the provision of basic needs, and a life that is at least comparable to the one which the animal would have if it was not a pet

¹³ RCVS ‘Supporting Guidance’ <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/>> at 29.31

¹⁴ *ibid*

¹⁵ The RCVS advises that stray animals should be checked for microchips and kept for sufficient time to allow owners to be sought.

¹⁶ Animal Welfare Act, S9.2(e)

¹⁷ The RSPCA will, however, often issue improvement notices to owners, rather than prosecuting them, which has some parallels with Specific Orders issued for parents, although the RSPCA notices are non-statutory (76460 improvement notices

Initially, the Animal Welfare Act's 'positive duties' approach to animal welfare produced relatively few convictions, although the situation seems to be changing, according to latest figures from the Royal Society for the Prevention of Cruelty to Animals (RSPCA). Convictions for 'causing, permitting or failing to prevent unnecessary suffering' peaked between 2010 - 2012, and have since fallen to 821 in 2017, while the number of convictions for 'failing to ensure the needs of animals are met' rose from around 100 in 2010 to 741 in 2015, before dropping again to 554 in 2017.¹⁸ There is, inevitably, some crossover between failing to ensure that the animal is free from pain, injury and disease, and causing unnecessary suffering; indeed, many defendants face charges under both Sections 4 and 9 of the Animal Welfare Act.¹⁹ Thus, owners have both positive and negative duties towards animals, reinforcing an approach that protects animals' interests in not being harmed, while promoting their entitlement to adequate care. A more radical approach to these duties would place stronger obligations on owners, for example, by giving animals the *right* to be protected from harm, and the *right* to be provided with adequate care. Nevertheless, the change in focus of welfare legislation from negative to positive duties can be considered as progressive. I now turn to consider how this could be progressed further.

4.2 The duties of those with responsibility for animals and children

The problems identified with the property status of animals, and with the term 'ownership,' have caused many of those concerned with animal rights and animal protection to propose various options for changing this status.

There have been attempts in other jurisdictions, particularly in the USA, to reclassify animals as more than just property, i.e., to give them enhanced legal status. While some authors

were issued in 2017, vs. 1490 prosecutions) See RSPCA 2017 Prosecutions Report <<https://view.pagetiger.com/RSPCA2017PR/RSPCA2017prosecutionreport>> 32 accessed 06 August 2018

¹⁸ *ibid*, 33, Table 4

¹⁹ *ibid*, see case studies

propose that animals should be legal subjects, rather than legal objects,²⁰ there is little prospect of such a change, in view of the criteria required to be considered as a legal subject.²¹ Of course, this depends on which definition of 'legal subject' is used. According to Naffine,²² legal persons can exist in three forms, from an inclusive, abstract, law-defined construction (which could include animals), through a 'legal human' entitlement from birth to death, to a rational and responsible human legal agent.

Whichever definition of legal personhood is chosen, animals are excluded from the second and third types of legal person, while children are excluded from the third. The first definition is inclusive. It allows the law to define what it intends the legal person to be, but it avoids having to build a metaphysical conception of a person, potentially, therefore, including animals.²³ With the second definition, children become legal persons at the moment of birth,²⁴ simultaneously acquiring an entitlement to rights. Some of these rights are universal (e.g., the right to life), and some are particular to children (e.g., the right to education, rights of protection).²⁵ The rights of parents to make decisions on behalf of a child are secondary to protecting the rights of the child; indeed, parental rights are subsumed under 'parental responsibilities' in the Children Act in England.²⁶ However, parental authority wields considerable power, with parents retaining rights over decision-making for their children up to the point that their decisions put the child "at least at risk of significant harm."²⁷ Sometimes, children may need protection from their parents.²⁸ Young children's rights initially prioritise protection of their welfare or interests, but gradually

²⁰ WA Adams (2009) Human Subjects and Animal Objects: Animals as "Other" in Law 3 *Journal of Animal Law and Ethics* 29

²¹ See, for example, S Lindros-Hovinheimo, 'Excavating Foundations of Legal Personhood: Fichte on Autonomy and Self-Consciousness' (2015) 28 *Int J Semiot Law* 687, 689. She describes the "tenuous relationship between participation and protection," and concludes that children and disabled humans are legal subjects because of their potential for autonomy (at 701) but that animals are problematic.

²² N Naffine, 'Who Are Law's Persons? From Cheshire Cats to Responsible Subjects' (2003) 66 *Modern Law Review* 346

²³ *Ibid*, at 350

²⁴ Jo Bridgeman, *Parental Responsibility, Young Children and Healthcare Law* (Cambridge University Press 2007) 14

²⁵ *Ibid*, 15-16

²⁶ Section 3 of the Children Act 1989 describes parental responsibility as "the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property."

²⁷ J Bridgeman, 'The provision of healthcare to young and dependent children: the principles, concepts, and utility of the Children Act 1989' (2017) 25 *Medical Law Review* 363, 365

²⁸ See J Montgomery, 'Children as Property?' (1988) 51 *Modern Law Review* 323 at 324

evolve to protect their will or choices as they attain capacity to make their own decisions; thus, the rights of younger children are fashioned to protect the autonomy of their future selves.²⁹

In contrast, with animals, there is no concept of a future autonomous self, at least from the perspective of their human owners. Animals are not regarded as being on a 'journey to autonomy.' In fact, any attempt on the part of an animal to indicate choice is frequently interpreted as a problem by those who own or treat them (see section 4.3.1 on ascertaining the wishes of the animal patient). Regan, however, maintains that animals have capacity for what he terms "preference autonomy," in that they have the ability to make choices.³⁰ Of course, animals have limited opportunity to display this form of autonomy, and therefore to earn consideration as being worthy of rights. As Peters observes, animals could be initially be given rights that are "founded in interests," while allowing for emerging research that substantiates their ability to choose, and therefore provides evidence for rights that are based on choices.³¹ Alternatively, Mellor suggests that the Five Freedoms could be regarded as rights, in view of the similarity of the language used in the descriptions of the freedoms and in the UN Universal Declaration of Human Rights.³²

In light of the problems involved with reclassifying animals as legal subjects, many authors have suggested a change in status that does not require their consideration as legal subjects. These proposals range from giving animals a degree of "equitable self-ownership," where the relationship between owner and animal is more of a custodial one,³³ through regarding owners as 'guardians' of animals' best interests,³⁴ to reclassifying animals as 'sentient' or

²⁹ Bridgeman (n24) at 10; also see S Brennan, 'Children's choices or children's interests: Which do their rights protect?' In D Archard, C Macleod, eds, *The Moral and Political Status of Children* (Oxford University Press 2002)

³⁰ Although he differentiates this from Kantian autonomy which is associated with moral and legal agency. Regan T, *The case for animal rights*. (2nd edn, University of California Press 2004) 85-86

³¹ A Peters, 'Liberté, Égalité, Animalité: Human-Animal Comparisons in Law' (2016) 5 *Transnational Environmental Law* 25, 43

³² Mellor (n10) at 4

³³ D Favre, 'Equitable self-ownership for animals' (2000) 50 *Duke Law Journal* 473; see also BJ Bearup, 'Pets: Property and the Paradigm of Protection' (2007) 3 *Journal of Animal Law* 173

³⁴ D Sullivan and H Vietzke, 'An Animal Is Not an iPod' (2008) 4 *Journal of Animal Law* 41

'living' property.³⁵ In some US states,³⁶ changes in terminology from 'owner' to 'guardian' have been enacted.³⁷ Self-description by those who keep animals as 'guardians', rather than 'owners', is often accompanied by better attitudes towards animals and their care, suggesting that a move to guardianship is a positive one for animals.³⁸ If many of us, including the researcher, regard animals as family members,³⁹ then it makes sense to reclassify owners as 'guardians', thus ensuring higher levels of care for those animals that are part of our family circle.

Perhaps surprisingly, even this change in nomenclature has proved controversial. For example, in 2007 the American Veterinary Medical Association (AVMA) changed its advice on consent by removing the adjective 'informed', because of a perceived association of informed consent with guardianship. The AVMA feared the threat of higher awards in cases of negligence if the term 'informed consent' was retained.⁴⁰ Many agree with this stance, regarding the reclassification of animals' status in law as a path to higher monetary awards in such cases.⁴¹ In the UK, the BSAVA queried the use of the term 'guardians' in its response to the publication of the Review and Recommendations for Developing an England-Wide Strategy for Dogs.⁴² However, more recently, the BVA's first strategy for Animal Welfare includes the statement that "a comparison [of veterinary surgeons] with paediatricians is relevant."⁴³ The BVA's document therefore provides indirect support for the notion of guardianship in the UK, despite the concerns of its sister organisation. My personal views

³⁵ D Favre, 'Living Property: a New Status for Animals Within the Legal System' (2010) 93 *Marquette Law Review* 1021

³⁶ For example, many municipalities in California, and Rhode Island

³⁷ Deckha (n6)

³⁸ P Carlisle-Frank and JM Frank 'Owners, Guardians and Owner-Guardians: Differing Relationships with Pets' (2006) 19 *Anthrozoos* 225

³⁹ For example, in Charles N, Davies CA, 'My Family and Other Animals: Pets as Kin' (2008) 13 *Sociological Research Online* 1, a sociological study of families, a significant proportion of interviewees included pets in their kinship network.

⁴⁰ American Veterinary Medical Association, "Informed consent" versus "owner consent," (2007) AVMA News <<https://www.avma.org/News/JAVMANews/Pages/071215d.aspx>> accessed 06 August 2018

⁴¹ MS Roukas, 'Determining the Value of Companion Animals in Wrongful Harm or Death Claims: a Survey of US Decisions and Legislative Proposal in Florida to Authorize Recovery for Loss of Companionship' (2007) 3 *Journal of Animal Law* 45; SJ Hankin, 'Making Decisions About Our Animals' Health Care: Does It Matter Whether We Are Owners or Guardians?' (2009) 2 *Stanford Journal of Animal Law and Policy* 1

⁴² All-Party Parliamentary Group for Animal Welfare Sub-Group for Dogs, *Review and Recommendations for Developing an Effective England-wide Strategy for Dogs* (The Stationery Office Ltd. 2014) 37

⁴³ British Veterinary Association, *Vets speaking up for animal welfare: BVA animal welfare strategy* (BVA 2016) 20

support the reclassification of animal owners as guardians of the animal's interests, and the move to give animals more than property status, perhaps even supporting their acquisition of legal personhood. Nevertheless, I appreciate that this would require a mechanism that ensures protection of the animal's interests in cases where the guardian makes a decision that is contrary to these interests. This leads to the question, what are an animal's interests?

4.3 Animal interests and 'welfarism'

Suggesting that animals should have rights requires a comprehensive and extensive reassessment of their use, which is beyond the scope of this thesis.⁴⁴ In accepting the current legal situation that animals do not have rights and are unlikely to achieve them in the near future, but also desiring that animals are viewed as more than property, I must investigate ways of protecting their interests. As discussed in 4.1, welfare legislation is one means of protecting interests, albeit it can be considered as a narrow approach that focuses mainly on the interest in not suffering. The Animal Welfare Act requires that a person with responsibility for an animal ensures that "the needs of an animal for which he is responsible are met to the extent required by good practice,"⁴⁵ although 'good practice' is not defined and would require consensus regarding the 'reasonable' animal owner. However, it is possibly the simplest way to protect interests, even with these limitations.

The term 'welfarism' has been used to describe the approach of those who wish to improve the protection of animals, while rejecting the idea of rights; such an approach has been accused of perpetuating the lower moral value of nonhuman animals, and supporting their legal status as property.⁴⁶ Welfarism has also been charged with regarding animals as instrumental, i.e., they can legitimately be used by humans, for a variety of purposes, as long

⁴⁴ See, for example, Tom Regan, 'The Case for Animal Rights' in MW Fox, LD Mickley (eds), *Advances in Animal Welfare Science 1986/87*, vol 3. (Springer 1987) and Tom Regan and Peter Singer (eds), *Animal Rights and Human Obligations* (2nd edn, Prentice Hall 1989)

⁴⁵ Animal Welfare Act 2006, S9.1

⁴⁶ GL Francione, 'Animal welfare and the moral value of nonhuman animals' (2010) 6 *Law, Culture and the Humanities* 24

as pain and suffering are minimised during such use.⁴⁷ Depending on which point of view is utilised, welfarism either 1) provides legal sanctions for the exploitation of animals, i.e., has negative connotations,⁴⁸ or 2) provides some compensation for the removal of animals' choice and liberty through domestication by preventing harm.⁴⁹

Opponents of welfarism argue that by continuing to legislate for animal welfare, through creating a legal obligation not to cause harm to animals while using them for sport, food or research, we condone such use. However, a legal objective duty (for humans) not to treat animals cruelly does not automatically give animals the "right" not to be treated cruelly; there is still a wide gap between the two.⁵⁰ In fact, many pieces of animal welfare legislation, including the UK's Animal Welfare Act, include the offence of allowing 'unnecessary suffering', thereby implying that there is a necessary version. Suffering is considered as necessary if it is carried out "in compliance with any relevant enactment or any relevant provisions of a licence or code of practice issued under an enactment."⁵¹ This definition seems to fit with the views of Francione and Satz regarding the provision of legal sanctions for animal exploitation. Those accused of causing 'unnecessary suffering' need to show, in their defence, that a reasonable body of animal owners in their situation would have acted identically (the 'objective' test).⁵²

Thus, there is a legal acceptance that animals may suffer in the course of their use by humans, but that any suffering must be 'necessary', and also that there is a 'reasonable' version of the animal owner, against whom others can be judged. However, it may prove difficult to categorise the 'reasonable' animal owner. One option is to utilise the description

⁴⁷ As suggested by R Haynes in 'Competing Conceptions of Animal Welfare and Their Ethical Implications for the Treatment of Non-Human Animals' (2011) 59 *Acta Biotheoretica* 105, at 106

⁴⁸ Gary Francione, *Animals as Persons: Essays on the Abolition of Animal Exploitation* (Columbia University Press 2008) 30-36; see also AB Satz, 'Animals as Vulnerable Subjects: Beyond Interest-Convergence, Hierarchy and Property' (2009) 16 *Animal Law* 65

⁴⁹ Kevin Dolan, *Ethics, Animals and Science* (Blackwell Publishing 1999) 144

⁵⁰ Peters (n31) at 43

⁵¹ Animal Welfare Act 2006, s4.3b

⁵² Radford (n3) 245-258

of a 'responsible' animal owner⁵³ where the use of preventative health treatment, including neutering,⁵⁴ and prevention of roaming are regarded as key features of responsibility. The categories chosen for these studies suggest that the most important responsibility of the human owner is to prevent the animal from causing a nuisance to other humans and other animals. Whilst acknowledging these duties to society, I contend that the responsibility of an owner extends beyond prevention of harm/nuisance to others, and that it primarily involves protecting the animal's interests.

4.3.1 Protection of interests and 'best interests'

In addition to legal obligations to provide for their animals' basic needs, and to prevent suffering, owners may be considered to have moral obligations to protect the interests of their companion animals, by virtue of the relationship that they have with these animals.⁵⁵ Regardless of a companion animal's moral or legal status, it is the relationship between the animal and the caregiver (usually the animal's owner) that is fundamental to making decisions on a 'best interests' basis. Beverland and others' study found two main variations of the human-companion animal relationship, the first involving owners who see pets as "loved family companions that are valued for who they innately are,"⁵⁶ and the second involving owners who consider pets as "a self-project,"⁵⁷ for example, as toys, status symbols or brands. This study therefore contrasts those who consider pets as beings and those who see them as possessions. Hirschman's investigation into the human-companion animal relationship added a third category – the animal as a friend.⁵⁸ These categories have

⁵³ See, for example, LA Selby and others, 'A Survey of Attitudes Toward Responsible Pet Ownership.' (1979) 94 *Public Health Reports* 380 and Rohlfs and others (n102)

⁵⁴ For example, McKay and others identify the overpopulation of dogs and cats and their effects on native fauna as reasons for "responsible" owners in New Zealand to have their pets sterilised. SA McKay, MJ Farnworth, NK Waran, 'Current Attitudes Toward, and Incidence of, Sterilization of Cats and Dogs by Caregivers (Owners) in Auckland, New Zealand' (2009) 12 *Journal of Applied Animal Welfare Science* 331

⁵⁵ S Cooke, 'Duties to Companion Animals' (2011) 17 *Res Publica* 261. Cooke identifies three sources of moral obligation to companion animals, based on their status as property, as participants in caring relationships and as 'sentient beings with a good of their own'.

⁵⁶ MB Beverland, F Farrelly, EAC Lim, 'Exploring the Dark Side of Pet Ownership: Status- and Control-Based Pet Consumption' (2008) 61 *Journal of Business Research* 490, 491

⁵⁷ *ibid*, at 493

⁵⁸ EC Hirschman, 'Consumers and Their Animal Companions' (1994) 20 *Journal of Consumer Research* 616

parallels in the study by Rötzeimer-Keuper and others,⁵⁹ which is revisited in Chapter 8, section 8.4.1.

Turning to studies that specifically address dog-human relationships, Dotson and Hyatt examined various aspects of dog ownership. These authors found that acknowledgement of a 'symbiotic' relationship, with mutual benefits to both parties, was higher in dog owners under 35 years of age, thus indicating a "more recent societal phenomenon of increased involvement with and indulgence of dogs."⁶⁰ Other studies have documented the historical stages through which the human-dog relationship has moved, from a master-slave relationship, through employer-employee, to human-child or friendship-based.⁶¹ Focusing on the latter stage, Schicktanz describes one type of human-animal relationship as a "friendship model," requiring that the human provides for basic needs and veterinary care; she also defends an ethical basis for partiality towards these animals.⁶² In the latter example, the animal owner *should* be best placed to advocate for the animal's interests.

Protection of interests, however, involves more than just prevention of harm or suffering. There is a difference between 'preference interests' which promote positive emotional states and 'welfare interests' which provide for basic needs.⁶³ In the UK, welfare interests, which are protected under the Animal Welfare Act, are objectively defined through the listing of the Five Freedoms.⁶⁴

It is, however, more challenging to provide for animals' preference interests. With current levels of knowledge about cognition in many animal species, it is difficult to ascertain their

⁵⁹ Rötzeimer-Keuper J and others, 'Triadic Relationships in the Context of Services for Animal Companions' (2018) 85 *Journal of Business Research* 295

⁶⁰ MJ Dotson and EM Hyatt, 'Understanding Dog-Human Companionship' (2008) 61 *Journal of Business Research* 457, 463

⁶¹ See, for example, K Hens, 'Ethical Responsibilities Towards Dogs: an Inquiry Into the Dog-Human Relationship' (2008) 22 *Journal of Agricultural and Environmental Ethics* 3

⁶² S Schicktanz, 'Ethical considerations of the human-animal relationship under conditions of asymmetry and ambivalence' (2006) 19 *Journal of Agricultural and Environmental Ethics* 7

⁶³ Regan (n30) 87

⁶⁴ Farm Animal Welfare Council 'Press release – Five Freedoms' <<http://webarchive.nationalarchives.gov.uk/20121010012427/http://www.fawc.org.uk/freedoms.htm>>. See Table 4

wishes or test their preferences.⁶⁵ Nevertheless, Wise argues that many animals are capable of expressing what he calls ‘practical autonomy’, which consists of having desires, being able to act intentionally to try to fulfil these and having a sense of ‘self’.⁶⁶ Companion animals can appear to react to any proposed treatment by showing aggression, which could be regarded as a form of ‘dissent.’⁶⁷ However, it is only in rare cases that the animal’s preferences are taken into consideration. For example, in research, animal preferences are recognised in studies that are specifically designed to define preferences; in other studies, animals that are resistant to frequent handling and treatment may be excluded from participating on welfare grounds.⁶⁸ In the context of veterinary practice, a more common reaction to such ‘dissent’ is behavioural modification, through training, desensitisation, and the use of food rewards, to persuade a reluctant animal patient to acquiesce to the treatment decided by the humans involved.⁶⁹ If the situation is more urgent, then the patient may be administered sedatives to enable treatment to be given.⁷⁰ Thus, it is common to promote the animal’s health interests above other welfare interests; indeed, this may be a reason for prioritising human decisions over animal decisions, in what Yeates terms a “benevolently paternalistic” approach.⁷¹

This contrasts with the stated aim of ‘best interests’ calculations for human patients unable to consent. For such patients, ‘best interests’ no longer equates merely to ‘best medical

⁶⁵ See, for example, T Beckers, J De Houwer, DM Dwyer, ‘Reasoning Versus Association in Animal Cognition: Current Controversies and Possible Ways Forward.’ (2016) 130 *Journal of Comparative Psychology* 187 and RC Shaw and M Schmelz, ‘Cognitive Test Batteries in Animal Cognition Research: Evaluating the Past, Present and Future of Comparative Psychometrics’ (2017) 20 *Animal Cognition* 1003. Both papers explore the difficulties in conducting this type of research.

⁶⁶ Steven Wise, ‘The Capacity of Non-Human Animals for Legal Personhood and Legal Rights’ in R Corbey and A Lanjouw (eds), *The Politics of Species: Reshaping our Relationships with Animals* (Cambridge University Press 2013) 243. Wise recognises possession of practical autonomy as being sufficient for level one legal personhood and level two basic liberty rights.

⁶⁷ For further discussion on whether animals can indicate preferences, see H Kantin and D Wendler, ‘Is There a Role for Assent or Dissent in Animal Research?’ (2015) 24 *Cambridge Quarterly of Healthcare Ethics* 459

⁶⁸ *ibid.*

⁶⁹ K Moffat, ‘Addressing Canine and Feline Aggression in the Veterinary Clinic’ (2008) 38 *Veterinary Clinics of North America* 983

⁷⁰ See, for example, K van Haaften and others ‘Effects of a single preappointment dose of gabapentin on signs of stress in cats during transportation and veterinary examination’ (2017) 251 *Journal of the American Veterinary Medical Association* 1175

⁷¹ J Yeates, ‘Why Keep a Dog and Bark Yourself? Making Choices for Non-Human Animals’ (2018) 35 *Journal of Applied Philosophy* 168, at 174. Yeates does, however, later point out that animals’ choices may be unachievable *because* of the constraints we place on them.

interests.⁷² Since the decision in *Airedale NHS Trust v Bland*,⁷³ the ‘best interests’ standard for humans has evolved. Primarily as a result of the Mental Capacity Act 2005 it is now necessary to incorporate the patient’s previously stated wishes and values in any decisions where possible.⁷⁴ The decision of the Supreme Court in *Aintree University Hospitals NHS Foundation Trust v James*,⁷⁵ which can be thought of as a ‘landmark’ case, clarified the thinking in cases of end-of-life care for a patient without capacity.⁷⁶ Lady Hale’s judgment raised several important questions. The first concerned the balance between the patient’s ‘best interests’ in receiving treatment to prolong life, versus their interests in *not* having severely invasive treatment that is not beneficial. Second, it was argued that the correct question for the courts was whether it should give consent for treatment that may or may not be in the patient’s best interests, rather than whether treatment should be withheld. Finally, the judgment prioritised the subjective interpretation of quality of life for an individual patient, rather than its interpretation for a ‘reasonable patient.’

The subjective interpretation of quality of life is more difficult to apply to cases involving young children or animals, where the decision-maker is not the patient. Such cases may require an objective approach, as the patient’s previously expressed wishes, opinions and values will not be known, except through interpretation by a parent or owner. There is a difference, of course, when considering older children who may be able to express their wishes, and whose consent can be accepted when they are able to understand the proposed treatment.⁷⁷ Thus, an important question when deciding best interests for different

⁷² J Coggon ‘Mental capacity law, autonomy and best interests: an argument for conceptual and practical clarity in the Court of Protection’ (2016) 24 *Med LR* 396

⁷³ [1993] AC 789.

⁷⁴ Coggon (n72) at 409.

⁷⁵ [2013] UKSC 67

⁷⁶ I Wise ‘Withdrawal and withholding of medical treatment for patients lacking capacity who are in a critical condition – reflections on the judgment of the Supreme Court in *Aintree University Hospitals NHS Foundation Trust v James*. (2014) 82 *Medico-Legal Journal* 144. Wise based this description on it being the first case under the Mental Capacity Act 2005 to reach the highest court, and its first opportunity to consider such a case since *Bland* in 1993.

⁷⁷ Although their consent to treatment can be accepted, following case law such as *Gillick v West Norfolk and Wisbech AHA* [1985] 3 All ER 402, children’s refusal of treatment that is deemed to be in their ‘best interests’ cannot. See S Woolley, ‘The limits of parental responsibility regarding medical treatment decisions’ (2011) 96 *Arch Dis Child* 1060

categories of patient lacking capacity to consent is whether the patient has had capacity in the past, or has never had capacity. The latter applies to young children and animals.

In attempting to protect the interests of patients who have never had capacity, a simple solution may be to employ an approach that prioritises the ‘avoidance of harm’. Such an approach attempts to maximise the patient’s interests in remaining in good health, not being harmed and not suffering pain. However, this approach is reminiscent of the narrow ‘welfarist’ approach discussed in 4.3, and it involves maximal application of ‘benevolent paternalism’ as described by Yeates.⁷⁸ Moreover, the avoidance of harm has been rejected as a basis for making decisions for terminally ill babies and young children, as will be considered in 4.4.

Therefore, I consider that this approach would be equally inappropriate for calculating ‘best interests’ in animals, given my previous argument that best interests involve more than just avoiding pain and suffering. When considering the ‘best interests’ of animal patients in subsequent discussions, I will presume that their interest in not suffering is paramount, but that a focus solely on harm avoidance can result in animals leading unfulfilled lives, albeit free from pain.⁷⁹ A more holistic understanding of interests is therefore required. In proposing that a comparison of decision-making for companion animals with decision-making for young children is valid, the case law surrounding healthcare decision-making for children provides a rich source of varied approaches, although ultimately it may not provide a solution.

4.4 Decisions regarding healthcare for children

⁷⁸ Yeates (n71)

⁷⁹ One feature that may be missing from a “harm avoidance” approach is the dignity of the animal. See R Humphreys, ‘Dignity and its violation examined within the context of animal ethics’ (2010) 21 *Ethics & The Environment* 143

Many cases have involved decision-making for children with life-limiting conditions. High-profile cases, such as those involving Charlotte Wyatt⁸⁰ in 2005, Charlie Gard⁸¹ in 2017, and Alfie Evans⁸² in 2018, provide the opportunity to analyse the use of a ‘best interests’ approach in the context of end-of-life decision-making. As in cases involving adults, judges are careful to interpret ‘best interests’ as being more than just best medical interests.⁸³ The best interests test originated as a legal requirement in child custody cases at common law and was later applied to paediatric healthcare.⁸⁴ In an ideal situation, parents and healthcare professionals agree on the best interests of the child. If they fail to agree, then a court declaration is sought. Parental power to consent on behalf of a child is limited by the lawfulness of the procedure, the best interests of the child, the prior sanction of the court for some procedures, and incorporating the child’s views if old enough to understand.⁸⁵

However, neither parents nor courts can mandate that the treatment will take place. As Donaldson LJ remarked in *Re J*,

No one can dictate the treatment to be given to the child—neither court, parents nor doctors. There are checks and balances.(.....)..... The inevitable and desirable result is that choice of treatment is in some measure a joint decision of the doctors and the court or parents.⁸⁶

⁸⁰ *Wyatt v Portsmouth NHS Trust, Charlotte Wyatt (A Child)* [2005] EWCA Civ 1181

⁸¹ *Yates and Gard v Great Ormond Street Hospital for Children NHS Foundation Trust* [2017] EWCA Civ 410

⁸² *Alder Hey Children’s NHS Foundation Trust v Evans* [2018] EWHC 308 (Fam)

⁸³ “Best interests are not limited to best medical interests” in *Re MB (Medical Treatment)* [1997] 2 FLR 426, at 439, per Butler Sloss LJ. See also Ian Kennedy, ‘Patients, doctors and human rights’, in R. Blackburn and J. Taylor (eds). *Human Rights for the 1990s: Legal, Political and Ethical Issues* (Continuum International Publishing 1991) 90-91, who points out that, subsequent to the Human Rights Act, doctors must consider wider interests and involve other members of the healthcare team.

⁸⁴ G Birchley ‘Deciding Together? Best Interests and Shared Decision-Making in Paediatric Intensive Care’ (2014) 22 *Health Care Analysis* 203; Interestingly, in some jurisdictions, there have been moves to incorporate a “best interests of the animal” test in pet custody cases. See D Rook ‘Who Gets Charlie? The Emergence of Pet Custody Disputes in Family Law: Adapting Theoretical Tools from Child Law’ (2014) 28 *International Journal of Law, Policy and The Family* 177; and see Deckha (n94).

⁸⁵ See Allen N, ‘Care and Treatment of Those Lacking Decision-Making Capacity’ in J. Laing and J. McHale (eds), *Principles of Medical Law* (4th edition, Oxford University Press 2017) 499

⁸⁶ Per Lord Donaldson in *Re J (a minor): (wardship: medical treatment)* [1991] Fam 33, at 41F

Therefore, parents or the courts can make a decision based on their calculation of the ‘best interests’ of the child, but there may still be problems in accessing the treatment.

A second problem with an objective ‘best interests’ standard has been the difficulty of defining ‘best interests.’ According to Baines,⁸⁷ this may derive from ontology (there may be no such thing as objective best interests), or epistemology (best interests may exist, but there is no way of discovering what they are). Indeed, Kennedy refers to the idea of best interests as “empty rhetoric” that is often used by the courts to justify their decisions.⁸⁸ The difficulty of defining ‘best interests’ applies to child and animal patients, although the current deficit in our knowledge of animal cognition and behaviour may suggest that it is more difficult in the case of animals.

The Children Act offers a list of factors which courts should take into account in determining the best interests of the child, including the risk of any harm, and assessing the emotional as well as physical needs of the child.⁸⁹ Butler-Sloss LJ’s definition of best interests in *Re A*, which widens best interests beyond medical interests, is often cited in such cases:

In my judgment best interests encompasses medical, emotional and all other welfare issues.⁹⁰

Agreeing with this approach, Thorpe LJ suggested that one way to evaluate best interests is to draw up a balance sheet:

The first entry should be of any factor or factors of actual benefit.(....)..... on the other sheet the judge should write any counterbalancing dis-benefits to the applicant.(....)..... Then ... (...) the potential gains and losses in each instance

⁸⁷ P Baines ‘Death and best interests: a response to the legal challenge’ (2010) 5 *Clinical Ethics* 195, at 196.

⁸⁸ Kennedy (n83) 91.

⁸⁹ Children Act 1989 s.1(3)

⁹⁰ Per Dame Butler Sloss, *Re A (medical treatment: male sterilisation)* [2000] 1 FLR 549 at 555

making some estimate of the extent of the possibility that the gain or loss might accrue.⁹¹

Drawing on these dicta, Wall LJ adds other criteria to the basis for 'best interests' decision-making for children in *Wyatt*:

The judge must decide what is in the child's best interests. In making that decision, the welfare of the child is paramount ... (...) The court must conduct a balancing exercise in which all the relevant factors are weighed (*Re J*) and a helpful way of undertaking this exercise is to draw up a balance sheet (*Re A*).⁹²

Of course, it is presumed that, in most cases, parents will make decisions for their children based on their best interests and are therefore the most appropriate decision-makers. As observed by Baker J, in *Re Ashya King (a child)*,

In most cases, the parents are the best people to make decisions about a child and the State (...).... has no business interfering with the exercise of parental responsibility unless the child is suffering or is likely to suffer significant harm as a result of the care given to the child not being what it would be reasonable to expect a parent to give.⁹³

However, it seems that in many cases involving children the avoidance of harm and the 'reasonableness' of the decision is not enough. Some early cases took the approach that a procedure may be performed provided it would "... at least do... no harm,"⁹⁴ but this has been firmly rejected, first by the Court of Appeal in the Charlie Gard case, where the child's parents, seeking to take him overseas for treatment with an unproven therapy, appealed on

⁹¹ *Ibid*, per Thorpe LJ, at 560

⁹² *Wyatt* (n80) at 87

⁹³ [2014] EWHC 2964 (Fam), at para 31

⁹⁴ Per Lord Reid in *S v S* [1972] AC 24 at 45D. This case involved an appeal to the courts to allow a blood test to be taken from a child to prove paternity.

the grounds that the judge had erred in preventing such treatment when there was no risk of the treatment causing significant harm to the child.⁹⁵ McFarlane LJ. In dismissing the appeal, stated that “best interests is the yardstick which applies to all cases” and he saw “no justification..... to endorse the creation of a subset of cases based upon establishing significant harm.”⁹⁶ This ruling was endorsed by the Supreme Court in *Evans and James v Alder Hey Children’s NHS Foundation Trust and Evans* where the court unanimously dismissed an argument made by the parents of a terminally ill child that the appropriate test for their request to take their child to Italy for treatment should be that such an intervention would not cause ‘significant harm’ even if it were not in the child’s ‘best interests’.⁹⁷

An earlier case involving a child with a progressive muscular disorder⁹⁸ illustrates the balanced approach. In this case, Holman J asked both advocates to draw up a list of ‘benefits’ and ‘burdens’ of continuing to provide supportive treatment for the child involved. In using these lists to help make the decision that it was in the child’s best interests for treatment to continue, he also identified additional procedures (such as CPR and blood sampling) that he regarded as painful and therefore not in the child’s interests.⁹⁹ Thus, the ‘gold standard’ to be applied is now a positive version of best interests, where a decision should positively promote the interests of the child, rather than a negative version where the focus is on the avoidance of harm. The gold standard should also extend to more than just medical interests, as illustrated in *Re T*,¹⁰⁰ where a child’s best medical interests would have been served by undergoing a proposed liver transplant. However, the Court of Appeal upheld the appeal, thus overturning the decision in the lower courts, which had found for the medical professionals based on the ‘unreasonableness’ of the mother’s refusal to consent. In her judgment, Butler-Sloss LJ stated that “to prolong life (...) ... is not the sole

⁹⁵ *Yates* (n81)

⁹⁶ *ibid*, per McFarlane LJ at 74

⁹⁷ *Evans and James v Alder Hey Children’s NHS Foundation Trust and Evans*, 20 March 2018, Supreme Court. An important factor was that the ‘significant harm’ test should only be used to remove a child from a family (para 15) <<https://www.supremecourt.uk/cases/docs/alfie-evans-reasons-200318.pdf>> accessed 8 April 2018

⁹⁸ *An NHS Trust v MB* (a child represented by Cafcass as guardian ad litem) [2006] EHW 507 (Fam)

⁹⁹ *Ibid*, at 58

¹⁰⁰ [1997] 1 All ER 906

objective of the court and to require it at the expense of other considerations may not be in a child's best interests."¹⁰¹

Thus, a 'best interests' decision for children cannot be based solely on the preservation of life, nor on the avoidance of harm. I now turn to examine whether these criteria should form the basis of a similar test for animals. Harms can involve suffering or deprivation. Rollin regards pain as the worst harm that can be inflicted on an animal, due to the perceived inability of animals to anticipate the end of their suffering.¹⁰² Thus, although death can be regarded as the ultimate deprivation, it may not be the worst harm.¹⁰³ Such an argument could also be applied to end-of-life decision-making for the infants considered earlier in this section. Yeates expands on this argument, stating that if "the presence of a life" has positive value to the animal then death is a harm, but conversely if that life has negative value then death is a benefit.¹⁰⁴ End-of-life decision-making in veterinary medicine prioritises the prevention of suffering, requiring that in cases of poor welfare, the decision is made for euthanasia.¹⁰⁵ In agreeing with the priority given to avoidance of pain in these situations, I invoke Rollin's assertion that animals cannot see beyond their current emotional state, i.e. they cannot envisage the cessation of their pain.¹⁰⁶ Indeed, Andrew Linzey proposes that, faced with a choice between the duty to preserve life and the duty to prevent suffering, the second duty should take precedence.¹⁰⁷ Therefore, decision-making in animals tends to prioritise the avoidance of harm. Although it has been rejected as the *basis* for decision-making for babies with life-limiting conditions, where the intention to preserve life must take priority, input from a 'harm avoidance' perspective would help to define the limits to

¹⁰¹ *ibid*, at 916 b-c

¹⁰² Bernard Rollin, 'Animal Pain' in T Regan and P Singer (eds) *Animal Rights and Human Obligations* (2nd edn, Prentice Hall 1989) 60

¹⁰³ Regan (n30) 100

¹⁰⁴ J Yeates, 'Death is a welfare issue' (2010) 23 *J Agric Environ Ethics* 229, 234 See also Francione, (n48) at 32, who argues that any sentient being has an interest in, and indeed desires, remaining alive.

¹⁰⁵ Christiansen SB and others, 'Veterinarians' Role in Clients' Decision-Making Regarding Seriously Ill Companion Animal Patients' (2016) 58 *Acta Veterinaria Scandinavica* 30. See also RCVS (n13) s8.8

¹⁰⁶ Rollin (n102) 60

¹⁰⁷ Andrew Linzey, 'Conclusion: Re-establishing Animals and Children as a Common Cause, and Six Objections Considered' in *Why Animal Suffering Matters: Philosophy, Theology and Practical Ethics* (Oxford University Press 2013) Nevertheless, Linzey agrees that this decision should not be taken lightly, asserting that our power over vulnerable beings necessitates a 'fundamental responsibility for their welfare'.

‘best interests’ decision-making. Accordingly, paediatric cases argued from a ‘best interests’ basis are relevant to this study and will be essential for attempting to define what a similar approach for animals may look like.

4.5 Owner autonomy and non-therapeutic neutering of companion animals

If animals are regarded as their owners’ property, albeit a special type of property, and have their welfare interests (but not their preference interests) protected via legislation, the boundaries of the autonomy of the owner can be defined. It seems that, in the UK at least, society is willing to accept that owners can make autonomous decisions about their animal property up to the point that these decisions have a negative impact on welfare interests (or, to use similar language to decision-making for children, up to the point that these decisions cause serious harm). I will now consider this in the context of bodily integrity, where I will again attempt to draw comparisons with decisions made for children. This will require an investigation into the power given to parents in making such decisions, and therefore will allow comparisons to be drawn between animal owners and parents.

In Chapter 1, Section 1.3, I explained the reason for choosing elective, non-therapeutic neutering as the focus of empirical work on informed consent. In this section, I will investigate the reasons for the common decision to perform this procedure on a healthy animal.

Many veterinary practices offer elective neutering surgery at discounted prices to encourage its uptake, recommending the procedure at initial visits for puppy or kitten vaccinations, or promoting it via their websites.¹⁰⁸ The approach taken by veterinary professionals prioritises the ‘greater good’ for society over any calculated risks or benefits for the individual animal,

¹⁰⁸ See, for example, veterinary practice websites such as Vets4Pets ‘Neutering’ <<https://www.vets4pets.com/pet-health-advice/neutering/>> accessed 2 October 2018; The Vet ‘Why Neuter Your Pet?’ <<https://www.thevet.co.uk/pet-advice/why-neuter-your-pet/>> accessed 2 October 2018; The Blue Cross ‘Neutering Your Dog’ <<https://www.bluecross.org.uk/pet-advice/neutering-your-dog>> accessed 2 October 2018

introducing a normative utilitarian approach that also appears in many public health debates.¹⁰⁹ Thus, the case of neutering of companion animals provides an example of owners being encouraged, by animal welfare messages through social and traditional media, and by the veterinary profession, to have non-therapeutic procedures performed on their companion animals. Indeed, in the United Kingdom, this could now be classed as a ‘social norm’.

Nevertheless, although there is a strong bias in the veterinary profession and in animal welfare organisations, certainly in the UK, in favour of routinely neutering companion animals, such views are by no means unanimous. Some authors question the ethical basis of neutering, concluding that from a range of ethical standpoints, it is difficult to support the non-therapeutic neutering of companion animals.¹¹⁰ I will discuss the arguments for and against routine neutering in 4.7.

The example of neutering illustrates a version of autonomy that can be applied to the human right to own property and to do as wished with that property, so long as the action is not illegal.¹¹¹ The widespread performance of non-therapeutic neutering on animals invites comparison with similar procedures in children, such as the non-therapeutic circumcision of male infants, and leads to further investigation into one of the underlying principles of autonomy in human healthcare, that is, the right to bodily integrity.

4.5.1 Non-therapeutic procedures and bodily integrity

Humans are considered to have a moral right to bodily integrity, which is closely associated with the principle of autonomy that underpins medical treatment.¹¹² This right was highlighted by Baroness Hale in *Montgomery* and previously discussed in Chapter 3.2. Animals, however, are not regarded in law as having any rights to autonomy (see 4.2) and

¹⁰⁹ Although the tendency to use a “naïve” version of utilitarianism to justify some public health initiatives is questioned by Stephen Holland, in ‘The naïve utilitarian view of public health’ in *Public Health Ethics* (Polity Press 2014)

¹¹⁰ See, for example, Palmer C, Corr S, Sandøe P, ‘Inconvenient Desires: Should We Routinely Neuter Companion Animals?’ (2012) 25 *Anthrozoos: A Multidisciplinary Journal of The Interactions of People & Animals* 153

¹¹¹ Under the Human Rights Act 1998, Sch1 Pt 2, Article 1

¹¹² J Herring and J Wall, ‘The Nature and Significance of Bodily Integrity’ (2017) 76 *Cambridge Law Journal* 566

therefore presumably do not have the claim to bodily integrity that is inherent in autonomy. However, for those who lack autonomy, bodily integrity may be an important value, and one that is worthy of protection. For young children unable to consent, parental consent authorises the performance of several non-therapeutic procedures that are considered 'normal', despite interfering with the child's bodily integrity. For animals, non-therapeutic neutering is permissible as this type of interference with bodily integrity is allowed. This can proceed with owner consent, or for stray animals, without anyone giving consent on their behalf.¹¹³

In contrast, other surgical interference with an animal's bodily integrity is much more controversial, and the focus of legal restriction and challenge. For example, under the Animal Welfare Act, it is prohibited to carry out "... a procedure which involves interference with the sensitive tissues or bone structure of the animal, otherwise than for the purpose of its medical treatment..."¹¹⁴ while Section 6 of the Act defines the precise circumstances under which a dog's tail may be docked. Although elective neutering is non-therapeutic and therefore contradictory to the statement above regarding not being for medical treatment, it is not regarded as a mutilation, and was specifically excluded under the terms of the subsequent secondary legislation, The Mutilations (Permitted Procedures) (England) Regulations 2007.¹¹⁵

Thus, although the Act makes some reference to bodily integrity,¹¹⁶ it is not listed as a fundamental requirement for welfare under the Five Freedom-derived welfare needs. Indeed, 'normal behaviour' must implicitly exclude normal sexual behaviour, otherwise millions of animal owners could be prosecuted under the Act, for failing to allow the animal to fulfil "its need to be able to exhibit normal behaviour patterns."¹¹⁷

¹¹³ Although see previous discussion regarding neutering of stray animals at 4.1

¹¹⁴ Animal Welfare Act 2006 s5.3

¹¹⁵ The Mutilations (Permitted Procedures) (England) Regulations SI 2007/1100 list castration and spaying in Schedule One, as permitted procedures for 'other species' which include cats, dogs and rabbits.

¹¹⁶ Animal Welfare Act s5.3, albeit not couched in the specific terms of bodily integrity

¹¹⁷ *ibid*, s9.2e

However, allowing interference with an animal's bodily integrity in this way sends out a forceful message about the moral status of the animal, implying that owners have the right to do as they wish with their 'property' provided that what they wish to do is not illegal. Such views may reinforce the idea that animals are disposable and of low moral status. In this way, non-therapeutic neutering of animals is quite different from non-therapeutic procedures in children. Nevertheless, I will now attempt to draw some parallels between the two.

4.6 Decisions that interfere with children's bodily integrity

In seeking comparisons between non-therapeutic procedures performed on companion animals and children, a second body of case law, involving interference with children's bodily integrity, merits inclusion. Although parents may make decisions about such interference without reference to the courts, for example, if both parents agree regarding male circumcision,¹¹⁸ there are two situations that require legal involvement; first, when the decision involves sterilisation of a child, and second, when dealing with disagreements between parents regarding male circumcision. Other areas of interference with bodily integrity, for example, vaccination (where courts only become involved if there is parental disagreement) and surgery to change a child's sex (so-called 'intersex' surgery) were also considered as potential procedures for comparison with non-therapeutic neutering.

Until 1987, the Courts had seldom been involved in what was termed "non-therapeutic" sterilisation of minors, but when cases did reach court, judges were usually reluctant to permit such procedures.¹¹⁹ The case of *Re B* was the first of its kind to reach the House of Lords. It concerned a 17-year-old woman, described in the case as 'mentally retarded,'

¹¹⁸ Advice to doctors is that these procedures are considered as legal in common law if both parents are in agreement, and the child is too young to express any consent. See BMA, *The Law and Ethics of Male Circumcision: Guidance for Doctors* (BMA 2006). See also GMC, 'Personal Beliefs and Medical Practice' <<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors>>

¹¹⁹ For example, in *Re D (a minor) (wardship: sterilisation)* [1976] Fam 185, Heilbron J decided that it would not be in the best interests of D for the procedure to be performed.

having the ability to understand of a 6-year-old child, but with the ability to express herself of a 2-year-old.¹²⁰ She was in local authority care, and one reason given for bringing the case was to try to reach a decision before her 18th birthday, when she would no longer be a ward of court.¹²¹ Lord Templeman regarded sterilisation as a procedure of last resort, and one which should only be decided by a High Court judge.¹²² The case failed on appeal by the Official Solicitor (acting as the plaintiff's guardian) to overturn the original decision to allow the sterilisation to proceed. It was also notable for the judges' views regarding the lack of differentiation between therapeutic and non-therapeutic sterilisation when the treatment was held to be for the future benefit of the young woman, and also to prevent future injury and disease.¹²³ Following this case, the Official Solicitor issued a Practice Note outlining the procedure for future applications for sterilisation of minors or incompetent adults. This confirmed that the decision should be made by a High Court judge, that the judge would need to be persuaded that the decision was in the best interests of the patient, rather than being a convenience decision for her carers, and it listed the evidence required, including proof that less invasive methods of contraception would not be suitable in the particular case.¹²⁴

In the case of *Re B*, there was no attempt to try to evaluate her capacity, which was assumed to correlate to the ages ascribed to her level of understanding and level of expression. Later cases demonstrate the Court's reluctance to authorise non-therapeutic sterilisation, unless as a last resort.¹²⁵ Thus, although sterilisation of minors would seem to be the obvious comparison with non-therapeutic neutering of companion animals, the complicated

¹²⁰ *Re B (a minor) (wardship: sterilisation)* [1988] AC 199, per Lord Oliver at 207C-F

¹²¹ *ibid*, per Lord Hailsham at 203E

¹²² *ibid*, per Templeman LJ at 205H

¹²³ *ibid*, per Lord Hailsham at 204A-B, Lord Bridge at 205C and Lord Oliver at 211G

¹²⁴ Practice Note: Sterilisation [1993] 3 All ER 222 at 224c-h

¹²⁵ The courts are keen to uphold the child's right to reproduce (or, more correctly, right to retain the capacity to reproduce – see Laurie GT, Harmon SHE, Porter G, 'The Control of Fertility' in Mason and McCall Smith's *Law and Medical Ethics* (10th edn, Oxford University Press 2016). One interesting exception to this is *Re M (A Minor) (Wardship: Sterilisation)* [1988] 2 FLR 497, where the medical expert persuaded the court that the operation was reversible in up to 75% of cases, and therefore could be considered as contraception.

circumstances of those involved prompted the search for a procedure which is a) more commonly performed, b) involves younger children and c) is not usually decided in court.

In considering whether to use vaccination¹²⁶ as an appropriate procedure for comparison, I was unsure whether this provided an equivalent level of interference with bodily integrity and long-term effects on life. Indeed, Elliston contends that immunisation should neither require joint parental consent nor a court order. She posits that, as it is a procedure designed to safeguard the child's health and as it is low risk, it should require the consent of only one parent.¹²⁷ A third procedure, surgery on infants born with abnormal genital anatomy due to a disorder of sex development (DSD, also known as intersex) has generated no case law in England.¹²⁸ Therefore, comparative evaluation will focus on the non-therapeutic circumcision of male children.¹²⁹

There have been a number of cases where the proposed circumcision of male children has caused disputes between parents, who are usually of differing religious faiths. In *Re J*,¹³⁰ it was decided that male circumcision is not a mutilation, and does not cause harm, but that it is painful and not without risk. The appeal by the child's father against the original decision to refuse permission was disallowed. The refusal to allow surgery was replicated in *S (Children)*,¹³¹ both decisions being made in the interests of the children, and both allowing the children to make their own decisions when they reached an age where they could do so. The case of *Re L and B (children)*¹³² in 2016 produced a similar outcome, with Roberts J agreeing with the mother's request to allow the children to make their own decisions

¹²⁶ For example, *F v F* [2013] EWHC 2683 (Fam), in which, similar to other cases involving disputes between parents regarding vaccination of children, it was decided that it was in the best interests of the children involved to receive the vaccination.

¹²⁷ Sarah Elliston, *The Best Interests of the Child in Healthcare* (Routledge-Cavendish 2007) 98

¹²⁸ M Newbould, 'When Parents Choose Gender: Intersex, Children and the Law' (2016) 24 *Med Law Review* 474, 489

¹²⁹ I chose male circumcision as the female equivalent is illegal in the UK, although there is an 'emerging consensus' that, with some variations of female genital cutting, the two are analogous, see BD Earp, J Hendry, M Thomson, 'Reason and Paradox in Medical and Family Law: Shaping Children's Bodies' (2017) 25 *Med Law Review* 604 at 608

¹³⁰ *Re J (A Minor)* (Prohibited Steps Order: Circumcision) [2000] 1 F.L.R. 571

¹³¹ *S (Children)* [2004] EWCA Civ 1257

¹³² *Re L and B (children)* (*Specific Issues: Temporary Leave, Circumcision*) [2016] EWHC 849 (Fam). This case involved the major issue of the father seeking to take the children out of the country, with his request for circumcision as a later addition.

regarding circumcision when old enough to do so. In such cases, it is important to note that if both parents agreed, then the procedure would have been lawful. Indeed, Fox and Thomson observe that legal challenges in cases of male circumcision seem to confirm it as “a legitimate choice for parents, justifiable in the best interests of the child,”¹³³ a view previously expressed by Howard Gilbert following the judgment in *Re J*, observing that “the male infant has no rights that need to be protected in this situation; it will always be in his interests to be ritually circumcised where both his parents desire it.”¹³⁴ Even more forcefully, Woolley considers that non-therapeutic circumcision should constitute a “special offence under the Child and Young Persons Act 1933,” if judged against the guidelines for lawful surgical intervention, although she concedes that court intervention is uncommon.¹³⁵

Thus, we see that children’s bodily integrity can be legally breached in specific circumstances. Sometimes this requires referral to the court system, but often it can be done without legal reference. When referred to the courts, the decision is based on the best interests of the child. When decided by the parents, there is controversy over whether their priority is the child’s best interests. Therefore, further examination is required of the arguments for and against the view that non-therapeutic male circumcision is in the best interests of the child.

Starting with purely medical reasons to refute the argument that circumcision benefits male infants, short term risks such as the anaesthetic, bleeding, and infection, and long-term complications associated with sexual dysfunction are listed.¹³⁶ The opposing view offers arguments that the procedure carries little risk, with no more pain involved than a vaccination, and that it offers longer-term benefits of increased protection from transmission of the HIV virus, with reported lower rates of other sexually transmitted

¹³³ M Fox and M Thomson, ‘Bodily Integrity, Embodiment, and the Regulation of Parental Choice’ (2017) 44 *Journal of Law and Society* 501, 505

¹³⁴ H Gilbert, ‘Time to reconsider the lawfulness of ritual male circumcision’ (2007) 3 *European Human Rights Law Review* 279 at 286

¹³⁵ Woolley (n77) 1064. The guidelines require the intervention to be medically necessary, to be in the child’s best interests, and not to expose the child to unnecessary suffering/injury.

¹³⁶ G Hinchley, ‘Is infant male circumcision an abuse of the rights of the child? Yes’ (2007) 355 *BMJ* 1180

diseases.¹³⁷ Fox and Thomson observe that the risks and the amount of pain involved are downplayed by those in favour of the procedure.¹³⁸ Furthermore, the British Medical Association (BMA), in its advice to doctors, warns that “..the medical literature on the health, including sexual health, implications of circumcision is contradictory, and often subject to claims of bias in research,” before advising that parents should be “fully informed about the lack of consensus.”¹³⁹ The BMA’s advice is that both parents must give consent and that if only one parent is present, the doctor must make efforts to contact the other. It also states that the consent should be in writing, thus emphasising the controversy surrounding the procedure.¹⁴⁰

In cases where parents disagree over circumcision, however, the courts have used predominantly social and cultural reasons to argue for or against allowing the procedure. Returning to the case of *Re J*, one aspect of the child’s upbringing that was considered was whether his peers would be circumcised, therefore he would be regarded as different, and the effect that the procedure would have on his relationship with his father. In this case, despite the positive benefit of the latter, the fact that he was being raised in a secular household (by his mother) led to the decision to refuse permission for the procedure to proceed.¹⁴¹ This case was followed in *S (Children)*, where a similar decision was reached.¹⁴² Thus, it appears that interference with the child’s bodily integrity for a non-therapeutic procedure is not a major consideration for the courts, rather it is the surrounding culture and environment that influences judicial reasoning.

It appears that cases can be made for and against circumcision of male infants on the basis of best interests. These include best medical interests founded on disputed evidence, although it is interesting that arguments generated from the basis of ‘best medical interests’

¹³⁷ K Patrick, ‘Is infant male circumcision an abuse of the rights of the child? No’ (2007) 355 *BMJ* 1181

¹³⁸ M Fox and M Thomson ‘Short Changed? the Law and Ethics of Male Circumcision’ (2005) 13 *The International Journal of Children’s Rights* 161 at 167

¹³⁹ BMA (n118) s4.4, p4

¹⁴⁰ *ibid*, s4.2.2, p3

¹⁴¹ *Re J* (n130) at 10-11.

¹⁴² *S (Children)* (n131)

do not feature in any of the case law. I will now investigate how a similar 'best interests' balance sheet may be constructed for non-therapeutic neutering of companion animals.

4.7 Applying a 'best interests' test to non-therapeutic neutering of companion animals

The decision to neuter a companion animal is often taken without much thought for the 'best interests' of the individual animal, due to the prevailing opinion amongst veterinary professionals and in wider society that all animals should be neutered to prevent the birth of unwanted litters (see 4.5). However, increasingly, there is evidence that neutering does not have universally positive effects. In presenting both sides of a 'best interests' argument for neutering, I will initially focus on potential benefits for the individual animal and for the animal owner, before then exploring the risks to both.

4.7.1 Benefits of neutering for the animal

The list of health-related benefits of neutering for the individual animal commences with longevity, with most studies that have examined lifespan concluding that neutered animals live longer.¹⁴³ Neutering protects some animals from specific disease risks; for example, neutering female cats, dogs and rabbits protects them to various degrees against tumours arising from mammary tissue and the reproductive tract.¹⁴⁴ Neutering removes the risks involved with pregnancy and giving birth, which in some breeds of dog are considerable, leading to the necessity for surgical intervention.¹⁴⁵ Neutering male dogs at a younger age prevents benign prostate enlargement and the development of testicular cancer.¹⁴⁶

4.7.2 Benefits of neutering for the animal owner

¹⁴³ Root Kustritz MV, 'Effects of Surgical Sterilization on Canine and Feline Health and on Society' (2012) 47 *Reproduction in Domestic Animals* 214

¹⁴⁴ *ibid*, 216

¹⁴⁵ McKenzie B, 'Evaluating the Benefits and Risks of Neutering Dogs and Cats.' (2010) 5 *CAB Reviews: Perspectives in Agriculture, Veterinary Science, Nutrition and Natural Resources* 45, 2-3

¹⁴⁶ Reichler IM, 'Gonadectomy in Cats and Dogs: a Review of Risks and Benefits' (2009) 44 *Reproduction in Domestic Animals* 29

The primary benefit to the owner of the neutered animal is the reduction or elimination of unwanted sexual behaviour, such as roaming, urine marking and mounting.¹⁴⁷ For owners of female dogs, neutering allows off-lead exercise all year round as there is no necessity to restrict exercise when the dog is in season and attractive to males. Neutering female dogs and cats removes the problem of unwanted pregnancies and dealing with the resulting offspring. Neutering increases the likelihood that the animal will *not* be rehomed, as un-neutered dogs and cats are more likely to be relinquished by their owners.¹⁴⁸ Overall, therefore, the benefits to the owner are that the unique owner-companion animal relationship will be preserved.

4.7.3 Risks or burdens of neutering for the animal

Research shows that, in some breeds, neutered dogs are more prone to injuries such as knee ligament damage.¹⁴⁹ There is an association between neutering and incontinence in spayed female dogs,¹⁵⁰ and evidence that neutered animals of both sexes have higher body condition scores, although obesity is acknowledged as being a multifactorial problem.¹⁵¹ Neutering some individuals at younger ages can worsen, rather than improve, behavioural problems such as aggression.¹⁵² Higher rates of prostatic cancers have been found in neutered male dogs,¹⁵³ and neutered dogs of both sexes in specific breeds have higher rates of bone cancer.¹⁵⁴ In addition, there is the risk of post-surgical complications that may cause pain, distress and may require repeat surgery.¹⁵⁵

¹⁴⁷ Root Kustritz (n143) 215

¹⁴⁸ McKenzie (n145) 2

¹⁴⁹ G Torres de la Riva and others, 'Neutering Dogs: Effects on Joint Disorders and Cancers in Golden Retrievers' (2013) 8 *PLoS ONE* e55937 doi:10.1371/journal.pone.0055937 accessed 10 October 2017

¹⁵⁰ Reichler (n146) 31

¹⁵¹ Houlihan KE, 'A Literature Review on the Welfare Implications of Gonadectomy of Dogs' (2017) 250 *Journal of the American Veterinary Medical Association* 1

¹⁵² *ibid*, 1160

¹⁵³ E Teske and others, 'Canine prostate carcinoma: epidemiological evidence of an increased risk in castrated dogs' (2002) 197 *Molecular and Cellular Endocrinology* 251

¹⁵⁴ Reichler (n146) 32.

¹⁵⁵ Adin CA, 'Complications of Ovariohysterectomy and Orchiectomy in Companion Animals' (2011) 41 *Veterinary Clinics of NA: Small Animal Practice* 1023

Thus far, I have only considered health-related risks. However, it is important to widen the scope of risks, or ‘burdens’, as was the term used by Holman J in *An NHS Trust v MB*.¹⁵⁶ In addition to health risks, neutering interferes with the animal’s bodily integrity, and in so doing, deprives the animal of a fundamental aspect of life, the capacity to reproduce. However, herein lies a conundrum. Perhaps surprisingly, even staunch proponents of animal rights support the routine neutering of companion animals, to prevent the production of more ‘slaves’, as they term companion animals.¹⁵⁷ Thus, as companion animals, they would be denied the right to reproduce by those who promote animal rights, because allowing them to do so exacerbates the problem by increasing the population of companion animals.

4.7.4 Risks or burdens of neutering for the animal owner

The main risk associated with neutering for the animal owner is the death of the animal during the procedure. This small, but universal risk¹⁵⁸ could result in the owner losing a healthy companion animal. I have classified this as a risk for the owner, rather than for the animal, therefore focusing on the effect of the loss on the owner. I realise that this view supports the assumption that death does not impact on animal welfare or interests, but I acknowledge that this is controversial. Under the new definition arising from *Montgomery*, death would be classified as a ‘material risk’ that must be disclosed to every animal owner in this situation. However, as discussed in Chapter 3, Section 3.6.3, it is doubtful whether *Montgomery* will have immediate impact on cases of veterinary negligence.

A more philosophical risk is the development of an attitude that the animal is property, and therefore anything can be done to ensure that the animal fits in with the owner’s lifestyle. Such an attitude may also lead to regarding the animal as disposable. However, this is balanced to an extent by the finding that more un-neutered animals are abandoned by their owners (see 4.7.2).

¹⁵⁶ *An NHS Trust v MB* (n98)

¹⁵⁷ Fوسفeld L, ‘Sterilization in an Animal Rights Paradigm’ (2007) 2 *Journal of Animal Law and Ethics* 255

¹⁵⁸ FL Pollari and others, ‘Postoperative complications of elective surgeries in dogs and cats determined by examining electronic and paper medical records’ (1996) 208 *Journal of the American Veterinary Medical Association* 1882. This paper reported a risk of death of less than 0.1% in these patients.

4.7.5 Constructing a 'best interests' argument in favour of neutering

Although the calculation of the best interests of the animal is a joint enterprise between the veterinary professional (who can provide evidence of health-related benefits) and the owner, it is the latter who bears more responsibility for making the decision in those interests.

“We make a covenant with our pets in return for enrichment of and benefit to our life that is the consequence of a mutual exchange between owner and pet”¹⁵⁹

However, as is noted by McGreevy and Bennett, humans often fail in their duties towards companion animals.¹⁶⁰ Improvements in veterinary treatment have led to companion animals living longer, requiring more attention from their owners, but becoming less appealing as they age. Milligan considers caring for pets to be “morally significant,”¹⁶¹ arguing that humans should value companion animals as “unique and irreplaceable.”¹⁶² Their dependency, unlike that of children, is lifelong, placing more duties on their guardians. For example, Burgess-Jackson maintains that humans have acquired duties (those taken on as a result of voluntary acts) to shoulder the responsibility for those animals' needs.¹⁶³ This responsibility arises from the custody of ownership, which deprives the animal of alternative methods of fulfilling its needs, thereby making it “vulnerable and dependent.”¹⁶⁴ The selection of needs to be fulfilled for each companion animal is left to the caregiver. To protect the companion animal from potential dangers, its desires may need to be thwarted. For example, by roaming free, as it may desire if given the choice, it would be at risk of being

¹⁵⁹ Ellson T, 'Can We Live Without a Dog? Consumption Life Cycles in Dog-Owner Relationships' (2008) 61 *Journal of Business Research* 565, 573

¹⁶⁰ McGreevy and Bennett, in 'Challenges and Paradoxes in the Companion-Animal Niche' (2010) 19 (S) *Animal Welfare* 11, give the example of selecting companion animals for social traits, but then leaving them alone for long periods

¹⁶¹ T Milligan, 'Dependent Companions' (2009) 26 *Journal of Applied Philosophy* 402, 403

¹⁶² *Ibid*, at 410

¹⁶³ K Burgess-Jackson, 'Doing Right by Our Animal Companions' (1998) 2 *The Journal of Ethics* 159

¹⁶⁴ *ibid*, at 169

injured by motor vehicles. Such paternalism¹⁶⁵ is justified, as it would also be justified in making decisions for young children. In calculating the best interests of the animal with regard to non-therapeutic neutering, it is necessary to extend this 'justified paternalism' to prevent the animal from fulfilling the desire to reproduce.

A 'best interests'-based approach to consent for non-therapeutic neutering therefore balances the individual benefits (mainly health-related) with the risks involved, but also involves justifying the owner's decision to thwart the animal's desire to reproduce. On balance, the benefits outweigh the risks for most animals, although McKenzie maintains that it is difficult to support the universal neutering of male dogs through this calculation.¹⁶⁶ By including a relational aspect in my deliberation, i.e. the interests of the owner in maintaining this unique human-animal relationship in a way that benefits both participants, a case can be made for non-therapeutic neutering as being in the animal's 'best interests'. The caveat to this must be that in certain individuals, belonging to certain breeds, there is an increased association between early neutering and health problems.¹⁶⁷

From a wider perspective, the messages emanating from veterinary practices and animal rescue organisations are designed to persuade owners to agree to their animals undergoing this non-therapeutic procedure. However, these messages may in fact convey the perception that animals are property, that their bodily integrity is not worth preserving, and that owners can decide if and when to interfere with that bodily integrity.

It appears easier to construct a 'best interests' argument in support of non-therapeutic neutering of companion animals than in support of the routine circumcision of male infants. However, there are similarities between the two situations. Both involve patients who cannot give consent, and both involve carers (either parents or owners) who can give

¹⁶⁵ In this situation, and when making decisions for young children who cannot indicate choices, I have proposed that beneficence is a more appropriate term than paternalism, however, I have followed the author's use of the latter term.

¹⁶⁶ McKenzie (n145) 10

¹⁶⁷ Torres de la Riva and others (n149)

consent on their behalf. The medical procedure in both situations is elective, and non-therapeutic, i.e., it is not required to improve the patient's health. Both procedures have questionable health benefits and well-defined risks. The comparisons drawn with parental decision-making with regard to non-therapeutic circumcision of young male infants are valid. Both procedures are performed in response to pressure, from religious or cultural groups in the case of circumcision, and from veterinary practices or society in the case of neutering. The results are similar, with parents able to consent to a procedure that interferes with the bodily integrity of their male infants, and owners able to consent to interference with the bodily integrity of their companion animals.

4.8 Conclusion

In this chapter, I have attempted to compare decisions made by parents on behalf of young children, and decisions made by animal owners on behalf of companion animals. The validity of such a comparison can be questioned on several accounts, with the main differences arising from the differing legal and moral status of the respective patients, and the involvement of the courts when parents disagree, between themselves or with medical professionals. However, in focusing on the calculation of the best interests of the patient, and the difficulty involved with this calculation, both for very young children and for animals, I have demonstrated a link between the two contexts.

At this point, I must declare my own position. I have had all of my companion animals neutered (sometimes after breeding from them) and was a staunch advocate of neutering when in practice. This study has allowed me to reflect on my position, and although recognising that it is not a trivial procedure, I remain in favour of neutering companion animals. This opinion is undoubtedly coloured by two periods of employment with animal charities. However, if still in practice, I would be very careful to work out the needs and risks for each individual animal and to involve the client in the decision-making process.

The work in the preceding two chapters provides a theoretical foundation for the subsequent chapters, where the findings from the empirical studies on consent to neutering of animal patients will be presented. The analysis of the doctrinal legal research influences the data analysis from the three empirical studies. Legal research has provided a medico-legal basis for the requirements for a valid consent, focusing on the increased emphasis on respect for the patient's autonomy in human medicine. In the veterinary setting, this can be translated as demonstrating respect for the client's autonomy. For those unable to make decisions for themselves, further legal research has provided a 'best interests' basis for decision-making on behalf of others. The approach taken by the Courts to the calculation of 'best interests' for those unable to consent provides a potential basis for decision-making on behalf of animal patients.

The attempt at performing a 'best interests' calculation for non-therapeutic neutering of companion animals has revealed the possible tension between respecting client autonomy and making decisions that are deemed to be in the 'best interests' of the animal patient. This tension will be explored further in light of findings from the empirical studies. These studies begin with an investigation into the role of the consent form.

CHAPTER FIVE: EVALUATING CONSENT FORMS AND THEIR PLACE IN THE VETERINARY CONSENT PROCESS

5.0 Introduction

Having examined the legal interpretation of an autonomy-based consent and contrasted this approach with the one involved in giving consent on behalf of young children or animals, I now consider how consent is evidenced, starting with an examination of the role of the consent form. Evaluating the place of the form in the consent process in human and veterinary medicine, I review previous research examining its utility in informing the patient or client, and eliciting participants' understanding of its role. The resulting recognition of the dual purpose of the veterinary consent form, both as evidence of the discussion and as a written contract, prepares for my empirical work. I describe the methods used for data collection, setting the scene for thematic analysis of the language used on a sample of consent forms from veterinary practices in the UK. Finally, I critically evaluate the role of the veterinary form in the consent process, offering suggestions for improvement in order to maximise its contribution.

5.1 Consent forms in human and veterinary medicine

A consent form often forms part of both human and veterinary consent processes. As discussed in Chapter 1, there are similarities and differences between human and veterinary medical informed consent, but one area of similarity is the use of a form to record consent.

Consent that is given or received does not necessarily involve a form. Currently, the law governing human medical treatment in the United Kingdom recognises consent that is given 1) verbally, 2) through a person's behaviour, or 3) in writing.¹ The recording of consent in writing offers evidence that a discussion has taken place, but is not proof of consent, and is

¹ Maclean A, *Autonomy, Informed Consent and Medical Law* (Cambridge University Press 2009) 255

therefore not a legal requirement for most forms of medical treatment.² However, written consent is legally required for some medical treatments under the Mental Health Act 1983,³ and for those under the Human Fertilisation and Embryology Acts 1990⁴ and 2008.⁵ For other medical treatments, the form is merely a record that a discussion took place. The situation is different regarding consent forms used in research.

Consent forms used for participants in clinical trials have a regulatory function under The Medicines for Human Use (Clinical Trials) Regulations 2004.⁶ There has, consequently, been more emphasis placed on the content and design of consent forms used for research, which have multiple purposes. For example, they are required by the legislation governing clinical research, they have a 'pseudo-contract' function when dealing with property rights, and they are viewed as protectors of patient autonomy and privacy.⁷ The research consent form therefore can be regarded as having a "more complex role than its clinical counterpart."⁸

In many ways, the veterinary 'consent to treatment' form also fulfils multiple purposes. In addition to recording the consent given by the owner of the animal patient, it acts as a written contract for payment between the veterinary practice and the client. The RCVS gives advice on when written consent is required:

".... (...).... signed consent forms are required for all procedures including diagnostics, medical treatments, surgery, euthanasia and when an animal is admitted to the care of a veterinary surgeon."⁹

² Ibid, 255

³ Mental Health Act 1983 Part IV, s57, 58, 58A

⁴ Human Fertilisation and Embryology Act 1990 Sch3, para1

⁵ Human Fertilisation and Embryology Act 2008 Sch3, para3.1

⁶ The Medicines for Human Use (Clinical Trials) Regulations SI 2004/1031 Sch1.1, para3.1; Sch3.1, para3(i)

⁷ G Laurie and E Postan, in 'Rhetoric or Reality: What Is the Legal Status of the Consent Form in Health-Related Research?' (2013) 21 *Medical Law Review* 371, refer to the form as protecting participants' "privacy interests" and also "property interests" in their tissues.

⁸ Ibid, 375

⁹ RCVS 'Supporting Guidance' <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/>> 11.11

Specific consent is also required in writing when a drug is used under the “Cascade” procedure as outlined in the Veterinary Medicines Regulations 2013,¹⁰ i.e., where unlicensed products can be used in animals if there is no licensed product available.¹¹

Thus, specific consent is required for the use of unauthorised medicines, many of which are human medicines used for post-surgical pain relief in animals.

It is considered good practice to provide written evidence of the discussion that has taken place between veterinary professionals and their clients about proposed treatments, risks and benefits, usually through both parties (or, sometimes, the client alone) signing a consent form. However, the presence, or production, of a signed consent form does not in itself confirm the validity of any associated consent. In this sense, consent in human and veterinary medicine are similar.¹²

Research that focuses exclusively on the consent form therefore misses out on a large part of the process, where there may be multiple conversations between the healthcare provider and the patient. As has been pointed out by several authors, the form represents only a small part of the consent process, whether for research, where “it is unlikely that informed consent for research in medical settings would occur in the absence of any verbal discussion whatsoever”¹³ or for treatment.¹⁴

Nevertheless, a well-designed consent form can provide a substantial foundation for physician-patient discussions, despite the conclusion from a large-scale study of hospital consent forms that “forms as designed have limited value.”¹⁵ This study found that most forms seem designed to provide authorisation for treatment rather than to facilitate a

¹⁰ Veterinary Medicines Regulations 2013 Sch4, para1

¹¹ RCVS (n9) 4.17 states that clients should be made aware of their use and potential side-effects, and their consent should be obtained in writing

¹² See Chapter 1.0 for the definition of a valid consent

¹³ VA Miller and RM Nelson, ‘Moving Beyond the Consent Document in Research on Informed Consent’ (2005) 159 *JAMA Pediatrics* 396

¹⁴ C Grady, ‘Enduring and Emerging Challenges of Informed Consent’ (2015) 372 *New England Journal of Medicine* 855

¹⁵ MM Bottrell and others, ‘Hospital Informed Consent for Procedure Forms: Facilitating Quality Patient-Physician Interaction’ (2000) 135 *Archives of Surgery* 26, 29

discussion. However, a considerable amount of research into consent focuses on the form itself.

5.2 Problems with consent forms used in medicine

Two major problems have been identified with consent forms used in human healthcare, whether for treatment or for clinical research. The first lies with the purpose of the form, and its perceived role as ‘protecting’ the institution from which the form originates. The second problem concerns the utility of the form as both a conveyor of information and as a record of the conversation between healthcare provider and patient. In trying to perform multiple functions, it perhaps fails to achieve any of them.

5.2.1 The forms are designed to avoid litigation

There are two main approaches to conducting research on consent forms. Patients’ views may be sought on the impact and purpose of the form itself, or the language used on the form may be analysed. Much of the existing research into the use of consent forms in human medicine is situated in the United States healthcare system; this research involves comparative analyses of the legal (harm avoidance) approach of consent forms and the ethical (autonomy enhancing) approach, which is the stated goal of the informed consent doctrine in this setting. The harm avoidance approach regards disclosure of information as a means of avoiding lawsuits, with consent forms seen as “waivers of liability.”¹⁶

This perception of the form’s purpose as an instrument of ‘harm avoidance’ has been reproduced in several UK studies. A 2006 study by Akkad and others reported that 46% of patients believed that the main function of the forms was to protect the hospitals from litigation, while 68% thought the forms gave doctors control over what happened to the patient.¹⁷ In a more recent study of dental patients, Hajivassiliou found that 60% regarded

¹⁶ V Ali, ‘Consent Forms as Part of the Informed Consent Process: Moving Away From “Medical *Miranda*”’ (2003) 54 *Hastings Law Journal* 1575, 1577

¹⁷ A Akkad and others, ‘Patients’ Perceptions of Written Consent: Questionnaire Study’ (2006) 333 *BMJ* 528

consent forms as a means of protecting the practice or hospital, with up to 16% of patients thinking that, in signing the form, they were “relinquishing their right to compensation.”¹⁸ The findings from this study of dental patients is perhaps particularly relevant to veterinary practice; in both settings, patients and clients enter into a financial contract with the healthcare provider.¹⁹

Such views resonate with Lord Donaldson’s reference in *Re W* to consent as a “legal ‘flak jacket’ that protects the doctor from the litigious....”²⁰ However, if the main purpose of consent is to enable the patient to be fully involved in medical decision-making, then such views should raise concerns in those involved in obtaining consent. Perhaps it is the language used on consent forms that leads to patients’ beliefs that the process is designed to protect those who provide treatment and not those who receive it.

5.2.2 Consent forms are difficult to read

A considerable proportion of medical and social science research conducted on consent forms focuses on the readability of the text used. This approach assumes that the main method of conveying essential information to the person giving consent is via the printed text on the consent form, thus diminishing the role of the consent discussion. Research involves assessment of the language used, according to established grade level readability measures.²¹ When examining forms used for clinical research, the focus on readability and length intensifies. Many studies use measures such as the Flesch reading ease score,²² the Flesch-Kincaid grade level readability formula,²³ or a combination of Flesch-Kincaid reading

¹⁸ EC Hajivassiliou and CA Hajivassiliou, ‘Informed Consent in Primary Dental Care: Patients’ Understanding and Satisfaction with the Consent Process’ (2015) 219 *British Dental Journal* 221, 223

¹⁹ See Chapter 1, section 1.2.1 for more discussion of the contractual basis to veterinary treatment.

²⁰ Per Lord Donaldson in *Re W (A Minor) (Medical Treatment)* [1993] Fam. 64 at 78H

²¹ See, for example, JML Williamson and AG Martin, ‘Assessing the Readability Statistics of National Consent Forms in the UK’ (2010) 64 *International Journal of Clinical Practice* 322 and AEM Eltorai and others, ‘Readability of Invasive Procedure Consent Forms’ (2015) 8 *Clinical and Translational Science* 830

²² For example, in KJ Tarnowski and others, ‘Readability of Pediatric Biomedical Research Informed Consent Forms’ (1990) 85 *Pediatrics* 58 and in BJ Cardinal, JJ Martin, ML Sachs, ‘Readability of Written Informed Consent Forms Used in Exercise and Sport Psychology Research’ (1996) 67 *Research Quarterly for Exercise and Sport* 360

²³ For example, in E Larson, G Foe, R Lally, ‘Reading Level and Length of Written Research Consent Forms’ (2015) 8 *Clinical and Translational Science* 355

level scores and the Gunning-Fog index of difficulty,²⁴ to investigate the simplicity of the language used.

The focus on text perhaps even reinforces the ‘harm avoidance’ approach to consent. The message delivered by these researchers seems to be that if the language used is made clear and simple enough, then it can be maintained that patients understand what they are signing, or that researchers have satisfied their obligations towards research participants. Emphasis in both research and practice has been placed on the clarity and legibility of consent forms, to the detriment of their purpose as evidence of a discussion. The reliance on standardised, pre-printed forms may, in fact, “allow the reader to be “off-guard,”²⁵ through dependence on their consistency and conveyed seriousness. Jacob argues that handwritten information, because it contains variations from the standard template, requires more careful reading.²⁶

Here lies the dilemma. Handwritten forms, or handwritten components of forms, are discouraged, as they may not be sufficiently legible²⁷ and they may deviate from a standardised template. However, a standardised template may discourage patients from reading the contents of the form carefully, as the form looks official and legal. A consent form that includes space for handwritten information, agreed by the healthcare professional and the patient, may offer a more appropriate effort at genuinely shared decision-making, focusing on the individual patient, but it would also require legibility.

Consent forms have also become longer and increasingly difficult to read as more ‘legally required’ statements have been added. This trend has, according to some authors, reduced

²⁴ For example, in M Terblanche and L Burgess, ‘Examining the Readability of Patient-Informed Consent Forms’ (2010) 2 *Open Access Journal of Clinical Trials* 157 and in A Samadi and F Asghari, ‘Readability of Informed Consent Forms in Clinical Trials Conducted in a Skin Research Center’ (2016) 9 *Journal of Medical Ethics and History of Medicine* 1

²⁵ M-A Jacob, ‘Form-Made Persons: Consent Forms as Consent’s Blind Spot’ (2007) 30 *PoLAR: Political and Legal Anthropology Review* 249 at 254

²⁶ *Ibid*, 254

²⁷ A Shahu and others, ‘Discerning Quality: an Analysis of Informed Consent Documents for Common Cardiovascular Procedures’ (2017) 26 *BMJ Quality & Safety* 569

the 'informed-ness' of the patient.²⁸ The increasing lengthiness of forms is particularly apparent in the research context, where, over the last 25 years, the number of risks being described has increased, adding to the length of the forms.²⁹

Measures to increase readability sustain the myth that the form needs to be "read" by the patient so that the patient can become 'informed'. In Jacob's study, many patients signed the form without reading its contents as they viewed the form as a means of moving forward with treatment.³⁰

Mariner and McArdle found readability measures to be an inadequate evaluation of patient understanding of written medical information, highlighting that consent forms require an "immediate, reasoned decision."³¹ The context of that decision, in terms of staff involved, time allocated and presence of distractions, contributes to facilitating patient understanding.³² Nevertheless, orthopaedic patients who were given enhanced consent forms, with information related to their individual procedures, demonstrated greater knowledge of their procedures.³³

However, increased knowledge does not necessarily equate to reduced uncertainty. Reading consent forms may, in fact, increase patient uncertainty about risks, the procedure itself and the patient's own knowledge.³⁴ Perhaps unsurprisingly, the use of medical 'jargon', legal terminology and insufficient detail or statistics regarding the risks mentioned led to greater

²⁸ DS Kaufer, ER Steinberg, SD Toney, 'Revising Medical Consent Forms: an Empirical Model and Test' (1983) 11 *Law, Medicine and Healthcare* 155; TA Faunce, 'Medical Disclosure and Consent Forms: Proposal for an International Standard' (1997) 16 *Medicine and Law* 581

²⁹ I Albala, M Doyle, PS Appelbaum, 'The Evolution of Consent Forms for Research: a Quarter Century of Changes' (2010) 32 *IRB Ethics and Human Research* 7

³⁰ Jacob (n25) 256. This finding is replicated in the study by J Probyn and others, 'Percutaneous Coronary Intervention Patients' and Cardiologists' Experiences of the Informed Consent Process in Northern England: a Qualitative Study' (2017) 7 *BMJ Open* e015127 where patients interviewed saw the consent process as a means of allowing treatment to proceed.

³¹ WK Mariner and PA McArdle, 'Consent Forms, Readability, and Comprehension: the Need for New Assessment Tools' (1985) 13 *Law, Medicine and Healthcare* 68, 73

³² *ibid*

³³ AW Barritt and others, 'Assessing the Adequacy of Procedure-Specific Consent Forms in Orthopaedic Surgery Against Current Methods of Operative Consent' (2010) 92 *The Annals of The Royal College of Surgeons of England* 246

³⁴ E Donovan-Kicken and others, 'Sources of Patient Uncertainty When Reviewing Medical Disclosure and Consent Documentation' (2013) 90 *Patient Education and Counseling* 253

uncertainty.³⁵ Studies that focus solely on the consent form seem to support the conclusion that the accompanying consent discussion is the more important part of the process.

5.3 The role of the consent form in veterinary medicine

Research into veterinary consent in general is sparse (see Chapter 1.1), but there is even less available data on veterinary consent forms. One study, conducted at a large veterinary referral hospital, replicated the study methods employed by Akkad and others,³⁶ with similar findings regarding client views of the role of the form. The veterinary study found that one-third of respondents thought consent forms were used to protect the veterinary surgeon, and one-fifth thought their main purpose was to protect the hospital.³⁷

Passantino and others considered the ethical and legal bases of veterinary informed consent in Italy, proposing a draft consent form for use in veterinary practice, with a generic approach that could be used for all types of treatment.³⁸ The form includes reference to any subsequent adverse event, and statements outlining the owner's responsibilities for after-care. One sentence contains a reference to the accompanying consent discussion:

“..... Reaffirms his/her IC to Doctor....., who has clearly explained the reasons for which the aforesaid treatments and/or tests are necessary, also illustrating the risks of the potential contraindications, complications and/or reactions.”³⁹

However, the form's primary purpose appears to be 'harm avoidance' as evidenced by its use of formalised legal language. Veterinary consent forms that use this type of language

³⁵ *ibid*

³⁶ Akkad and others (n17)

³⁷ MC Whiting and others, 'Survey of Veterinary Clients' Perceptions of Informed Consent at a Referral Hospital' (2017) 180 *Veterinary Record* 20

³⁸ A Passantino, V Quartarone, M Russo, 'Informed Consent in Veterinary Medicine: Legal and Medical Perspectives in Italy' (2011) 01 *Open Journal of Animal Sciences* 128

³⁹ *ibid*, 134

may reinforce the client's assumption that the form is designed to protect the veterinary professionals involved.⁴⁰

5.3.1 The consent form acts as a written contract

As most veterinary treatment incurs costs, the consent form also acts as a record of the contract for payment of veterinary services. This dual purpose is not without problems. In veterinary healthcare, and in human healthcare in most other countries, consideration, or payment, for healthcare is inextricably linked to consent. This means that the form may represent a written contract. However, like any other contract, it could be voided if the terms are too vague. As Bix observes, "(o)ne cannot consent to terms (.....)..... without knowledge of the terms."⁴¹

There has been a tradition of vague wording on consent forms, implying that the healthcare professional can carry out any treatment deemed necessary. This is no longer acceptable, for either medical or veterinary treatment, as it fails on both counts, primarily, as sufficient information to underpin valid consent, but also as a clearly stated contract term.⁴² There is, however, permission in veterinary healthcare to use a form of vague wording to achieve continuous 'blanket' consent to the use of off-label (unlicensed) drugs for the treatment of exotic pets.⁴³

The veterinary healthcare consent process could therefore be regarded as a mixture of a consent process for treatment and a contract for payment for this treatment. This gives a unique format and purpose to the associated consent form. The information provided and agreed by both parties must fulfil the minimum required for valid consent, but there also needs to be clear discussion and recording of costs. This seems a lot for one form to achieve.

⁴⁰ As suggested in the study by Whiting and others (n37)

⁴¹ Brian Bix, 'Contracts' in Franklin Miller and Alan Wertheimer (eds), *The Ethics of Consent Theory and Practice* (Oxford University Press 2015) 5

⁴² N van Dokkum, 'Hospital Consent Forms' (1996) 7 *Stellenbosch Law Review* 249

⁴³ RCVS (n9) Section 4.17 refers to the treatment of exotic pets (for example, reptiles). Here, it states that "in the case of exotic species, most of the medicines used are unlikely to be authorised for use in the UK and owners should be made aware of, and consent to, this from the outset."

It has been proposed that the use of two separate forms could improve veterinary consent protocols,⁴⁴ however, this could merely add to the information overload that already threatens to defeat a valid consent process. Moreover, the two aspects may be more intertwined than is anticipated, for example, where there are financial constraints that rule out one or more options for veterinary treatment.

5.3.2 The RCVS's exemplary consent form

In the UK, a specimen form of consent is suggested and provided for use by the Royal College of Veterinary Surgeons.⁴⁵ The first page of the form consists of the confirmation of ownership or agency, details of the animal patient, and a description of the proposed treatment. Page two contains six statements; a 'consent to treatment' statement; a statement referring to the explanation of the nature or description of treatment; risks of treatment; financial costs; agreement of the client to treatment without consent to protect the animal's best interests, and consent for use of unlicensed medicines. There is a free text section for "notes and instructions", a section for provision of estimated costs, and finally space for a signature by the person giving consent (either the owner or their agent, who must tick a box if under 18 years of age). Additionally, it recommends that a copy be given to the client, thus also fulfilling its role as a financial contract.

The RCVS suggests that "(c)onsent forms should be viewed as an aid to consent, in conjunction with a discussion with the client."⁴⁶ However, on the specimen form produced by the College, there is no space provided to record a summary of these discussions. In suggesting amendments to the form (see Appendix 11), I have included more free space to record the discussion.

⁴⁴ Kirstie Dye, 'Consent to Treatment in Veterinary Practice' in S. Pullen and C. Gray (eds) *Ethics, Law and the Veterinary Nurse* (Elsevier 2006)

⁴⁵ RCVS 'Specimen Form of Consent for Anaesthesia and Surgical Procedures' <<https://www.rcvs.org.uk/document-library/specimen-form-of-consent-for-anaesthesia-and-surgical-procedures/>> A copy of the form is included in Appendix 1.

⁴⁶ RCVS (n9) S11.6

The language used on this form is formal and quasi-legal, exemplified by the sentence, “I hereby give permission for the administration of an anaesthetic to the above animal and to the surgical or other procedures detailed on this form together with any other procedures which may prove necessary.”⁴⁷ This sentence presents two obvious problems. First, the use of such language reinforces the view that the Royal College’s focus is on ‘harm avoidance’ rather than as evidence of a shared decision-making process, by referring to ‘one-off’ consent being given or withheld for the procedure(s) listed. Second, the use of the phrase “any other procedures...” does not fulfil the requirements of a contract, where the terms must be clearly stated.

To investigate whether these problems are replicated in forms used in veterinary practice, I designed the first empirical study to analyse forms currently in use in a sample of UK practices.

5.4 Methods of data collection

I set out to collect a selection of consent forms, intending to conduct thematic analysis of the language used. Blank consent forms were used for this study, for two important reasons.

- i) There were no data protection issues arising from handling blank consent forms with no client details recorded, and
- ii) It provided an opportunity to determine the role that the form could play in the overall consent process, without individual and detailed information.

5.4.1 Sources of data

Consent forms were obtained from a selection of veterinary practices in the UK and Ireland via requests placed on social media. An initial request via posts on Twitter (on 21.07.16, 25.07.16, 09.08.16, 11.08.16, and 15.08.16) and Facebook, (21.07.16 and 15.08.16) invited submission, via email, of blank forms used in practice. This approach produced less than 10

⁴⁷ RCVS (n45) at p2

responses. I then performed an internet search, using the Google search engine, for veterinary practices in six randomly selected counties in the United Kingdom. One county was selected for each of northern, southern, eastern and western England, Scotland and Wales. For the first five practices listed in each area, I sourced email addresses and sent individual invitations to participate, together with email invitations to the main veterinary charity organisations which offer clinical services. This resulted in one response.

Subsequently, a forum post on a veterinary professional membership site,⁴⁸ and requests sent to personal contacts, resulted in the submission of 60 forms in total. This number was lower than I originally anticipated and suggests that my professional background may have acted as a barrier to the submission of more forms.⁴⁹

From the original number of forms (60) submitted, a total of 41 forms were included in the analysis. Exclusion was based on the ability of the forms to be used for routine elective surgery (neutering) of small animal patients (dogs, cats or rabbits). Those considered unsuitable were removed before analysis, with exclusion for the following reasons:

- a) they sought consent for other procedures; 4 forms for the use of unlicensed drugs, 3 for euthanasia, and one giving options and obtaining consent for treatment of misalliance (unplanned mating)
- b) they sought consent to treatment of other species (mainly horses) or
- c) they were submitted from countries outside the United Kingdom and Ireland.

The forms were anonymised and uploaded to qualitative analysis software, QSR NVivo,⁵⁰ for organisation and storage prior to initial content analysis. This software was chosen because I was already familiar with its layout and operation, and because it provided a simple way of storing the results of the thematic analysis of the forms.

⁴⁸ Vetsurgeon.org Members' Forum <www.vetsurgeon.org> Initial post 4.8.16, also circulated in the site's newsletter on 26.8.16. Copy of post included in Appendix 2.

⁴⁹ I was upfront in social media posts and emails about my veterinary qualifications and interest in consent, so practices may have feared being 'judged'. Or, it may have been that practices don't have a policy on research participation and the members of staff responsible for monitoring social media or email traffic did not have the authority to submit the forms?

⁵⁰ ©QSR International Pty Ltd, Victoria, Australia

5.5 Data analysis

A quantitative approach to content analysis was considered, and rejected, in view of the variety of terminology used in each form. However, I did attempt to produce some quantitative findings that I could share with professional colleagues when interviewing them about their perspectives on consent, especially regarding risk disclosure and the 'quasi-legal' aspects of the consent forms used. These findings are presented in Table 5.1:

Criterion	No. of forms (/41)	Percentage
<i>Confirmation of ownership or agency</i>	10	24
<i>Confirmation of client's understanding</i>	15	37
<i>Estimates of costs provided</i>	31	76
<i>Risks of GA/surgery mentioned</i>	38	93
<i>Specific risks identified</i>	10	24
<i>Provision to act without consent</i>	16	39
<i>Reference to accompanying discussion</i>	1	2
<i>Indication of copy provided to client</i>	1	2
<i>Signature of person taking consent</i>	5	12

Table 5.1: A quantitative analysis of consent forms

The variation in the language used on the forms required my interpretation and judgment on how best to categorise sections of text. I therefore utilised qualitative content analysis, based on aspects of grounded theory,⁵¹ and its interpretation of data through thematic analysis.⁵²

A grounded theory approach allowed themes to be generated from the data collected, rather than being constrained by the use of pre-determined categories. I was careful to

⁵¹ BG Glaser, AL Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Aldine 1967)

⁵² G Guest, KM MacQueen, EE Namey, *Applied Thematic Analysis* (Sage 2012)

avoid expecting themes to ‘magically appear’ from the data,⁵³ but also hesitant to use themes already elicited from legal research⁵⁴ and therefore attempted to allow them to form inductively. However, the language of consent is unique and requires some legal influence. I cannot be sure that my theoretical approach to analysis of the forms was completely ‘grounded’. Inevitably, as the level of analysis increased, the influences from doctrinal research crept in. For example, there was a clear separation of themes into those where client autonomy was respected and those where the veterinary practice was using ‘paternalistic’ language.⁵⁵

With a true ‘grounded theory’ method, the researcher does not bring any pre-existing knowledge to the analysis of the data, thus ensuring a completely data-derived approach to coding and analysis. However, with my experience as a member of the profession that I studied, I brought existing knowledge of the topics included on the consent forms, and from prior doctrinal research, I brought some ideas of the nature of informed consent itself. Initial coding therefore followed a variation on a constructive ‘grounded theory’ methodology.⁵⁶ I then used a constant comparative method to check the validity of any themes that arose from the data. Basic themes were derived from the ‘open coding’ approach to the text contained in all forms. These themes were then grouped into the following higher-level themes:

- I. The form is used to confirm the nature of the procedure, and to offer additional procedures
- II. The form is used as a means of disclosing risks and benefits of the procedure(s)
- III. The form is used to convey details of financial responsibility

⁵³ K Charmaz and A Bryant , ‘Grounded Theory and Credibility’ in David Silverman (ed), *Qualitative Research* (3rd edn, Sage 2011) 294

⁵⁴ For example, ‘respect for autonomy’ or ‘best interests of the patient’

⁵⁵ I use ‘paternalistic’ rather than ‘beneficent’ here because it was language designed to have an effect on the client rather than the patient.

⁵⁶ Charmaz and Bryant (n53) 302-4

IV. The form acts as authorisation or proof of consent (and possibly, therefore, as a shield against complaints and litigation)

These inter-related themes were analysed in more depth and extrapolated into a thematic summary.⁵⁷ Next, synthesis and thematic conceptualisation produced a conceptual description of the form's role in the consent process. The different levels of analysis are represented in Table 5.2 below.

Topical survey	Thematic summary	Conceptual description
<i>Description of procedure(s)</i> <i>Offer of additional procedures</i> <i>Recommendation for additional procedures</i>	Using the form to define the proposed procedure, and to offer other procedures	Respecting client autonomy vs. demonstrating paternalism
<i>Eliciting health details</i> <i>Outline of risks of GA</i> <i>Outline of other risks</i> <i>Listing post-operative complications</i> <i>Listing requirements for aftercare</i> <i>Reference to uncertainty</i>	Using the form to convey risks and benefits	Deciding on level of risk disclosure
<i>Estimate of costs</i> <i>Contract for payment</i> <i>Charges for additional services</i> <i>Reference to payment for unexpected outcomes</i>	Using the form to detail financial responsibility	Respecting client financial autonomy
<i>Confirmation of ownership or authorised agency</i> <i>Confirmation of consent</i> <i>Seeking consent for unspecified procedures/unlicensed drugs</i> <i>Confirmation of understanding</i>	Using the form as a quasi-legal document, to authorise treatment	Identifying the role of the form in the consent process

⁵⁷ M Sandelowski and J Barroso, 'Classifying the Findings in Qualitative Studies' (2016) 13 *Qualitative Health Research* 905, 910

Table 5.2: The analytic levels achieved for analysis of consent forms, from Sandelowski and Barroso⁵⁸

5.6 Findings from the data analysis

The results of the thematic summary of the consent forms are presented in two sections. The first section describes the content analysis of the forms and provides a “topical survey”. This is the most concrete and descriptive part of the findings, where the analysis remains closest to the original wording on the forms. The forms are numbered as “CFxx”, where CF = Consent Form, followed by a randomly assigned number. In the second section, at 5.7, the level of analysis is raised to conceptual description, combining themes where they converge under a more abstract interpretation.

5.6.1 Description of the procedure

All consent forms analysed provided space for a description of the procedure being undertaken. The prompt for identifying the procedure varied amongst forms. For example, “Operation/procedure: _____” or “Surgical procedure: _____” appeared on twenty forms; “Proposed operation: _____” on three forms, and “Reason for admission: _____” on four forms.

However, little space was provided for giving more detail about the surgical procedure, suggesting that a more detailed explanation may be offered during the accompanying discussion. There were no examples where space was allocated for recording options given for treatment. However, as will be seen in Chapter 6, there are few alternatives to surgical neutering, and where these exist, they are rarely offered. Therefore, for the purposes of this study, the description of the proposed procedure would be sufficient.

5.6.2 Additional procedures

⁵⁸ Ibid, 910-914

The “additional procedures” theme included making recommendations for, and offering, additional procedures. The division into two sub-themes was decided primarily on the language used on the forms, leading to identification of the person making the decision for the optional procedure. “Offering” involved listing the available additional procedure(s) without a strong recommendation for the specific patient, thus apparently leaving the decision to the client. “Recommending” involved making a strong recommendation for a specific procedure, although giving the client a choice of whether to accept this optional extra.

a) Offering additional procedures

Additional services offered included the provision of post-operative recovery diets:

“Would you like your pet to go home with a special postoperative diet pack upon discharge? (There will be a small additional fee for this) YES/NO”

(CF33)

and the option of having laboratory investigations performed on any lumps removed:

“In case of mass removal, do you wish to have histopathology Yes/No”

(CF9)

However, the most commonly offered additional procedure was the insertion of a microchip for identification (eighteen of 41 forms).

Thirteen practices offered pre-operative blood tests to all clients whose animals were scheduled for surgery, for example:

“Would you like your pet to have a pre-anaesthetic blood test? YES/NO”

(CF2)

But some practices included the financial implications for the client:

“Would you like a blood test before your pet’s anaesthetic? (£41.34)?”

(CF58)

One practice offered a blood test to screen for canine lungworm, as an undetected infection with this parasite can affect blood clotting during surgery:

“I would like my dog tested for lungworm – Cost ~£24 ☐”

(CF49)

In the above examples, the wording of the consent forms suggested that clients were given options and left to make decisions on their own. It is not known how much involvement the person obtaining consent would have in helping the client make a decision. However, the options being offered did not pertain to the main reason for the animal being admitted, so were more peripheral to the focus of consent. They also inevitably involved additional costs. Sometimes these costs were explicit, and sometimes they were referred to in an oblique way as, for example, a “small additional fee”. In some cases, therefore, clients were given the option of additional services without information about the costs involved.

b) Recommending additional procedures

On these forms, the veterinary practice either recommended procedures, or included a statement that the practice may carry out certain procedures and charge the client accordingly. For example, in treating parasitic infestations:

“Please note that appropriate flea control will be applied where necessary at the owners (sic) expense.”

(CF23)

Recommended therapy to accelerate wound healing was included on an “opt-out” basis:

“At the time of operation and post op check we automatically perform subject to availability laser surgery of the wound to speed up the healing process at a cost of £10.00. Would you like to opt out? Yes No ”

(CF50)

One practice recommended, rather than offered, the “recovery diet,” which is a diet designed to help with recovery from anaesthesia and surgery:

“We highly recommend that _____ has a specifically formulated diet for post-op nutrition.”

(CF23)

Thirteen practices made strong recommendations for pre-operative blood tests, either for every patient:

“We recommend a pre-anaesthetic blood test to eliminate many pre-existing problems that may not be evident physically, but could lead to complications.”

(CF1)

or, only for those for whom the veterinary professional considers there is a clinical need:

“In some animals we will recommend blood/urine tests to help identify any problems that may not be evident physically but which may lead to complications that could be averted.”

(CF32)

However, the client was usually able to opt-out:

“We will perform a pre-anaesthetic blood test if we believe it to be necessary – this is usually in ill or elderly animals. This does involve an extra cost. If you do not want us to do this test please tick the box.”

(CF33)

The examples shown demonstrate what could be termed a more “paternalistic” approach to consent, in that the client is strongly directed towards certain procedures or actions.

However, as was the case with the practices that “offered” additional procedures, the costs of these procedures were sometimes hidden. The significance of the two different approaches, i.e. offering vs. recommending, is discussed in Section 5.7.1.

5.6.3 Eliciting health details

Twelve out of 41 consent forms asked about current medication and when it had been last given, for example:

“Is your pet on any medication? YES/NO

When was the last dose? _____ “

(CF2)

However, some forms included a brief “health questionnaire” which may have acted as a structured guide to the discussion between the two parties:

“Healthy at home Y/N

V+? [vomiting] Y/N

D+? [diarrhoea] Y/N

Cough/Sneeze? Y/N

On medication? Y/N Name _____ Last Given? _____

Has your pet ever had any adverse reactions to any medication? Y/N _____”

(CF15)

Some health questions were specifically aimed at patients admitted for neutering:

“In case of bitch spay, when was end of last season?.....”

(CF9)

with some requiring greater detail, and a physical examination which, presumably, would be completed by the veterinary professional:

“NEUTERING MALE / FEMALE

MALE: 2 TESTICLES PRESENT

FEMALE: CHECK MAMMARY GLANDS

DATE OF LAST SEASON _____

CHECK SIGNS OF HEAT ”

(CF45)

In this section, it is more likely that the person obtaining consent discussed these questions with the client, rather than leaving the client to complete the form. However, it does suggest that the form may be used to structure the accompanying discussion, as will be revisited in Section 5.7.4.

5.6.4 The risks of anaesthesia and surgery

The risks of anaesthesia can be reduced by checking that the patient has been starved prior to the procedure, to prevent vomiting and resulting complications, although there is some dispute regarding how long the patient should be deprived of food and water.⁵⁹ Some consent forms provided space for confirming the patient’s fasted status:

⁵⁹ K Clarke, C Trim and LW Hall ‘An Introduction to Anaesthesia and General Considerations’, in Clarke, Trim and Hall (eds) *Veterinary Anaesthesia* (11 edn, WB Saunders 2014) 15. These authors suggest that 12 hours’ fasting may predispose canine patients to complications such as gastroesophageal reflux, but do not propose an alternative period of fasting. I Savas and D Raptopoulos, in their trial, ‘Incidence of gastro-oesophageal reflux during anaesthesia, following two different fasting times in dogs’ (2000) 27 *Veterinary Anaesthesia and Analgesia* 54, found that 3 hours’ fasting prevented reflux, so the recommendation may eventually change.

*“Has your pet been starved? YES/NO
When did they last eat? _____”*

(CF2)

Others were more overt about the dangers of failing to starve the patient:

*“IF YOUR PET HAS EATEN THIS MORNING IT IS ESSENTIAL THAT YOU INFORM
US NOW.”*

(CF6)

One consent form contained useful pre-admission information, but there was no indication that the client had been given a copy of the form in advance of the day of the proposed surgery:

*“Do not allow your pet to eat for 12 hours prior to admission unless specified
by the staff beforehand. This does not apply to rabbits. Water should be given
freely. Cats must be presented in a secure basket and dogs with a correctly
fitting lead and collar, and muzzle if necessary. Admission may be refused if it
is considered unsafe to do so (sic).”*

(CF14)

The provision of a copy of the form to the client is recommended in the RCVS’s guidance on consent, which also advises that the consent discussion for elective procedures should take place in advance of the surgery.⁶⁰ In these circumstances, the latter form would provide useful information about bringing the pet in for surgery.

⁶⁰ RCVS (n9) sections 11.2 and 11.11

Thirty-eight of 41 forms mentioned risks. Therefore, the figure of 93% is in line with the 87% of medical consent forms that mentioned risks in the previous study by Bottrell and others.⁶¹

Clients should be made aware of ‘material risks’⁶² that may affect their decision whether to go ahead with the proposed procedure. For elective neutering surgery, the main risk that needs to be conveyed is the statistically small risk of death occurring under general anaesthesia. On the forms analysed, the risks involved in sedation and/or general anaesthesia were usually described in generic terms, requiring the client to confirm that they understood the risks. Sometimes the risks of anaesthesia and surgery were combined into one statement:

“I understand that all anaesthetic and surgical procedures involve some risk to the animal.”

(CF1)

However, some forms explicitly highlighted the risks of anaesthesia:

“I acknowledge that all anaesthetic procedures carry a risk.”

(CF2)

In some cases, these risks were clarified in terms of the status of the patient:

“Operations and procedures, however small, which require sedation or anaesthesia to facilitate their performance, carry a slight risk to the patient. These risks may be increased if your pet is old, overweight or ill and in a number of other circumstances.”

(CF6)

⁶¹ Bottrell and others (n15)

⁶² For a current definition of material risks and a discussion on which would be appropriate for elective neutering of companion animals, see Chapter 3, section 3.6.3 and Chapter 4, section 4.7.4

The striking feature of the phrases used in the above examples is that the nature of the risk is not explained. It may be that the nature of the risks involved is covered during the accompanying discussions, or that clients are left to construct their own ideas of what these risks might be. One form explained the risks in more detail, while stopping short of stating that the material risk is death:

"I understand that all diagnostic and therapeutic procedures, including sedation and general anaesthesia, involve some risk to the life and health of my animal"

(CF7)

Although this is an improvement on the generic risks statement, careful reading and interpretation by the client is required to deduce that the risk is death from the words "some risk to the life..." A clearer statement of risk would inform the client directly, but only one form clarified this risk, and even then, stopped short of using the word 'death':

"I acknowledge and agree to the risks involved and understand that in extreme circumstances these may include loss of life."

(CF44)

One form left space for documenting the risks discussed during the consent discussion:

"Risks and complications associated with diagnosis and treatment may include:

_____ "

(CF32)

The failure of most forms to clearly state the material risk involved in anaesthesia for elective neutering procedures is discussed in more detail later in this chapter (at 5.7.2).

Most consent forms included the risks of surgery and anaesthesia in a single statement, but some acted as evidence that a more comprehensive discussion had taken place, e.g.:

"I have also been informed that there are certain risks and complications associated with any operation or procedure of this type. These have been explained to me."

(CF26)

Others required the client to accept the risks involved, with no indication of how these had been conveyed:

"..... [I] understand that there may be risks and complications associated with the planned procedures."

(CF48)

One form listed common adverse outcomes following surgery, leaving space to document specific risks that had been discussed:

"I accept that possible complications from the procedure may occur such as sepsis, wound breakdown, haemorrhage and anaesthetic reaction. Further possible complications: _____"

(CF50)

Another form listed the most common post-operative complications:

"Complications are rare but can occur (e.g. infected wounds from licking, burst stitches from the pet having too much exercise or jumping, wound breakdown or delayed healing, side effects from medication – vomit/diarrhoea etc.)"

(CF60)

None of the consent forms listed the benefits of surgery, nor provided space to record any discussion about these benefits. These discussions are particularly relevant to decisions about elective neutering and other types of elective surgery, but it is an area where practices could

improve their consent procedures for all surgery. I will develop this recommendation in Chapter 8, in Section 8.3.1.

5.6.5 Requirements for aftercare

Because consent forms focus on consent for the anticipated procedure, there was little reference to aftercare in the text of the forms. One form referred to the provision of details of post-operative care, in the form of a discharge sheet:

“I confirm that I have received a discharge sheet ”

(CF34)

while another required confirmation that details of post-operative care had been provided when the patient was collected:

“Post Op Information Given Out By: _____”

(CF45)

The only example of more detailed advice about aftercare was found in form 33:

“Neutered animals put on weight due to hormone changes, so if your animal is coming in to be neutered please take this into account and reduce their food accordingly. Please ask the nurse/vet for advice upon patient discharge.”

(CF33)

As appropriate aftercare is an important factor in preventing post-operative complications, a sub-group of potential risks of surgery, it is worrying that there was so little reference to aftercare on the forms. This may be a topic that is primarily covered during consent discussions, so will be revisited in Chapter 6.

5.6.6 Reference to uncertainty of outcome

Most forms were designed for use prior to any type of surgical or medical procedure. Four out of 41 forms referred to the uncertainty of the results of the treatment. Several forms included a statement that the practice could not guarantee positive outcomes:

"I realise that positive results cannot be guaranteed."

(CF4)

"I also accept that the success of medical or surgical treatment cannot be guaranteed."

(CF21)

Such statements reinforce the lack of guaranteed outcome that applies to medical procedures, although the involvement of financial obligation on the part of the client has similarities with a written contract. However, even when medical treatment involves a contract between service provider and patient, it would be unusual to guarantee success.⁶³ Thus, it is debatable whether such a statement is required on consent forms.

5.6.7 Detailing financial obligations

Thirty-one out of 41 forms provided estimated costs of treatment on the consent form. For the rest, it was unclear whether there was a separate written estimate provided, or if the discussion was documented in the patient's clinical records. Some of the language used on the forms pertained to the financial contract:

"I understand that the complete fee is due for payment when I take my pet home."

(CF1)

This was sometimes reinforced by asking for details of payment method at the time of consent:

⁶³ See R Mulheron, 'Duties in Contract and Tort', in Judith Laing and Jean V McHale (eds) *Principles of Medical Law* (4th edn, Oxford University Press 2017)

"I understand that all fees must be settled at the end of surgery. I will pay my account by Cash Cheque Card"

(CF12)

while some practices asked for partial payment in advance:

"A deposit of 50% of the initial estimate will be required on admission; the balance must be paid in full on discharge unless otherwise agreed in writing in advance."

(CF14)

One form added a cautionary statement that the client would still be required to pay in the event of an adverse outcome:

".... the charges apply regardless of the eventual outcome."

(CF7)

One area that could lead to financial dispute is payment for treatment required due to post-operative complications; is this extra cost included in the initial estimate or not? One practice stated the position very clearly:

"Complications are rare but can occur..... (.....) if they do occur then consultations within the first 2 weeks are included in the price of the operation. All costs of medication needed during this time, further consultations beyond 2 weeks or any repeat surgery if indicated will be additional to the costs involved initially."

(CF60)

Such clarity respects the client's financial authority, as they are fully informed about when they would be required to pay for postoperative care.

5.6.8 The language of a 'quasi-legal' document

The requirements for the consent form to be used as a quasi-legal document are taken from the Supporting Guidance to the RCVS Code of Professional Conduct.⁶⁴ Requirements include confirming that the correct person is giving consent; that this person has been given the information about the proposed treatment, options, risks and benefits; that this person understands the information and can indicate consent, usually in writing.

All consent forms analysed had provision for recording the identity and contact details of the client and the animal.

a) Ownership

Most forms gave options for the client to sign as the owner or the owner's agent, but only required ticking of the relevant box, or deletion of whichever term was not appropriate. Ten out of 41 forms included a statement requiring the client to confirm that they were the owner of the patient, or that they had the owner's permission to make treatment decisions.

"I am the owner or I am acting with the full knowledge and authority of the owner."

(CF29)

The requirement for agents to confirm that they had the authority to make decisions was stated clearly in form CF26:

"I certify that if I am signing as an agent, I have the authority to execute this consent"

The statement confirming decision-making authority included confirmation that the person signing the form was at least 18 years of age on seven out of 41 forms:

"I am the owner or agent of the above animal and have the authority to give this consent. I am over 18 years of age."

⁶⁴ RCVS (n9) Section 11

(CF23)

In view of the age restrictions for entering into financial contracts,⁶⁵ it is advisable that the requirement for both parties to the contract to be at least 18 years of age is recorded, and confirmed, on consent forms.

b) Confirmation of consent

All forms required specific consent to be given, via a clear statement of intent, such as:

“I hereby give permission” (28 of 41 forms); *“I give my consent to ...”* (8 forms); *“I authorise”* (3 forms).

In some cases, it was also an opportunity to confirm understanding, and lack of coercion:

“I have read and understood this form and hereby voluntarily give my consent.”

(CF12)

c) Consent for additional treatment

Some forms required additional consent for the use of unlicensed drugs:

“I understand that it may be necessary to use an unlicensed (sic) drug during the above procedure. I do/do not give my consent.”

(CF15)

Others provided comprehensive information about the use of unlicensed drugs, designed to be read and understood before giving consent:

⁶⁵ See RCVS (n9) Sections 11.27-11.29

“I understand that there may be occasions when it will be necessary to use medicines which, while not specifically authorized for the treatment of this species, may be used legally when justified clinically. I have been made aware, and accept, that there may be unknown side-effects associated with the use of such medicines in this species, and I consent to their use.”

(CF42)

This paragraph expands on the text regarding use of unlicensed drugs from the RCVS specimen form of consent.

The most unusual request for consent sought permission for use of photographs and stories involving the patient on social media platforms:

“Would you be happy for us to use photos & stories of your pet on Facebook & other social media? YES / NO”

(CF44)

Although it was commendable that the practice concerned was seeking permission for the use of stories or images of the patient, it gave no guarantee that the client’s identity would be kept confidential.

d) Proceeding without consent

Several forms sought consent for unforeseen treatment that may have been required during the procedure. Sometimes this was expressed as a comprehensive statement suggesting that the veterinary surgeon could perform any procedure deemed necessary:

“I hereby give consent to and authorise the performance of such procedures as are necessary and desirable in the exercise of the veterinary surgeon's professional judgement.”

(CF23)

Sometimes the financial aspect of this “blanket” consent was clarified:

“... if I can't be contacted the Veterinary Surgeon will act in the best interests of my animal. I accept this may incur additional costs.”

(CF29)

This approach was explained in more detail in form CF44:

“In the event that the veterinary surgeon discovers a problem which needs addressing whilst my pet is under the anaesthetic, and I cannot be contacted on the number that I have provided, I consent to the veterinary surgeon using their judgement to do what is best for my pet.”

Others emphasised that they would make decisions based on the animal’s best interests:

“We will attempt to contact you on the numbers provided to discuss variations. However, if we are unable to make contact we will proceed with the treatment which the veterinary surgeon considers to be in your pet’s best interests.”

(CF48)

However, many forms included this as part of the overall consent statement, either in detail:

“I further understand that during the course of the operations or procedures, unforeseen conditions may arise that may necessitate the performance of additional procedures.”

(CF26)

or as an additional phrase to the confirmation of consent for the procedure. The most common format of the additional statement was *“together with any other procedures which*

may prove necessary".⁶⁶ This appeared on twenty-three out of 41 forms and is taken directly from the RCVS's suggested consent form.⁶⁷ The problem with enforcing this clause is discussed further in Chapter 8, Section 8.3.4, together with a plea for its removal.

5.6.9 The role of the veterinary professional in the process

Rather than asking the client to confirm that they understand the components of the consent discussion, as alluded to in the "confirming consent" section above, some forms required the veterinary professional involved in the process to confirm that the client had been given the information in a suitable format:

"I confirm I have discussed the content of this form with the owner. I am satisfied the owner understands the content.

Signed Position Date"

(CF6)

"Declaration by Veterinary Surgeon: I confirm I have explained the risks of the anaesthetic and procedure in terms that I judged were understood by the owner/authorised agent."

(CF31)

Several forms required a counter-signature by the person obtaining consent, although only one form required confirmation that a copy had been provided to the client.

5.7 Raising the analysis to the level of conceptual description

Several themes emerged at the level of conceptual description when the topical survey was complete; all were derived from examination of the language used on consent forms, were

⁶⁶ In reality, there is very little chance of something unexpected happening during neutering surgery, apart from an anaesthetic or surgical emergency that will be accepted as a possible risk by the client when giving consent. This phrase is therefore redundant. I have removed it from my amended consent form (see Appendix 11)

⁶⁷ RCVS (n45)

first grouped as thematic summaries, and were then analysed with reference to prior reading and doctrinal research. These 'higher level' themes comprised:

1. The demonstration of respect for client autonomy
2. The level of risk disclosure
3. Respect for the client's financial autonomy
4. The role of the form in the consent process

I will examine each of the above areas in turn.

5.7.1 Respect for client autonomy

The issue of how much respect is given to client autonomy can be explored through the analysis of the language used on consent forms. First, there was little evidence on the forms submitted of clients being given options for treatment. The space allocated for insertion of the proposed procedure did not usually allow listing of options that had been discussed with the client.

The autonomy versus paternalism debate that was highlighted in Chapter 3 is further illustrated by using the example of pre-operative blood tests and their "sale" on consent forms. Many veterinary practices routinely offer or recommend testing blood samples from a prospective patient before admitting for general anaesthesia. The evidence for the necessity of pre-operative blood testing is equivocal. Routine screening of older, or geriatric, clinically healthy dogs and cats can reveal clinically undetected abnormalities,⁶⁸ although there is no evidence that detection leads to increased quality or quantity of life.⁶⁹ The evidence for routine pre-anaesthetic blood testing of younger, clinically healthy animals is even less convincing. In Alef and others' 2008 study of 1537 dogs, they concluded that there was no evidence to justify routine pre-operative blood testing in clinically healthy dogs.⁷⁰

⁶⁸ D Dell'Osa and S Jaensch, 'Prevalence of Clinicopathological Changes in Healthy Middle-Aged Dogs and Cats Presenting to Veterinary Practices for Routine Procedures' (2016) 94 *Australian Veterinary Journal* 317

⁶⁹ A Willems and others, 'Results of Screening of Apparently Healthy Senior and Geriatric Dogs.' (2017) 31 *Journal of Veterinary Internal Medicine* 81

⁷⁰ M Alef, F Von Praun, G Oechtering, 'Is Routine Pre-Anaesthetic Haematological and Biochemical Screening Justified in Dogs?' (2008) 35 *Veterinary Anaesthesia and Analgesia* 132

The question is, therefore, whether it is more respectful of client autonomy for the veterinary professional to give the client the facts about these tests, then leave it completely up to the client to decide? Alternatively, practices could consider that this is an area where the professional should 'guide' the client on whether the tests are recommended for the individual patient. Both approaches were used on the consent forms analysed, although in most cases the client was not given all the information that necessary to make an informed decision. Some forms included strong recommendations for pre-anaesthetic blood tests for all patients. Some contained recommendations for particular patients (e.g. older animals), and others left the decision completely to the client. My view is that the approach used should be dependent on the client's knowledge and experience. For an inexperienced client, the presentation of options for blood tests may detract from the discussion regarding the risks of the main procedure, therefore a strong recommendation from the veterinary professional regarding blood tests allows the client to focus on the risks of the procedure itself. For more experienced clients, their prior knowledge and understanding could validate giving them the option and leaving them to decide.

Analysis of the forms submitted inevitably raised questions regarding the role of the accompanying consent discussion, for example, whether it closely followed the text on the form, or whether it gave the client additional information. The correlation between the form and the discussion will be investigated in Chapter 6.

5.7.2 Level of risk disclosure

Associated with respect for client autonomy is the level of risk disclosure. When communicating risks, the forms analysed were usually non-specific about a) the type of risk and b) the level of risk involved.

Historically, the types and levels of risk involved in a procedure were considered as tacit knowledge, retained by paternalistic healthcare professionals (in whom their patients trusted), but not communicated to patients, in case this knowledge upset them or

influenced their response to treatment.⁷¹ The requirement for full disclosure of risks, given legal force in *Montgomery* (see Chapter 3, Section 3.2), means that healthcare professionals now have responsibility for communicating the types and magnitude of risk involved in proposed treatment to patients, as an integral part of modern informed consent protocols.⁷²

Risks are usually quantified numerically, an approach that was developed in the 1840s but is still used today.⁷³ However, the use of population-derived risk statistics to describe risk is far removed from the effect on the individual patient of an adverse outcome.⁷⁴ This can be illustrated for the study context of elective neutering of companion animals. A population risk of death under general anaesthesia (around 1 in 1000 for cats) is numerically small, but the effect on the owner of an affected animal may be catastrophic, especially if this is an unexpected loss, as would be the case with a healthy animal undergoing a “routine” non-therapeutic procedure. This example illustrates the problem of generalising about the term “risks” on the consent forms that were analysed. If an owner is unaware that there is even a very small risk of death from anaesthesia, then an informed decision to go ahead with a non-therapeutic surgical procedure is impossible. When attempting to ameliorate this level of risk with the offer of pre-anaesthesia blood testing, the danger is that, as in human healthcare, the incentives for the healthcare professional (through, for example, bonus payments or achieving targets) are not balanced by the small measurable health gain for the patient.⁷⁵

Some forms contained a reference to the uncertainty of the outcome, usually with a disclaimer that there was no guarantee of success. Uncertainty in medicine can cause

⁷¹ JF Will, ‘A Brief Historical and Theoretical Perspective on Patient Autonomy and Medical Decision Making’ (2011) 139 *Chest* 669

⁷² A Alaszewski and P Brown, ‘Risk, Uncertainty and Knowledge’ (2007) 9 *Health, Risk & Society* 1

⁷³ T Schlich, ‘Objectifying Uncertainty: History of Risk Concepts in Medicine’ (2004) 23 *Topoi* 211. Note, however, that the quantification of risk in legal judgments is still rare, and somewhat crude.

⁷⁴ *ibid*, 216

⁷⁵ See B Starfield and others, ‘The Concept of Prevention: a Good Idea Gone Astray?’ (2008) 62 *Journal of Epidemiology & Community Health* 580; also see A Kumar and U Srivastava, ‘Role of Routine Laboratory Investigations in Preoperative Evaluation’ (2011) 27 *Journal of Anaesthesiology Clinical Pharmacology* 174. Although the idea of bonus payments for individual physicians is not applicable in the NHS setting, there are bonus payments available for GP practices to achieve certain targets for testing for various conditions, for example.

problems for both healthcare providers and, in turn, patients/clients to whom they must convey the uncertainty associated with clinical decisions. Although risk (probability) is one component of uncertainty, it is accompanied by ambiguity (due to conflicting or insufficient evidence) and complexity (e.g. the potential for a variety of outcomes from treatment).⁷⁶ In the case of elective neutering surgery, there is little variation in outcome, so the main source of uncertainty is ambiguity regarding the benefits of the procedure for the individual patient. Disagreement amongst experts, and conflicting findings from studies make it difficult to quantify the risks of post-operative complications such as urinary incontinence.⁷⁷ The forms analysed often referred to immediate post-operative complications (wound breakdown, infection etc.) but not to more delayed effects such as behavioural changes or urinary incontinence, except for one reference (CF33) to post-neutering obesity.

Additional information about post-operative complications may be given in the accompanying consent discussion. Therefore, this investigation requires an accompanying analysis of consent discussions to construct a fuller appreciation of how much additional information is, in fact, given. Discussions regarding post-operative complications are analysed in Chapter 6, at section 6.3.8.

5.7.3 Respect for the client's financial autonomy

A third method of showing respect for client autonomy is informing the client about the costs involved in the treatment. The client is defined as whoever presents the animal for treatment (not necessarily the owner). As the RCVS notes, "a client is the person who requests veterinary attention for an animal and veterinary surgeons and veterinary nurses may charge the client for the veterinary service provided."⁷⁸ Some forms asked for confirmation of the status of the person signing the consent form, i.e., whether this was the owner or owner's agent.

⁷⁶ PKJ Han, WMP Klein, NK Arora, 'Varieties of Uncertainty in Health Care: a Conceptual Taxonomy' (2011) 31 *Medical Decision Making* 828

⁷⁷ CA Adin, 'Complications of Ovariohysterectomy and Orchiectomy in Companion Animals' (2011) 41 *Veterinary Clinics of NA: Small Animal Practice* 1023

⁷⁸ RCVS (n9) Section 9.19

The most obvious deficiency of some consent forms was the failure to state estimated costs clearly. In some cases, an estimate of costs may have been provided on a separate form. In my view, this is acceptable provided that both forms are provided to the client in advance of the procedure. Some forms included the provision for the veterinary surgeon to carry out unspecified procedures, based on what they considered necessary. These forms suggested that for unforeseen procedures, when the owner was not contactable, decisions would be made in the 'best interests' of the animal (see Chapter 4, Section 4.3.1 for a discussion on best interests) but the owner would be charged for the additional procedures. This wording fails to respect the client's financial autonomy.

To address this problem, an accompanying discussion could raise the possibility of additional procedures being required, allowing a protocol for this eventuality to be worked out. For example, a client may agree to financial obligations up to a specified limit, with a request to be contacted to authorise any spending beyond the set limit. Indeed, the RCVS advises as follows:

“If ... it becomes evident that the initial estimate or a limit set by the client is likely to be exceeded, the client should be contacted and informed.....”⁷⁹

Good practice would therefore suggest that the client should be involved in a discussion about a maximum fee that must not be exceeded without specific consent from the client. This recommendation requires that the form is considered alongside the accompanying consent discussion.

5.7.4 The role of the form in the consent process

⁷⁹ RCVS (n9) Section 9.11. However, the RCVS Specimen Consent Form also includes the sentence that if the veterinary surgeon is unable to contact the client, then they will act in the best interests of the animal.

All forms analysed used ‘quasi-legal’ terminology, which may originate from the RCVS’s own sample consent form (see 5.3.2). As previously discussed in 5.2.2, there are drawbacks to this “legal” appearance. Clients may not read the form carefully, assuming that they must sign the form to allow the procedure to go ahead, or they may be either falsely reassured, frightened or confused by the legal terminology. The perception that the form protects the veterinary practice, or the individual veterinary professional, is supported to some extent by the study by Whiting and others, which is discussed in 5.3.⁸⁰

Moreover, the consent form has other roles that have become apparent through this analysis. It can act as a “shopping list” to offer the client a range of additional procedures and extras, expanding on its role as a commercial document. It can serve as an aide-memoire for the person taking consent, by listing all the topics that should be covered in a consent discussion, therefore providing structure to this discussion. It can provide written evidence that there has been a discussion about the proposed surgical procedure, or that the client has authorised and agreed to pay for a specific procedure.

5.8 Conclusion

This study of veterinary consent forms is the first study to analyse the language used on these forms in the veterinary medical setting. It is also the first study to confirm that consent forms fulfil multiple roles in veterinary practice. The perceived view of the form as a way of protecting the veterinary practice against litigation by clients is reinforced by the use of quasi-legal language in most of the forms analysed. A consistent finding was the length of the forms submitted, none extending to more than two sides of A4 paper. Restricting the length of the forms results in them failing to provide useful evidence of the consent discussion; conversely, many forms used for consent to participation in clinical research are criticised for being too lengthy, yet still miss essential information.⁸¹

⁸⁰ Whiting and others (n37)

⁸¹ E Beardsley, M Jefford, L Mileskin, ‘Longer consent forms for clinical trials compromise patient understanding: so why are they lengthening?’ (2007) 25 *Journal of Clinical Oncology* e13 DOI: 10.1200/JCO.2006.10.3341

The form therefore does not act as a complete record of the consent discussion. The importance of the accompanying discussion is implied by the lack of detail on the forms analysed, especially in terms of alternative treatments, and the risks and benefits of the proposed treatment. Therefore, the consent form on its own does not convey respect for the autonomy of the client.

The forms analysed demonstrated an over-reliance on tick boxes and standard statements, particularly regarding risk and payment. While the form can provide some indication of the amount of information that the client has been given, recording the estimated costs that have been provided, it can also suggest that the client is responsible for a variety of undisclosed costs that may result from other procedures carried out by the veterinary practice and considered to be in the patient's 'best interests'. Therefore, respect for the client's financial autonomy is not indicated by many of these forms.

When comparing this study of veterinary consent forms with similar studies in human medicine and medical research, the same deficiencies are apparent. Overuse of legal jargon, statements that are unhelpfully generic and sentences containing too much information in terms that the average person may not understand, are prevalent.⁸² The key to successful confirmation of consent is therefore *not* to place sole reliance on the form, but instead to use it in conjunction with a consent conversation.

The importance of considering the role of the accompanying conversation between the client and the veterinary professional has been mentioned in several previous sections. As discussed by Wall and Pentz,⁸³ consent can be considered as a "series of conversations." The next part of my study, therefore, investigates the content of consent discussions, and

⁸² Albala and others (n29)

⁸³ LK Wall and RD Pentz, 'Another Look at the Informed Consent Process: the Document and the Conversation' (2015) 122 *Cancer* 352

provides a chance to examine the relative roles of the discussion and the form in greater detail.

CHAPTER SIX: THE CONSENT CONVERSATION AND ITS ROLE IN THE CONSENT PROCESS

6.0 Introduction

The second of my empirical studies was designed to investigate 'informed consent' discussions between veterinary professionals and clients (animal owners). As a sequel to the study of consent forms, it involved investigation of the language and information contained in consent consultations between veterinary professionals and clients, thus allowing exploration of the inter-relationship between the form and the consent discussion. As this is the first study to observe consent discussions in the context of veterinary practice, it is necessary to review similar observations conducted in human medical practice.

Previous research in human medicine acknowledges the importance of regarding the conversation and the form as complementary to each other during the consent process. Indeed, some research indicates that the discussion is more effective than the form in enhancing patient understanding.¹ However, much of this previous work focuses on consent for clinical research. For example, Koyfman and others² compared the consent discussion with the documentation used, through the use of validated readability measures on both. They found that the language used during the discussion was simpler than the language used in documentation, although the latter is designed to improve patient understanding of the proposed procedure. Conversely, they found that some elements considered essential for informed consent were omitted from the discussions.

¹ J Flory and E Emanuel, in 'Interventions to Improve Research Participants' Understanding in Informed Consent for Research' (2004) 292 *Journal of the American Medical Association* 1593 These authors found that the main intervention that improved participants' understanding was an extended discussion with a member of the research team, rather than an enhanced consent form.

² SA Koyfman and others, 'Informed Consent Conversations and Documents: a Quantitative Comparison' (2015) 122 *Cancer* 464

In the context of medical treatment, Hanson and Pitt evaluated how well surgeons documented the informed consent discussion, finding that the reporting of the discussion, which was often completed after the procedure, was incomplete.³ Gentry and others⁴ investigated consent for anaesthesia in the paediatric setting by recording consent discussions, then interviewing the parents involved to test their recall of essential pieces of information. These authors attempted to link specific components of consent with improved parental recall. The presence of three pieces of information: a description of the plan, discussion of risks and discussion of benefits, correlated with improved recall. However, the use of recall as the outcome for consent research has been accused of being 'narrow.' I agree that more innovative work is required to investigate fundamental components of consent, for example, understanding and capacity, in more breadth and depth.⁵ The study by Gentry and others did include (self-reported) understanding as an outcome, but this was not linked to the presence of the three consent components listed above.⁶

Braddock and others' large study of decision-making in medical practice⁷ evaluated recordings of consultations via a set of pre-determined criteria for informed decision-making, judging the overall 'informed-ness' of the consultation according to the presence or absence of information considered essential for different levels of treatment. Their study found surgeons to be slightly better than physicians at informing patients, although the differences were small.⁸

³ M Hanson and D Pitt, 'Informed Consent for Surgery: Risk Discussion and Documentation' (2017) 60 *Canadian Journal of Surgery* 69

⁴ KR Gentry, K Lepere, DJ Opel, 'Informed Consent in Pediatric Anesthesiology' (2017) 27 *Pediatric Anesthesia* 1253

⁵ S Kim and others, 'Research Methodologies in Informed Consent Studies Involving Surgical and Invasive Procedures: Time to Re-Examine?' (2013) 93 *Patient Education and Counseling* 559

⁶ Gentry and others (n4) 1257

⁷ CH Braddock and others, 'Informed Decision-Making in Outpatient Practice: Time to Get Back to Basics' 282 *Journal of the American Medical Association* 2313

⁸ Ibid, 2319. These authors suggest that surgeons have more experience in obtaining informed consent for surgery, and also spend a larger proportion of visit time on patient education and counselling.

One novel approach to investigating consent involved resident physicians undertaking simulated consent discussions in emergency scenarios with standardised patients.⁹ The focus of the study was on the language used by resident physicians, determining the complexity of their language via validated reading scores. The language used by the residents was more complex than that used by the patients, with the residents speaking for longer than the patients. These findings may be readily explained by the need to convey complicated clinical information to patients, but they highlight the lack of involvement of patients in consent discussions.

Paediatric studies may provide the nearest comparison to my present study. Many studies are evaluated through testing parental recall and comparing this with recordings of the consultations. A systematic review¹⁰ of paediatric consent discussions for research found one study¹¹ that used direct observation of the conversation, with the rest relying on interviews to determine parental recall of the information given. A study that investigated consent for an elective procedure recorded clinic visits by vaccine-resistant parents.¹² Using conversation analysis to evaluate the physician-parent interaction resulted in identification of distinct types of physician behaviour; for example, 'presumptive' (paternalistic) and 'participatory' (similar to shared decision-making) approaches were used to try to persuade parents to vaccinate their children.

The only previous consent study to report the use of an interpretive description methodology analysed interviews with patients about their impressions of consent.¹³ However, for my own study, although I also include an interview-based component, I

⁹ DM McCarthy and others, 'Language Use in the Informed Consent Discussion for Emergency Procedures' (2012) 24 *Teaching and Learning in Medicine* 315

¹⁰ G Alahmad, 'Informed Consent in Pediatric Oncology: A Systematic Review of Qualitative Literature' (2018) 25 *Cancer Control* 1

¹¹ LMT Byrne-Davis and others, 'Balancing High Accrual and Ethical Recruitment in Paediatric Oncology: a Qualitative Study of the 'look and feel' of Clinical Trial Discussions' (2010) 10 *BMC Medical Research Methodology* 101

¹² DJ Opel and others, 'Characterizing Providers' Immunization Communication Practices During Health Supervision Visits with Vaccine-Hesitant Parents: a Pilot Study' (2012) 30 *Vaccine* 1269

¹³ M Busquets and J Caïs, 'Informed Consent: a Study of Patients with Life-Threatening Illnesses' (2017) 24 *Nursing Ethics* 430

consider that direct observation of consent conversations provides an essential contribution to the overall understanding of consent in the veterinary setting. For example, it allows interpretation of the veterinary professional-client relationship during the observed interactions, which cannot be evaluated via interviews. Importantly, triangulation of the analysis of these consent discussions with the previous analysis of consent forms enables evaluation of the inter-relationship between the two components of the consent process.

6.1 Methods

This section will report on the strategies used to attempt to recruit participant practices, the decision taken to base the study in a single “case study” practice, and the approach taken to observe consent discussions in this practice.

6.1.1 Recruitment

My original intention for the observational study was to recruit a variety of practices, from single ownership, single site ventures, to large, corporately-owned multiple site businesses, allowing comparison of consent procedures in practices that used a variety of business models. However, recruitment proved more difficult than anticipated.

Personal visits to ten local veterinary practices produced some initial interest. However, after revisiting the practices several times to update staff and liaise with key personnel, eventually none of the practices agreed to take part. The main reason given for non-participation was that members of staff were nervous about being watched and/or recorded. At this point, I considered cancelling the observational part of the study. However, this would mean losing the intended triangulation of the analyses of the discussion and the forms described in 6.0.

A chance meeting at a national veterinary event with the director of a large veterinary practice, with whom I discussed the study and my recruitment problems, led to an invitation to send information directly to the practice. After contacting the senior veterinary surgeon at the practice to discuss the study in detail, she provided the other veterinary surgeons with

brief details, then arranged for me to attend a practice meeting to describe my research and to answer any questions from the potential participants. Everyone at the meeting was willing to participate. This practice was therefore used to provide the basis for a descriptive case study, which is defined as “a case study whose purpose is to describe a phenomenon (the “case”) in its real-world context.”¹⁴

In my view, prior experience as a veterinary professional was both a help and a hindrance to recruitment. It enabled the meeting with the practice director who facilitated my introduction to the case study practice, but it may have prevented the practices that I visited from participating, if they felt that I would be “judging” them in some way. In considering the latter possibility, a researcher without a veterinary background may have been more successful in recruiting different practices. Nevertheless, I now had one site in which to carry out observations of consent discussions.

6.1.2 The practice and data collection

The veterinary practice recruited is a large multi-site venture, consisting of one hospital and 9 branches, all in urban locations. Staffed by 17 veterinary surgeons, consultations at this practice are scheduled at 15-minute intervals, which is longer than the most commonly reported UK veterinary consultation time of 10 minutes.¹⁵ This practice requires the owners of all elective patients to attend a pre-admission consultation with a veterinary surgeon prior to the day of surgery. The appointment includes a full physical examination of the patient, and the consent discussion related to the proposed surgery. At the time the study was conducted (September – November 2016) the consent form was completed when the patient was admitted on the morning of surgery, rather than at this pre-surgical consultation.

¹⁴ RK Yin, *Case Study Research: Design and Methods* (5th edn, Sage 2014) 238.

¹⁵ CA Gray, PJ Cripps, “‘Typical’ Veterinary Consultation in the United Kingdom and Ireland” (2005) 156 *Veterinary Record* 381; N J Robinson and others, ‘Consultation Length in First Opinion Small Animal Practice’ (2014) 175 *Veterinary Record* 486

I arranged to visit the practice on days when there was more than one appointment identified on the practice management software system as a pre-operative consultation for routine neutering. This was decided on the basis of practical considerations; it was a round trip of 180 miles approximately between home and the practice. This also meant that I did not actively seek to include a range of species or sex of animal, as this may have prolonged the data collection period, thus allowing less time for analysis.

I planned to give information to all the veterinary surgeons who would potentially be involved in the study before I started collecting data. All veterinary staff at the practice had been informed about the study via email from the senior veterinary surgeon, and several had attended the practice meeting where I presented the study and answered any questions that they had. However, on several occasions, I obtained verbal consent for recording at the start of the consultation, and written consent following the consultation. This only applied to veterinary surgeons. The receptionists asked all clients identified as potential participants for their permission to allow me to speak to them in the waiting room prior to their consultations. I explained the purpose of the study, gave them a written information sheet¹⁶ to read and keep, and obtained their written consent¹⁷ prior to the consultation. All clients that I approached agreed to participate. This raises important questions about the voluntariness of their consent. I introduced myself as a veterinary surgeon. There is evidence that potential participants in clinical research studies in medicine are more likely to consent when asked by a physician. This finding demonstrates the effects of trust and power on the likelihood of agreement to participate,¹⁸ although the authors query whether this is, indeed, “undue influence.”¹⁹ I made clear to participants that I was not employed at the practice, therefore would have no input to their animals’ care, so I felt that there was less likelihood of influence on their decisions. However, I cannot completely rule out the possibility of influence.

¹⁶ See information sheets for vets and clients at Appendices 3a and 3b

¹⁷ See consent form for vets and clients at Appendix 4

¹⁸ RM Nelson and JF Merz, ‘Voluntariness of Consent for Research: an Empirical and Conceptual Review’ (2002) 40 *Medical Care* V69

¹⁹ *ibid*, V72.

A total of ten consent discussions were observed and recorded. I decided to stop after the tenth observation because no new themes were emerging from the conversations. Consent discussions took place in one of five consulting rooms. Each consultation was recorded on a digital voice recorder, which was placed in a suitable position in the consulting room. I was present as an observer, seated in a chair or on the floor, depending on the size of the animal being examined, and the design of the consulting room. In each case, I tried to be as unobtrusive as possible, making notes during the consultation, and noting events such as clinical examination tasks, which might correspond with periods of silence on the recording. The ten consultations each involved one veterinary surgeon and either one or two clients. I observed eight veterinary surgeons in total, therefore two veterinary surgeons were observed twice. In consultations 7, 8 and 10, there were two clients; all were couples consisting of one male and one female client. Most consultations concerned either a single animal patient or, in three consultations, two patients. These comprised two male dogs in Consultation 3, one male and one female cat in Consultation 2 and one male and one female rabbit in Consultation 7. In two of the consultations, there was a charity involved in either requesting the procedure for recently rescued animals, in Consultation 3, or in paying for the procedure on a recently rehomed dog, in Consultation 9. In all but one consultation, the owner of the dog was the client (or one/both of the clients). In consultation 3, the dogs were brought to the practice by a volunteer from the rescue charity.

6.2 Thematic Analysis

I transcribed the conversations as soon as possible after the observation, to enable the noting of any tasks that were observed to take place during key moments in the discussion, and also to allow initial data analysis to evaluate saturation. Transcripts were uploaded as anonymised versions to NVivo²⁰ software for organisation and coding, as described in Chapter 5, Section 5.4.1. However, I eventually recoded the transcripts by hand using hard

²⁰ ©QSR International Pty Ltd, Victoria, Australia

copies, after realising that a more holistic approach to coding was required to enhance the level of analysis that could be reached.

Using an interpretive description methodology, initial coding was performed using a thematic ‘topical survey’ approach, following a variation on grounded theory, and therefore using an open coding approach.²¹ Themes were then categorised into a thematic summary, informed by categories that arose from the legal doctrinal research regarding the requirements for informed consent (see Chapter 3) and from the prior analysis of consent forms (see Chapter 5). The final themes are shown in Table 6 below.

Topical survey	Thematic summary	Conceptual description
<i>Describing proposed procedure(s)</i> <i>Recommending specific procedure</i> <i>Offering additional procedures</i> <i>Recommending additional procedures</i> <i>Giving the client treatment options</i> <i>Considering best interests of patient</i>	Respecting client autonomy vs. demonstrating “paternalism” Who made the decision? Recommendations made on a “best interests of the patient” basis	Autonomy vs. beneficence as underpinning principle to consent
<i>Describing procedure(s)</i> <i>Evaluating health</i> <i>Outlining risks of GA</i> <i>Outlining risks of surgery</i> <i>Describing post-operative complications</i> <i>Describing requirements for aftercare</i>	Informing the client Level of disclosure of risks Responding to client questions or concerns	Degree of respect for client autonomy
<i>Estimating costs</i> <i>Contracting for payment</i> <i>Charging for additional services</i> <i>Expecting payment for unexpected outcomes</i>	Respecting client financial autonomy Providing realistic estimates	Recognising constraints on client autonomy

Table 6: The analytic levels achieved for analysis of consultations, adapted from Sandelowski and Barosso²²

²¹ K Charmaz, A Bryant, ‘Grounded Theory and Credibility’ in David Silverman (ed), *Qualitative Research* (3rd edn, Sage 2011)

²² Levels of analysis adapted from M Sandelowski and J Barroso, ‘Classifying the Findings in Qualitative Studies’ (2016) 13 *Qualitative Health Research* 905, 910-914

At this point, I discussed the emerging themes and the level of analysis required with my supervisors, realising that my analysis thus far had been mainly descriptive. As a result of this, and through more abstract thinking about the data, themes were raised to the level of conceptual descriptive analysis. This analytic approach provided a more holistic view of the principles that form the basis for consent in this setting.

The following sections are arranged according to the thematic summary, with each theme then discussed around the resulting conceptual analysis. 'Vet' refers to the veterinary surgeon in each consultation, and 'Client' refers to the owner of the animal patient.

6.3 Balancing respect for client autonomy with the 'best interests' of the patient

This section examines the topical survey themes. It starts by investigating whether clients were given options regarding the proposed surgery and any additional procedures available. It then evaluates the balance achieved between client autonomy and veterinary surgeon 'paternalism'. This evaluation includes the proposal that apparent paternalism may be an attempt to prioritise the best interests of the patient, and is therefore not paternalism, but beneficence (see Chapter 3, Section 3.1.4).

6.3.1. Giving the client options for surgery

In all cases, the decision for elective neutering had been made prior to the consultation. Many clients will contact a veterinary practice to book this procedure without consulting a veterinary professional prior to making the decision.²³ Some consultations opened with the veterinary surgeon asking the client to confirm that the reason for the consultation was a pre-neutering check and discussion, for example:

²³ For example, see MJ Downes and others, 'Neutering of Cats and Dogs in Ireland; Pet Owner Self-Reported Perceptions of Enabling and Disabling Factors in the Decision to Neuter' (2015) 3 *PeerJ* e1196 <https://doi.org/10.7717/peerj.1196> These authors found that of 35 owners who had decided to neuter their pets, only 4 considered veterinary advice important to their decision.

“So, she’s just in for us to check her over for her spay, is that right?”

(Vet, Consultation 1)

As a result of the veterinary surgeons’ assumption that the decision was already made, there were few options given to owners during the consultation. As this practice offers laparoscopic (or ‘keyhole’) surgery for neutering female dogs, reference was sometimes made to this option. According to research, laparoscopic spaying results in shorter recovery time and less post-operative pain, although the surgery itself may take longer and it is more expensive.²⁴ However, in most consultations, the decision regarding which type of surgery was going to be performed had already been made, having been discussed at a prior consultation or by telephone when the appointment was made. One veterinary surgeon indicated the reasons for recommending a particular surgical technique.

“The difference where keyhole is particularly helpful, is where we do have big breeds, where we have a lot of weight on the incision, there is a high risk of breakdown and things, so with her, she’s nice and slim, she’s a lovely weight, so with her I’d recommend a routine spay with a shorter anaesthetic.”

(Vet, Consultation 4)

Although alternatives to surgical neutering are available, particularly for dogs of either sex (see Chapter 1), none of the consultations contained any reference to these alternatives.²⁵ The veterinary surgeons had, therefore, already limited client choice, although they may have offered alternatives at previous consultations.

²⁴ L Rosewell, ‘Laparoscopic or Traditional Bitch Spay? a Comparison of Surgical Technique, Associated Risks and Benefits’ (2016) 31 *Veterinary Nursing Journal* 53

²⁵ This finding is not surprising in light of the paper by V Adams, ‘Attitudes to and Opinions of Dog Castration – Vet Survey Results’ *Veterinary Times* (Peterborough, 21st November 2016), where she reported that, although vets are often aware of alternatives, they do not always offer them.

The most unusual alternative offered to a client was reversal of the decision to neuter a male rabbit, and instead to follow the veterinary surgeon's recommendation to neuter his female companion. The client was given good reasons for changing the proposed surgery, although the initial reason for the consultation was to check whether the male rabbit's testicles had descended (they had not):

".... generally, from the rabbit neutering point of view, there are actually a lot more health benefits to getting the female rabbit neutered than the male rabbit..."

(Vet, Consultation 7)

In some cases, the patient presented with additional problems. In the first of these, the veterinary surgeon had previously detected a heart murmur in the patient. In this situation, the client was given two options for treatment, although with some direction:

"So, we've got two options at this stage. Given that she's bright and well ... (...) ... one option is to still go ahead with the anaesthetic as planned (...) ... the second option would be to go down the route of having her heart scanned ... (...) ... to see what's going on with that before she has an anaesthetic."

(Vet, Consultation 1)

The client indicated uncertainty regarding which option to choose, having been told that the heart scan would increase the costs:

"It's a tricky one, isn't it?"

(Client, Consultation 1)

To highlight the reason for giving these two options, the veterinary surgeon introduced a third option. This included a warning about the consequences of delaying the surgery, and therefore reinforced the reasons for the two options previously offered:

“The other thing we can do is delay it for now, but if she’s going out and about there’s the risk of her getting pregnant.”

(Vet, Consultation 1)

Although this “do nothing” option had not been offered originally, its role at this stage was to help the client to make the decision for neutering. The client did so, but without completely ruling out further investigation of the heart condition:

“I don’t want her to have kittens” ... and later, ... “I think - I want to go ahead with the neutering and then – could I still see the specialist after that?”

(Client, Consultation 1)

Thus, although there seemed to be a genuine attempt to leave the decision to the client, the veterinary surgeon’s reminder of the risk of pregnancy if surgery was delayed seemed to persuade the client to agree to the neutering procedure. This could be seen as a paternalistic intervention, or perhaps as a ‘nudge.’²⁶

In the only other consultation where the client was explicitly given a choice regarding surgery, the options were either to take a biopsy from a swelling on the patient’s leg, or to remove the whole lump, while she was being neutered:

“... you can either do a biopsy and not remove it, as it’s in a tricky place, right on the point of the elbow ... (...) so that would be the best thing to do unless you want to say, no, let’s just take it off in one sitting and send it away”

(Vet, Consultation 6)

In this consultation, it was the client that introduced the third option, i.e., to do nothing:

²⁶ For example, Emma Cave equates ‘soft’ paternalism with nudging or incentivising choice, in ‘Protecting Patients From Their Bad Decisions: Rebalancing Rights, Relationships, and Risk’ (2017) 25 *Medical Law Review* 527, at 537. See also Chapter 3, section 3.1.5.

“So what will happen if we just leave it, if we ignore that now and just leave it?”

(Client, Consultation 6)

The veterinary surgeon admitted that there was uncertainty:

“You don’t know, you can’t tell for certain. It might stay the same size ... (...) it might carry on growing and filling up and start to bother her (...) I don’t think it’s unreasonable just to keep an eye on it, it’s up to you, but while she’s under being spayed, you could remove it at the same time.”

(Vet, Consultation 6)

The reluctance to offer the “no treatment” option in this case perhaps relates to the veterinary surgeon advising on the basis of the ‘best interests’ of the animal patient, suggesting that it would be better to get both the spay and the lump removal performed under one anaesthetic, thus avoiding an extra surgery at a later date.²⁷

Thus, in this practice, the veterinary surgeons demonstrated a measure of respect for client autonomy when it came to procedures other than elective neutering. However, the general assumption regarding neutering was that the client had already decided to go ahead, based (perhaps) on information gleaned from other sources, or from prior visits to the practice. None of the observed consultations included a comprehensive calculation of the risks and benefits for the patient involved, unless there was a co-existing health problem, as in the case of the cat with a heart murmur. Where additional procedures were proposed, clients were given the available options and left to make the decisions themselves. If they wanted some direction from the veterinary surgeon, this often took the form of additional

²⁷ It is interesting to note that the veterinary practice would probably make more money through two separate surgeries, so the vet in this case was not motivated by financial interests.

information, specifically what would happen if the client chose to do nothing, to clarify the decision-making process.

6.3.2 Offering or recommending additional procedures

This theme comprised two different approaches to obtaining the client's agreement to additional procedures, which were non-surgical treatments that could be performed either prior to, or during, elective neutering surgery.

The distinction between 'offering' and 'recommending' depended on who made the decision for the optional procedure. 'Offering' was characterised by the veterinary surgeon offering the additional procedure(s) without a strong recommendation for the specific patient, thus leaving the decision to the client. 'Recommending' involved the veterinary surgeon making a strong recommendation regarding a specific procedure for a specific patient, although it was still the client's decision whether to accept this recommendation. Examples of both approaches are given below.

During the consultations, there was no evidence of clients being offered additional procedures without a recommendation from the veterinary surgeon. This finding is surprising in view of the findings from the consent form study (see Chapter 5, Section 5.6.2). Some forms incorporated lists of possible additional procedures, from which (apparently) the client could choose. In other practices, it is not known whether the veterinary professional guiding a client through such a form would recommend certain procedures or would offer all of them and leave the decision totally up to the client. An example of the client being left to make the decision about pre-operative blood tests is illustrated in Chapter 7, Section 7.6.3, AO5. The consent form used in this practice did not list any additional procedures, requiring these to be entered manually in the free text space left for describing the 'Surgical Procedure'.

During two consultations, veterinary surgeons made recommendations for the removal of retained deciduous (baby) teeth from the patients, both dogs, at the same time as neutering surgery. The veterinary surgeons advised removal of these teeth to prevent future problems.

“... he has his two baby teeth ... have they told you about removing them? ... (...) ... because, probably at this age, they are going to cause problems if they aren't removed.”

(Vet, Consultation 9)

Thus, where veterinary surgeons were firmly convinced that the additional procedure was the correct thing to do in terms of the 'best interests' of the patient, they were prepared to make strong recommendations or to influence the client's decision.

In several consultations, veterinary surgeons informed clients about the availability of pre-operative blood tests but did not push them for the specific patient. They gave reasons why they were not strongly recommending blood tests, although the offer was still included:

“There is an option for a pre-anaesthetic blood test beforehand if you'd like one, but because she's young, fit and healthy, the chance of it showing anything up is slim.”

(Vet, Consultation 5)

“You can think about doing what we call a preoperative blood test. We don't often do them in 6-month-old dogs because more often than not, they come back normal, but you don't know unless you do it. Just so you're aware that that option is available.”

(Vet, Consultation 6)

Thus, although many clients were offered the option for pre-operative blood tests, the veterinary surgeons in this practice decided which animals were likely to benefit from these tests, making recommendations accordingly. This has parallels with findings from the consent form study (see Chapter 5, Section 5.6.2). On some forms, pre-operative blood tests

were described as “strongly recommended”, either for every patient, or for those who fell into “higher risk” categories due to age or underlying health problems. In the population studied for the consent discussions, the only animal that may have been categorised as ‘higher risk’ was the cat with a heart murmur, and this client was not offered pre-operative blood tests.

6.3.3 Considering the ‘best interests’ of the patient

Apart from the instances in 6.3.1, where the veterinary surgeon may have recommended a particular option from a “best interests of the patient” perspective, this theme emerged from discussions regarding the timing or health benefits of having the elective neutering surgery carried out. As previously noted, there was no example of a comprehensive balancing of benefits and risks for an individual patient.

Regarding timing in the best interests of the patient, the most obvious example was found in a consultation about the proposed spaying operation for a female dog, which, owing to the clients’ circumstances, was being done at an earlier age than was usual for the practice. This consultation involved two clients, with both explaining the reason for the request at the start of the consultation:

“She’s 6 months ... (...) ... The reason we’re doing it as quickly as this is because....”

(Client 1)

“They’re minding her when we go away...”

(Client 2)

“They’ve got three other dogs, you see!”

(Client 1, Consultation 10)

Later in the consultation, the subject of timing was revisited.

“Well, ideally she’d be 6 months old (...) so it’s probably doing it a little bit before, and also we want her to have little more time with you before she goes to ... kennels, is it kennels?”

(Vet, Consultation 10)

The clients explained that the dog was going back to stay with her breeder, who also kept male dogs. In this example, both the veterinary surgeon and the clients considered that the benefits of preventing an unwanted pregnancy outweighed the risks of performing the surgery at a slightly younger age than was recommended.

A second example of timing the surgery to suit the best interests of the patient was seen in a discussion that also concerned spaying a female dog, where the client informed the veterinary surgeon:

“.....the reason that we want her done now is that she spends most of her time in the garden – her choice, she just about lives in the garden ... (.....) it would be better to get her done now, while the weather’s reasonably good.”

(Client, Consultation 5)

The client’s perception of the dog’s frustration at being confined to lead exercise while in season may also explain the client’s decision to have the procedure performed at this time:

“Everyone says let them have two (seasons), but she didn’t enjoy it, and she was demented when I couldn’t let her off the lead.”

(Client, Consultation 5)

The veterinary surgeon focused on the benefits for this individual patient of performing the procedure at a young age, thus reinforcing the client’s decision:

“And to be honest, from a medical point of view, the fewer seasons she has, the less risk of mammary cancer, so absolutely fine to neuter her after her first season, that’s no problem.”

(Vet, Consultation 5)

The same consultation involved an additional discussion regarding whether the dog could have a booster vaccination at the same time as being spayed. The owner was concerned that the vaccination was already overdue, so the veterinary surgeon initially planned to give the vaccination then book the neutering surgery:

“If we’re vaccinating her today, that’s Tuesday – we can have her in towards the end of the week, that’s Friday.”

(Vet, Consultation 5)

However, the client had already booked the surgery for the following day. The veterinary surgeon advised that the vaccination should be postponed until after the surgery, expanding on the reasons for postponing the vaccination. These centred on the health-related best interests of the dog:

“If we vaccinate her today, her immune system tomorrow will be doing other things rather than responding to the vaccination.”

(Vet, Consultation 5)

In a third example of timing the surgery in the best interests of the patient, the veterinary surgeon gave further information on the prevention of future disease in a patient who had already had a false pregnancy:

“If they have multiple seasons and multiple false pregnancies, they’re at risk of a pyometra, which is an infected womb, and it can be actually life-threatening if they get that when your hand is forced to do an emergency spay.”

(Vet, Consultation 8)

During the consultation with two rabbit owners, the veterinary surgeon explained the advantages of neutering female rabbits, based on both health-related and behavioural “best interests”:

“Female rabbits are prone to getting tumours of their uterus, (.....) something like 80% of rabbits, female rabbits, over the age of five that haven’t been neutered will develop these tumours. Female rabbits tend to be more territorial and aggressive than males as well, so neutering can have those behavioural benefits.”

(Vet, Consultation 7)

However, the only benefit mentioned for a male dog regarding neutering was a behavioural one:

“... if they’re really excited and things, it brings the testosterone down (...) ... I think he will be more calm.”

(Vet, Consultation 9)

Although this outcome may benefit the dog-owner relationship if it reduces the chances of behavioural problems in future, the veterinary surgeon in this case missed the opportunity to construct a more powerful health-related “best interests” argument for neutering male dogs. For further discussion on a “best interests” argument for neutering, see Chapter 4, Section 4.7.

Thus, it appears that the timing of the neutering procedure is sometimes influenced by practical concerns; in some consultations, the timing of the procedure depended on the owner’s availability for post-operative aftercare, due to work commitments or holidays etc. These are issues that required timing the procedure to suit the owner, rather than choosing the ‘best’ time for performing the surgery in the individual patient. However, in many cases the decision of when to perform surgery also appeared to consider the ‘best interests’ of the

animal, in allowing recovery outdoors, for example, or not having to be put into kennels. Additionally, timing to suit the owner ensured that the animal would receive more attention post-operatively.

6.3.4 Informing the client

A further measure of respect for the autonomy of the client is the level of information that is given, for example, in disclosing risks (see Chapter 3, Section 3.6.3). The more information that is shared with the client, the greater the respect for the autonomy of the client, and the nearer the consent process approaches the goal of shared decision-making (see Chapter 1, Section 1.3.2).

6.3.5 Explaining the proposed procedure

An important way of demonstrating respect for the autonomy of human patients is to give information about exactly what the proposed treatment entails.²⁸ The veterinary surgeons in this practice gave varying degrees of description of the proposed surgery:

“..... a midline incision, removing the uterus and the ovaries...”

(Vet, Consultation 5)

“The spaying procedure itself involves making an incision and we’ll remove her ovaries and uterus through that incision.”

(Vet, Consultation 7)

One veterinary surgeon did, however, give the client a comprehensive account of the procedure:

²⁸ See JV McHale, ‘Consent to Treatment: the Competent Patient’ in Judith Laing and Jean V McHale (eds), *Principles of Medical Law* (4th edn, Oxford University Press 2017) 8.06, 422 on the requirements for a valid consent

“ she'll come in and she'll have a little bit of sedation, and then she'll have a general anaesthetic. She'll have to have a little cannula put in her leg, to give us intravenous access. She'll have an ET tube down her throat, then she'll have an incision on her midline, on her tummy, then we'll remove her ovaries and her uterus and we'll stitch her up ...”

(Vet, Consultation 10)

Although the quoted speech contains some technical jargon, it was the most complete description given to a client during these consent discussions. None of the other consultations included a step-by-step account of the procedure.

6.3.6 Explaining who will perform the surgery

An increasingly important component of consent in human medicine is informing the patient which member of the team will carry out the surgery.²⁹ This is less common in veterinary medicine, as evidenced by the following examples from two consultations where clients asked questions regarding the identity of the person who would perform the procedure:

“Will it be you doing the surgery?”

(Client, Consultation 6)

“It won't be me, I don't do lap spays yet. It will be one of my senior colleagues.”

(Vet, Consultation 6)

The second example involved one of the consultations with two clients.

“All right, so we shall see you on Friday morning as planned, 8 o'clock, any problems before then”

²⁹ See *Jones v Royal Devon and Exeter NHS Foundation Trust* regarding the requirement to inform the patient who will perform surgery

(Vet, Consultation 8)

“Will it not be yourself that’s doing it?”

(Client 2, Consultation 8)

“Eehhh – I’m normally in theatre Friday, let me check ... (.....) ... Yes, I’m in theatre Friday morning, so do you want me to put her down, that I’ll do her for you?”

(Vet, Consultation 8)

“Yes..... At least you’ll know her ...”

(Client 2, Consultation 8)

Thus, clients were not routinely informed who would be performing the surgery, unless they asked the specific question. However, the practice prepared a theatre rota in advance; this information was available to the veterinary surgeons on the computerised practice management system. Some clients consider the identity of the surgeon a key component of the consent discussion (see Chapter 7, Section 7.7.2, AO10). Such information would be easy to include in the consent discussion in this practice, and I would recommend that it should be included due to its potential to improve the vet-client relationship.

6.3.7 Level of risk disclosure

Awareness of the ‘material risks’ (see Chapter 3, Section 3.6.3) involved with a proposed procedure may affect a client’s decision whether to go ahead. The main risk that should be conveyed in the case of elective neutering is the statistically small, but ‘material’ risk of death occurring under general anaesthesia (see Chapter 4, Section 4.7.4 for further discussion on the material risks that apply to elective surgery). In the observed consultations, there were differences in how this risk was presented. Some veterinary surgeons did specifically mention death as a risk:

“Worst case scenario is they can die from the anaesthetic. It is rare, but it does happen.”

(Vet, Consultation 2)

“There is always a risk with the anaesthetic, there is a risk that they won’t make it through the anaesthetic.”

(Vet, Consultation 4)

whereas others either referred to risks in a generic and abstract way:

“Again, with every anaesthetic there is a slight risk. She’s young, fit and healthy so there should be no risk, but we have to warn people about these things.”

(Vet, Consultation 5)

“There’s obviously a small risk in any GA that we do, even in young healthy animals”

(Vet, Consultation 6)

“There is a risk with every anaesthetic, the same as for people....”

(Vet, Consultation 7)

In three consultations, there was no mention of the risk of general anaesthesia. Thus, there was variation in the level and nature of risks disclosed between veterinary surgeons. In Chapter 8, section 8.2.3, I propose that all consent discussions should include information about the risk of death involved with every general anaesthetic.

The risks of surgery were described in most consultations and were emphasised in the female dog neutering consultations. The primary intra-operative risk referred to was that of haemorrhage. This was explained in more detail by the veterinary surgeon:

“There is a slight risk involved in removing any organ, as you can imagine, the major risk being bleeding”

(Vet, Consultation 5)

“..... the lap[aroscopic] spay itself, the risks of that are bleeding, essentially, because it’s quite a major surgery, you’re going into quite big vessels...”

(Vet, Consultation 6)

One veterinary surgeon explained the reasons for timing the surgery between seasons in females:

“... you wouldn’t want to spay her at the time of the season, just because it can cause an increase in complications.”

(Vet, Consultation 2)

This explanation was expanded by another veterinary surgeon, who explained the importance of neutering when the patient is not in season,

“..... we don’t want them to come back into season, there’s just a chance of blood vessels ... (....) ... are bigger, skin things as well, and obviously hormonally we’re in a different position.”

(Vet, Consultation 4)

Thus, for neutering female canine patients, the risks of surgery were explained in some detail, and used to clarify why the procedure needed to be carefully timed between seasons.

6.3.8 Disclosure of post-operative complications

Post-operative complications mentioned included wound breakdown and infection. These risks were used to explain the provision of a plastic collar to prevent the patient from interfering with the wound immediately after surgery.

“ the complications could be, if he’s licking at it, could be that the wound can break down or some infection, so we have to prevent that with the collar, okay?”

(Vet, Consultation 9)

The veterinary surgeons involved often pre-empted clients' concerns about the patient having a plastic collar fitted post-operatively to prevent interference with wounds:

"That's probably the main complication, actually getting at the wounds – it's just unnecessary. It turns a 7-10 day recovery into a couple of months, in terms of extra surgery, antibiotics, extra tests and things like that. It's just unnecessary, so you've just got to be cruel to be kind with them; some dogs don't like the collar but you've just got to put up with it."

(Vet, Consultation 6)

In terms of longer-term health risks due to neutering, there was little or no discussion about reasons *not* to perform the surgery. Reference to reasons not to neuter was limited to two consultations. The first of these involved a cat with heart problems, where the veterinary surgeon raised the possibility of delaying neutering until the heart problem had been investigated, but the client's priority was avoiding the cat getting pregnant. In the second, a male dog neutering consultation, it was the client who raised some concerns regarding information gathered from the internet about the possible negative effects of castration on the growth plates.³⁰

"I just wondered, when they get neutered, cause reading on the internet and daft things, does it do anything to the growth plates? Does it keep them open and then they can get problems with their back or is that just rubbish?"

(Client, Consultation 9)

In the latter consultation, the veterinary surgeon responded to the client's concerns by stating the advantages of having the dog neutered, such as improved behaviour, but did not specifically address the concerns regarding problems with bones or joints, nor indeed any

³⁰ These are areas of the bone where growth takes place in young animals

other longer-term health risks post-surgery. Answering questions from patients/clients is a fundamental component of informed consent, so will now be examined in more detail.

6.4 Responding to client questions or concerns

Similar to the above example (consultation 9) of the client raising concerns about the proposed procedure, another client expressed concern about the effects of lengthening the anaesthetic for the patient to be spayed and have teeth removed at the same time:

“There’s no problem while she’s what she’s having done, and then she’s having teeth out as well?”

(Client, Consultation 8)

This elicited a factual, but non-empathic response. The veterinary surgeon gave valid reasons for the combined procedure, but did not make any real attempt to deal with the client’s anxiety:

“Usually, you’re better coupling that in the one anaesthetic, rather than having a second anaesthetic at a later stage just to remove two teeth. You’re looking at adding on probably an extra 15 minutes to the anaesthetic time, (.....) and cost wise, it’s cheaper for you to do it under the one anaesthetic as well.”

(Vet, Consultation 8)

In six out of 10 consultations, the veterinary surgeon gave the client at least one explicit opportunity to ask questions. Many of these questions involved practical aspects of aftercare and what to look for post-operatively.

“What if the other cat bothers her?”

(Client, Consultation 1)

“How long will she be not herself for?”

(Client, Consultation 8)

“And it will be about a week before he can walk or anything?”

(Client, Consultation 9)

In response, veterinary surgeons usually gave detailed and clear aftercare instructions.

“Main thing we want is her resting and not licking at her wound. So the collar will help with that. She’ll probably be less stressed and happier if she’s with the other cat, but what I would do is just have her in one room, so she can’t go up and down stairs.”

(Vet, Consultation 1)

“We normally say strict rest for the first 7 days and we normally see them back at 3 days and 10 days post-operatively just to check on her wound and how things are healing. Normally after 7 days, we can just do some very gentle bits on the lead, but it’s a couple of weeks for it to fully heal and then she can get back up to normal.”

(Vet, Consultation 4)

Thus, clients seemed to be concerned with the practicalities of patient care following the surgery, and veterinary surgeons spent more time explaining post-operative care than explaining the details of the surgery.

6.5 Respecting client financial autonomy

In most consultations, the estimate for the cost of neutering was carefully worked out, based on the patient’s weight and the proposed surgical method.

“Can I just check that estimate you were given for surgery?”

(Vet, Consultation 1)

“Have you had any estimates for her so far? Would you like them now, today?”

(Vet, Consultation 4)

Where additional procedures were being performed, clients were informed of the likely total cost. For example, where 'baby' teeth were being removed at the same time as neutering:

"Eeemm – estimate I'd saved, it's working out at around 230 for the spay and the teeth removal, and the medication and stuff to go home with ..."

(Vet, Consultation 8)

One veterinary surgeon clearly separated the costs for the neutering surgery and for teeth removal:

"So – we said that he was 17.8³¹ – so just with the castration, it would be around 165, okay? And then if we add the deciduous canine on top of that, that would be £35.18 more, okay?"

(Vet, Consultation 9)

Thus, in this practice, clients were generally prepared well for the financial costs of neutering by being informed of the costs of the procedure, together with any additional procedures that they had been recommended. However, in no consultation was the client given a written estimate of the costs that were discussed, which would better demonstrate respect for the financial autonomy of the client (see Chapter 8, section 8.3.4)

6.5.1 Charging for additional surgical or diagnostic procedures

When discussing alternative procedures, in addition to leaving the choice of treatment to the client (see 6.3.1), the veterinary surgeons were careful to outline the costs involved. Provision

³¹ This referred to the dog's weight in kg.

of estimated costs may have helped clients to make the decision for or against additional surgical or diagnostic procedures.

The most complicated discussion involved a feline patient with a heart murmur. In this case, the client was given two options for having the cat's heart examined with ultrasound: either by the 'general practitioner' veterinary surgeons in the practice, or by a heart 'specialist'. The patient had been seen as a young kitten by the same veterinary surgeon, who had detected a heart murmur. A subsequent visit and examination by a colleague failed to reveal any murmur, but at the pre-neutering examination, the murmur was again detected. The choices given to the client about surgery were illustrated in 6.3.1 above, but the financial implications were clearly explained.

"... in terms of us doing the scan of the heart, it's about £110 for us to do... to see him (specialist) to do it it's generally more than that, we can end up about £500 or so."

(Vet, Consultation 1)

Similarly, in Consultation 6, which involved the patient with the skin lump which was to be removed at the same time as neutering, the client was given clear information about costs. Again, the choice was between having the procedure done by the 'general practitioner' surgeon or by the specialist surgeon.

"If it was on first opinion, while she was being spayed, then probably because you've already got the anaesthetic and everything included, it would probably be an extra £150-£200, something like that. If you wanted referral to our soft tissue surgeon to do it, the price is drastically more, like a grand or something. Is she insured?"

(Vet, Consultation 6)

The client confirmed that the dog was not insured. At this point, the client queried the total cost of the procedure:

“How much are we looking at in total, for the operation, for the whole thing?” and, on being asked whether an estimate had been given for the laparoscopic spay, added, “Well, she told me it was about £300.”

(Client, Consultation 6)

In response, the veterinary surgeon advised:

“Yeah, it’s about 300-350, something like that. So, with everything, you’re probably looking around 5-550, to spay laparoscopically and do the lump removal at the same time.”

(Vet, Consultation 6).

Interestingly, there was no explicit decision by the client to reject the specialist surgeon. Rather, this option seemed to be discarded by the veterinary surgeon when the client revealed that the dog was not insured. This example illustrates the danger of restricting choice based on financial assumptions. The client had already chosen the more expensive laparoscopic technique for the dog’s neutering surgery, therefore may also have opted to have the lump removed by a specialist surgeon, if given the choice. In fact, the veterinary surgeon removed that option by giving the estimated cost based on a non-specialist surgeon performing the surgery, before proceeding to arrange this. So, despite the majority of consultations demonstrating respect for the client’s financial autonomy, this consultation shows that sometimes it was not respected; the veterinary surgeon made the decision based on the client’s lack of insurance, without specifically asking the client. The tendency to assume that uninsured clients would not choose more expensive options is reflected in a comment by a veterinary surgeon interviewee (VS1) in Chapter 7, Section 7.6.4.

The consent form used by the practice has clear procedures for charging the client for post-operative treatment in the case of complications, and states what is included in the price of the surgery (for the exact wording, see CF60, Section 5.6.7). However, none of the consultations included this discussion. This leads on to the role of the form in the consent process in this practice.

6.6 Use of the form in conjunction with the discussion

Failure to refer to the practice's consent form was notable in all but two consultations. The first was the consultation involving the dogs for neutering from a charity organisation, where the surgery was being performed the same day. The consent process in this consultation was perfunctory. The charity representative was given the consent form to sign while the dogs were having identification tape collars fitted prior to surgery:

"So, I've got these consent forms; sign there....."

(Vet, Consultation 3)

The second consultation was a "normal" pre-operative consent discussion, where the veterinary surgeon referred to the form in closing the consultation:

"So we'll see you ... the nurse will be able to talk on Friday morning, she'll just go through the consent form and that's everything basically I've talked about, only in written format – all right?"

(Vet, Consultation 8)

Referring to the content and language of the consent form at the time of the discussion, perhaps using it as an aide-memoire and providing the client with a copy, would help to align the two components of the consent process. I have made this recommendation to the practice involved.

6.7 Conclusion

This study provided an opportunity to compare consent in veterinary practice with its equivalent in human medicine. However, this proved difficult in light of several factors. First, the giving of consent by a proxy decision-maker is less commonly studied. Thus, it was not possible to find a direct comparator for this study from either a paediatric medical setting or

a general medical setting (see 6.0). Next, the context of elective (non-therapeutic) treatment is even more rarely studied in medicine. Finally, the few previous studies into proxy decision-making for non-therapeutic procedures utilised different methods of analysis, for example, conversation analysis rather than thematic analysis. It is hoped, however, that this study may provide some foundation for future research into informed consent in the veterinary practice setting. It could therefore complement existing studies into small animal consultations.³²

The observation of the consent conversation in a 'general practice'³³ setting allowed the analysis of one practice's approach to consent. Although my initial intention was to compare several practices, observing a number of veterinary surgeons in the same practice was insightful. The practice's approach to consent, in conducting the consent discussion in advance of the day of surgery, aligns with the RCVS's updated guidance on when the consent process should be conducted.³⁴ Timing the conversation thus should result in a more focused discussion between veterinary surgeon and client, with less time pressure and less stress for both parties involved. I realise that this practice is not typical in arranging consent discussions in this way, however it provides an example of good practice in the timing of the consent process.

Nevertheless, in the study practice, there was considerable variation amongst the veterinary surgeons that I observed. These differences concerned the level of detail given to the client, specifically regarding risks, benefits and descriptions of the planned surgical procedures. The decision to focus the study on one procedure standardised the risks and benefits of the proposed surgery, and enabled comparison between the approaches used by the veterinary surgeons involved. The variation in the amount and type of information provided concurs with the findings from previous studies. For example, in Braddock and others' much larger study of

³² See, for example, NJ Robinson and others, 'Investigating Preventive-Medicine Consultations in First-Opinion Small-Animal Practice in the United Kingdom Using Direct Observation' (2016) 124 *Preventive Veterinary Medicine* 69.

³³ In contrast to, for example, a referral hospital setting

³⁴ RCVS 'Supporting Guidance' <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/>> Section 11.2

informed decision-making in outpatient settings, less than 20% of consultations contained the required elements for the patient to make an informed decision.³⁵

Three conceptual descriptive themes, balancing autonomy and beneficence, respecting client autonomy and appreciating constraints on this autonomy, were derived from the analysis of transcriptions of consent conversations in this practice but were also influenced by my prior research. These themes will be discussed in detail in Chapter 8, enabling triangulation with the findings from my other studies.

As I was provided with a copy of the practice's consent form, I attempted to identify the links between the consent conversation and the consent documentation in this practice. However, the lack of specific reference to the form, or production of a copy, during these consultations detracted from its usefulness as part of the consent process, leading to some important information being omitted from the conversation. The lack of association between the form and the conversation in this setting meant that I was unable to answer the research question regarding their relative roles, but it provided me with an opportunity to suggest practical improvements to the consent process in the study practice.

³⁵ Braddock and others (n7), 2318

CHAPTER SEVEN: THE CONSTRUCTION OF CONSENT – INTERVIEWS WITH KEY PARTICIPANTS

7.0 Introduction

The aim of the third of my empirical studies was to describe “informed consent” as experienced by those involved, and to solicit opinions from key stakeholders in the process. Triangulation of the analyses of consent forms (Chapter 5) and observational studies (Chapter 6) with the analysis of interview data results in a unique view of informed consent to non-therapeutic neutering in veterinary practice.

There is a commonly held view that observation *and* interviews together will produce a “complete” picture of a phenomenon, with one method compensating for deficiencies in the other. Atkinson and Coffey reject this view, regarding observations and interviews as “enactments”¹ and as equally valid methods of capturing a shared understanding of the social world, with key input from the researcher. My previous empirical studies relied on my interpretation of the consent process, potentially neglecting the views of participants. This study provides their perspective, with the choice of interviews rather than questionnaires explained in Chapter 2, section 2.5.5.

This study involves conducting ‘active’ interviews. Such interviews are regarded as “interactional events,” with each being treated as a “productive site of reportable knowledge itself.”² The active interview allows respondents to switch positions, that is, to take on new roles and perspectives, when prompted by interview questions, although many social scientists regard participants and interviewer as continuously switching roles during

¹ P Atkinson, A Coffey, ‘Revisiting the Relationship Between Participant Observation and Interviewing’ in JF Gubrium, JA Holstein (eds), *Handbook of Interview Research* (Sage 2002) 809-812

² JA Holstein and JF Gubrium, *The Active Interview* (Sage 1995) 2-3

interviews.³ In this study, ‘overt’ switching of roles, where participants indicated that they were responding as different stakeholders, happened during two interviews. In the first, a veterinary nurse switched roles to relate experiences of decision-making as an animal owner. In the second, a representative of a veterinary professional body answered several questions by describing previous experiences as a veterinary professional.

Importantly, active interviewing regards the interviewer’s background knowledge as a resource that can provide “direction and precedent” to link the research interests to participants’ experiences.⁴ It therefore allows “simultaneous coding and construction of knowledge”⁵ to take place during the interview. The role taken by both participants in the construction of knowledge reaffirms the suitability of the active interview for a social constructionist approach, as described in Chapter 2.

7.1 Using interviews with participants to investigate informed consent

The use of semi-structured interviews, conducted face-to-face or via telephone, is frequently described as a method in studies of consent and decision-making in human medicine, with many published in medical journals or journals of medical sociology. Most of the studies involve interviews with patients. For example, Probyn and others⁶ conducted face-to-face interviews with cardiac patients and their cardiologists in the UK, combining these with recordings of the consent discussions. Patients undergoing elective procedures (therefore, more relevant to my study) arrived at the consent discussion having already made the decision for surgery. These patients did not ask many questions, trusted the cardiologists, and saw the consent process as a means of allowing treatment to go ahead. Meanwhile, the

³ See, for example, EA Hoffmann ‘Open-Ended Interviews, Power, and Emotional Labor’ (2007) 36 *Journal of Contemporary Ethnography*, 318

⁴ Holstein and Gubrium (n2) 46

⁵ Ibid, 57

⁶ J Probyn and others, ‘Percutaneous Coronary Intervention Patients’ and Cardiologists’ Experiences of the Informed Consent Process in Northern England: a Qualitative Study’ (2017) 7 *BMJ Open* e015127

cardiologists viewed the consent process as a way of checking the patients' understanding of the procedure.

These findings mirror those from another study conducted in the UK by Doherty and others,⁷ who interviewed patients and caregivers. In this study, patients were content to let doctors make decisions, although they wanted full information about the recommended treatment. They also appreciated the opportunity for further discussions with nurses. Again, the patients interviewed regarded consent forms as a means of accessing treatment; they felt that the form had a legal focus, in confirming that they accepted the risks involved with the treatment.

An earlier study from the USA by Hall and others⁸ involved interviews with patients prior to surgery. Their findings agreed with Probyn's work in concluding that most participants had made the decision for surgery before the consent discussion. However, there were three distinct groups of patients: those who wanted their surgeon to give them all of the information, those who trusted the surgeon to recommend the best treatment, and those who found that the consent process interfered with a decision they had already made. This study provides useful evidence for the autonomy versus paternalism debate.

The latter debate is further enhanced by Sinding and others' in-depth interviews with cancer patients,⁹ which revealed an interesting rejection of the patient autonomy versus physician paternalism dichotomy. These patients with life-limiting conditions were willing to take full responsibility for their own care, although appreciating direction from physicians who were willing to invest in their lives. This reinforces the perception that consent to treatment may differ depending on the type of condition being treated. However, Busquets and Cäis, when interviewing patients with similar life-threatening illnesses, found that they regarded

⁷ C Doherty and others, 'The Consent Process: Enabling or Disabling Patients' Active Participation?' (2017) 21 *Health* 205

⁸ DE Hall and others, 'Informed Consent for Inguinal Herniorrhaphy and Cholecystectomy: Describing How Patients Make Decisions to Have Surgery' (2012) 204 *AJS* 619

⁹ C Sinding and others, "'I Like to Be an Informed Person but....'" Negotiating Responsibility for Treatment Decisions in Cancer Care' (2010) 71 *Social Science and Medicine* 1094

consent as a formality that allowed treatment to proceed. Perhaps more worryingly, these patients felt that consent allowed doctors to carry out whatever treatment they wished, relying heavily on nurses to explain their ongoing treatment.¹⁰

There are fewer studies that investigate the perspective of the medical professional. In the United States, two studies by Olumide Olufowote¹¹ analysed data from focus groups with radiology residents regarding their perception of consent. These residents felt that patient understanding was limited by procedures being too complicated to explain and by the use of medical terminology. They regarded informed consent as protecting doctors and hospitals, but also felt that the consent discussion offered a model for the protection of patients' interests. They found difficulties in choosing risk rates to disclose and in deciding whether to use vague or detailed language.

In a similar study in the UK, Wood and others¹² conducted interviews with doctors in two teaching hospitals. Perceived barriers to obtaining informed consent included the timing of the discussion, the time available, junior doctors' lack of knowledge of procedures, and the reluctance of some patients to be given the information required. Ideas for improving the consent process included simplifying the language used and translating risks into a format the patient can understand.

In terms of design, the study conducted in Germany by Müller-Engelmann and others¹³ bears most resemblance to my approach to interviewing. Their interview groups of patients, physicians, and health administrators/research professionals could be regarded as equivalent to my interview groups of veterinary professionals, clients and professional

¹⁰ Busquets M, Cais J, 'Informed Consent: a Study of Patients with Life-Threatening Illnesses' (2017) 24 *Nursing Ethics* 430

¹¹ Olumide Olufowote J, 'A Structural Analysis of Informed Consent to Treatment: (Re)Productions of Contradictory Sociohistorical Structures in Practitioners' Interpretive Schemes' (2009) 19 *Qualitative Health Research* 802; J Olumide Olufowote, 'A Dialectical Perspective on Informed Consent to Treatment: an Examination of Radiologists' Dilemmas and Negotiations' (2011) 21 *Qualitative Health Research* 839

¹² F Wood and others, 'Doctors' Perspectives of Informed Consent for Non-Emergency Surgical Procedures: a Qualitative Interview Study' (2014) 19 *Health Expectations* 751

¹³ M Müller-Engelmann and others, 'Shared Decision Making in Medicine: The Influence of Situational Treatment Factors' (2011) 82 *Patient Education and Counseling* 240

representatives. Each group is considered as “experts in the field.”¹⁴ The Müller-Engelman study focuses on medical decision-making, but the findings are relevant to consent. Factors such as the type of disease, whether preventive or therapeutic options were being offered, the urgency of the decision, the number of options and the risks involved all influenced decision-making. Situations requiring greater ‘sharing’ of decision-making between physicians and patients included preventive measures and options with no clear evidence regarding efficacy. Their study suggests that procedures such as vaccination or non-therapeutic neutering (see Chapter 1, section 1.3.2) require shared decision-making.¹⁵

Therefore, in summary, the findings from previous interview studies on the consent process produce several areas of agreement. In human medicine, patients view the consent process, and particularly the form, as a means of accessing treatment, but feel that the purpose of consent is to protect the medical staff and hospital, a view which is echoed by some of the physicians interviewed.

Many patients undergoing elective procedures have already made their decision to proceed with the surgery, but they appreciate having all the available information about the procedure. Physicians regard consent as a way of checking patients’ understanding, or of protecting their interests through the requirement for discussion. These topics will be considered in light of the analysis of my interview data.

7.2 Methods

To recruit participants, I used ‘purposive sampling’, where participants are sought “by virtue of some angle of the experience that they might help us better understand.”¹⁶ One

¹⁴ Ibid, 241

¹⁵ Here, I have interpreted preventive as preventing health problems in the animal patient in future, such as conditions associated with the reproductive system, or certain types of cancer. However, I also acknowledge the description of non-therapeutic procedures as being ‘*for the benefit of others*’ in GT Laurie, SHE Harmon, G Porter, ‘The Control of Fertility’ in Mason and McCall Smith’s *Law and Medical Ethics* (10th edn, Oxford University Press 2016)

¹⁶ S Thorne, *Interpretive Description* (2nd edn, Routledge 2016), 99

important feature of this method of sampling is to identify 'key participants' who may provide important access to what is happening, and why. The aim of this study was to obtain the perspectives of those involved in the consent process, i.e. the veterinary professional and the animal owner, but also to access the expertise of those involved in providing advice to the profession on matters of consent. In recruiting participants, I acknowledge the advantages I had through being a veterinary professional. These included a direct connection with several professional associations, and therefore access to their membership, and personal contacts within the veterinary professions, who either participated or provided links to potential participants.

I recruited two interviewees through personal contacts in relevant veterinary professional organisations. I then utilised social media to try to recruit interested veterinary professionals, as a number of 'followers' of my social media account are members of either veterinary medical or veterinary nursing professions. Information posted on Twitter on 28/11/16 and again on 14/2/17, with a link to a weblog describing the interview study, achieved two responses, one from a veterinary surgeon, and one from a veterinary nurse. A news article on a veterinary nursing CPD website¹⁷ featured a request for participants. This article received one response from a veterinary nurse, however, this participant subsequently withdrew due to personal circumstances. Meanwhile, a forum post on the *vetsurgeon.org* membership site¹⁸ on 7/1/17 received one response from a veterinary surgeon.

When recruiting clients, I requested that they should have had recent experience of having a companion animal neutered. I recruited one client through a personal contact. A client recruitment page was set up on a participant recruitment website¹⁹ and advertised through

¹⁷ Jill Macdonald, 'Informed Consent Project' <<http://www.oncoreepd.co.uk/newsitem-Informed-consent-research-project>> accessed 11 September 2017. Copy of article in Appendix 5

¹⁸ C Gray "More help with consent research" forum post on *vetsurgeon.org* (n607) Copy of post in Appendix 6

¹⁹ C Gray, 'Consent to Veterinary Treatment' <https://www.callforparticipants.com/study/C2700/consent-to-veterinary-treatment?re=cfp.cc&ca=directlink-study-5&utm_source=directlink&utm_medium=study-5> accessed 11 September 2017. Copy of page in Appendix 7

posts on Twitter and Facebook social media sites (on 14/12/16 and monthly thereafter). The page received 1136 views, 15 responses and, eventually, 2 participants.²⁰ In view of the difficulty encountered in recruiting client participants, I had to modify the original criteria for the clients interviewed. Of the three interviewees, one was a relatively new dog owner, who was planning to have a puppy neutered within the next six months, and the others were experienced dog owners who had been through the process of neutering for several animals, including one with very recent experience.

Through these various methods, my total number of recruits was ten, comprising three clients (all dog owners),²¹ two veterinary nurses, two representatives of veterinary professional organisations, and two veterinary surgeons, with a third veterinary surgeon recruited via a personal contact.

Recruitment proved to be much more difficult than I had anticipated, despite, or perhaps due to,²² my veterinary background, which I included in all recruitment material.

Nevertheless, this background did provide access to potential contacts, and I was eventually satisfied with the numbers recruited. I based the adequacy of my sample size on the quality of the dialogue with each interviewee and my familiarity with the area of research, thus following Malterud and others' advice on the use of "information power"²³ as a means of assessing sample size in qualitative interviewing.

7.2.1 The interview protocol

Interviews were organised to suit each participant, with four completed face-to-face, as they involved participants already known to the researcher; these interviews were conducted at

²⁰ Several respondents were from outwith the UK, a requirement inadvertently omitted from the project description.

²¹ Although the observations included cats and rabbits as well as dogs, I did not consider that limiting interviews to dog owners was problematic. The relationship between dogs and owners has been studied extensively and could be considered as the archetypal human-companion animal relationship.

²² Reflecting on this, perhaps veterinary professionals were reluctant to share their experiences of consent as they considered that I would be "judging" the effectiveness of their practice?

²³ K Malterud, VD Siersma, AD Guassora, 'Sample Size in Qualitative Interview Studies' (2016) 26 *Qualitative Health Research* 1753

their homes or places of work. Interviews were recorded on a digital voice recorder. Interviewees were sent a copy of the information sheet²⁴ and the consent form²⁵ for the study in advance of the interview, and consent was obtained verbally at the start of each interview.

The remaining six interviews were conducted using Voice Over Internet Protocol (VOIP) via Skype,²⁶ and recorded using Ecamm Call Recorder software.²⁷ Several factors informed the decision to use Skype for these interviews, including the ability to interview participants with limited time available, the convenience of not travelling to interviews, the ability to see the other person (compared with telephone interviews), and the safety aspects of interviewing remotely. There are, however, negative aspects of conducting interviews via Skype. Seitz²⁸ considers the major problems as being technical difficulties, problems caused by the surroundings, the inability to respond to nonverbal cues due to video lag, and increased difficulty in establishing rapport, especially when dealing with sensitive topics during the interview. Weller²⁹ explores this problem in more detail, observing that technology checks (audio and video) often replace the initial greetings and pleasantries of a “physical co-present”³⁰ interview. However, in some cases, the physical separation can actually encourage rapport and emotional connection due to the interviewee’s “increased sense of ease with setting and mode.”³¹ Thus, Weller concludes that we should not regard Skype interviews as second best to physical co-present interviews. In addition, my interview topic guide did not contain any overtly sensitive questions that may have required more of an emotional connection.

²⁴ A copy of the participant information sheet is provided in Appendix 8

²⁵ A copy of the participant consent form is provided in Appendix 9

²⁶ ©Microsoft 2018

²⁷ ©2018 Ecamm Network, LLC

²⁸ S Seitz, ‘Pixelated Partnerships, Overcoming Obstacles in Qualitative Interviews via Skype: a Research Note’ (2015) 16 *Qualitative Research* 229

²⁹ S Weller, ‘Using Internet Video Calls in Qualitative (Longitudinal) Interviews: Some Implications for Rapport’ (2017) 20 *International Journal of Social Research Methodology* 613

³⁰ *Ibid*, at 614. This term is used to define a face-to-face interview where both participants are present in the same physical space

³¹ *Ibid*, at 623

Interview length varied between 24 minutes (shortest) and 68 minutes (longest). The interviews followed a semi-structured format, using questions appropriate for each set of interviewees.³² The first interview with a veterinary surgeon was intended as a pilot interview, however it resulted in such rich data that it was included in the final analysis. In later interviews, I included a specific question about the timing of the consent process to address a topic raised in several of the earlier interviews. As the interviewer, I did not feel restricted to the questions on the topic guide, and I attempted to make the interview more like a conversation where possible, by following areas of interest raised by the other participant.

Interviews were initially transcribed, anonymised and imported to QSR NVivo software for organisation. Codes were suggested by following the development of categories in preceding studies (see Chapter 5, Section 5.5 and Chapter 6, Section 6.2), together with novel topics presented by the interviewees. These were refined into six main themes. Initial coding was performed on transcribed interviews within the NVivo software programme, as before, but I soon realised that this approach was ignoring some of the more holistic aspects of the interviews.³³ I therefore performed a second coding round on hard copy print-outs of the transcripts, using coloured highlighting pens to define codes. The two coding rounds were then compared and combined, to ensure that coding was comprehensive and consistent.

7.3 Analysis of interview data

Working from the assumption that interpretive description should be “located within ...existing knowledge”,³⁴ the coded data were analysed using a critical analytical framework that had been suggested by the preceding studies to construct the concept of informed

³² The topic guide for interviews, with specific variations for each type of participant, is included in Appendix 10

³³ The need to adopt a more holistic approach was discussed with one of my supervisors (PHW), who advised using hard copies to enable a new approach to coding.

³⁴ S Thorne, SR Kirkham, J MacDonald-Emes, ‘Interpretive Description: a Noncategorical Qualitative Alternative for Developing Nursing Knowledge’ (1997) 20 *Research in Nursing and Health* 169, 173.

consent.³⁵ However, I also incorporated a hermeneutics approach (see Chapter 2, Section 2.5.5). This allowed a clear indication of what was located in the original text, working directly from the interview transcripts, and what was “a presentation of my interpretation of its meaning.”³⁶ Data were analysed using thematic analysis, but with a fusing of horizons (mine as researcher, and the various horizons of the participants) that allowed discussion of the new knowledge within the framework of existing knowledge in this context, both from prior experience, from doctrinal research and from the preceding empirical data analyses.³⁷

Topical survey	Thematic summary	Conceptual description
<i>Oral v written consent</i> <i>Form provides structure to discussion</i> <i>Alternative forms of evidencing discussion</i>	The place of the consent form in obtaining a valid consent	Consent form as evidence or “protection”
<i>The content of the consent discussion</i> <i>Finances</i> <i>Risk disclosure</i> <i>Offering additional procedures</i> <i>Timing of the discussion</i> <i>Person responsible for obtaining consent</i>	The role of the consent discussion in informing the client	Degree of respect for client autonomy
<i>Offering choices</i> <i>Influencing the decision</i> <i>The role of trust</i> <i>Differences with medicine</i> <i>Consent as protection of interests</i>	Consent as shared decision-making between animal owner and veterinary professional	Balancing autonomy and beneficence

Table 7: The analytic levels achieved for analysis of interview data, after Sandelowski and Barroso ³⁸

³⁵ JM Morse, ‘Constructing Qualitatively Derived Theory: Concept Construction and Concept Typologies’ (2016) 14 *Qualitative Health Research* 1387

³⁶ K Austgard, ‘Doing It the Gadamerian Way - Using Philosophical Hermeneutics as a Methodological Approach in Nursing Science’ (2012) 26 *Scandinavian Journal of Caring Sciences* 832

³⁷ *ibid*, at 833.

³⁸ M Sandelowski, J Barroso, ‘Classifying the Findings in Qualitative Studies’ (2016) 13 *Qualitative Health Research* 905, 910-914

The use of a variation on a hermeneutics approach helped me to aim for the level of conceptual description. This level appears in Sandelowski and Barroso's levels of analysis, explained in more detail in Chapter 2, Section 2.6.1. With this study, I consider that I have been able to achieve this level of interpretation. The levels for each of the themes are depicted in Table 7.

A major part of each interview dealt with normative aspects of consent, such as how it should be recorded, what the discussion should contain, and when it should take place. As all participants were aware of my veterinary background, these areas may have elicited an 'ideal' answer to the question rather than an answer that reflected their own views. Such concerns may not apply to the representatives from the professional bodies, who give normative guidance to veterinary professionals as part of their job, but the practitioners (veterinary surgeons and veterinary nurses) may have told me what they thought I wanted to hear, or even what the professional bodies would want to hear. However, returning to the idea of the "active" interview, the aim of co-construction of knowledge requires that I work with the data and interpret these words as being representative of the perspective of the participant. I therefore analysed the data on the basis that participants were sharing their own views on consent. For the quotations from the interviews in the following sections, all participants were allocated a number relating to the order in which they were interviewed, prefixed with an abbreviation to describe them as follows:

AO	Animal Owner
PB	Representative of a professional association, or regulatory body
VN	Veterinary Nurse
VS	Veterinary Surgeon

7.4 Participants' reflections on the purpose of informed consent

When eliciting participants' views on the purpose of consent, its role included "protecting" the parties involved, the veterinary professional, the client and the animal patient. Initial

ideas from veterinary professionals, and animal owners, suggested that consent protects the veterinary professional against litigious clients:

"I think fear of litigation is obviously a big point. ...(...)... people are more willing to complain now....."

(VS2)

"There's also an extreme fear of being either sanctioned by the Royal College or sued, which we never had, it was extremely rare."

(VS3)

"I think that ... (...) veterinary professionals need to be protected from people who simply get an outcome that they don't like, and actually say then, ... (...) well my animal died or something went wrong, it's your fault."

(AO5)

Some participants acknowledged that consent could also protect clients:

"...but consent is primarily there to protect the owner and the animal, from doing things that they either don't agree with, or that they don't understand."

(VS2)

" you could say that it is a way of ensuring that owners have to know about the procedure and the costs as well, so I guess in that way, you can say it protects them as well."

(VN9)

Perhaps surprisingly, apart from one participant (VS2), consent was not viewed as protecting the animal, until interviewees were prompted to consider this aspect by a direct question from the interviewer. For example, in interview 8,

“So, you said that it [consent] protects the client and the veterinary professional, but what about the patient? Is there any aspect that protects the patient?”

(Interviewer, PB8), which elicited the response:

“ ... I think that it should benefit the patient, simply because if there has been a discussion, one would hope that the best possible outcome in the given circumstances will be achieved for that animal.”

(PB8)

Another disagreed that there was any role for consent in protecting the patient:

“ ... I don't think it really protects the animal, though. Because it doesn't, you know, they don't have a choice.”

(VN9)

In summarising this theme, my interpretation is that participants tended to regard consent as a means of protecting the veterinary professional against litigious clients, with an acknowledgement that the client is protected through being fully informed about procedures and therefore protected from unexpected costs. This potentially results in *some* protection of the animal patient. However, it is apparent that those interviewed felt that the consent process does not fully protect the ‘best interests’ of the patient. Thus, these views agree with the findings from human medicine, that patients regard consent as a means of protecting doctors or the hospital. They also concur with the findings from previous studies on consent forms in medicine and veterinary medicine,³⁹ where patients and clients saw the consent form as a legal document that protected the hospital or individual healthcare professionals. The views of the veterinary professionals, that consent offers protection

³⁹ See. For example, A Akkad and others, ‘Informed Consent for Elective and Emergency Surgery: Questionnaire Study’ (2004) 111 *BJOG: An International Journal of Obstetrics and Gynaecology* 1133 and MC Whiting and others, ‘Survey of Veterinary Clients’ Perceptions of Informed Consent at a Referral Hospital’ (2017) 180 *Veterinary Record* 20

against litigious, or more commonly, complaining clients, does little to counter the opinions held by patients and clients. In my opinion, this is potentially problematic, and may act as a barrier to the role that consent can play in improving vet-client communication and understanding on both sides.

7.5 Written consent

Participants conveyed a distinct separation of the purpose and utility of written consent from oral consent. This separation came mainly from the veterinary professionals involved, particularly from veterinary surgeons.

7.5.1 The purpose of the consent form

The consent form provides written evidence that some sort of discussion has taken place, however limited, and that the person giving consent has indicated a willingness to proceed with the proposed treatment. In the case of elective neutering, it would be usual to have a signed consent form for the procedure. For further discussion on the legal and ethical purposes of consent forms, see Chapter 5, Section 5.1.

One veterinary surgeon felt very strongly about the requirement for written consent by the profession's regulatory body (RCVS) and the profession's most frequently used indemnity insurer (VDS):

“And then you start thinking about your consent, and the reason we have written consent forms is for the Royal College, not because we believe they're better than oral consent. We have them because the Royal College will tell us off if we don't have them. And you could argue the same with the VDS, because the VDS want you to have a written consent form.....”

(VS2)

The view held by the latter participant, that veterinary professional bodies place emphasis on signed consent forms, was not confirmed by their representatives. As one noted:

“... (...)... and if I’m discussing a case with a colleague, I’m far more interested in the evidence of that conversation than I am in the signature on the consent form.”

(PB4)

This concurs with the legal position regarding consent forms, in that consent forms for medical treatment have no legal status other than acting as evidence that some sort of discussion has taken place.⁴⁰ However, participants also indicated the usefulness of having something in writing and the maintenance of the tradition of written consent:

“I think it’s wise to follow it up in writing. It’s a sort of ‘bog standard’ sign of consent.”

(PB8)

Other participants also saw the value of recording consent in writing, and the “protective” value of having written confirmation of consent discussions. For example, one veterinary surgeon, when discussing a consent procedure that had not gone well, observed that:

“..... luckily for me, I wrote all of this down. I wrote that I suspected a bladder obstruction and I wrote that I would like to refer it for investigation, which is crucial....”

(VS1)

Although this veterinary surgeon had not anticipated that the client would subsequently complain, the fact that there was a record of their discussion on the consent form provided useful evidence of what had been said.

⁴⁰ Note that consent forms are legally required for some treatments. For more on when written consent forms are required, see Chapter 5, Section 5.1

These examples offer confirmation that, although participants appreciated that a consent form provided useful evidence that a consent discussion had taken place, there was more emphasis on the form as a 'protective' document (for example, against future complaints) from veterinary practitioners than from representatives of professional bodies. This perception reinforces the view of consent as protecting the veterinary professional.

7.5.2 A form provides structure

In addition to providing evidence of the consent discussion taking place, one of the veterinary nurses felt that a pre-printed consent form helps with ensuring that all aspects of the consent process are covered during the discussion. It may also help with training student veterinary nurses to take on the responsibility of gaining consent:⁴¹

"..... it really double checks that you have in front of you who you should have in front of you.(....).... I think it's a good prompter for whoever is gaining the consent from the client, because you've got generally written on the form what you're going to do."

(VN6)

However, another veterinary nurse highlighted one of the problems with consent forms currently in use:

"Yeah ... [laughs] I see a lot of consent forms that are very scrunched up, trying to fit everything on to one single side of A4 sheet, (....) they're always on one side of A4 sheet..."

(VN9)

⁴¹ Student veterinary nurses are regarded as suitable persons to whom the task can be delegated, provided they have had training. RCVS 'Supporting Guidance' <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/>> Section 11.4

A client with recent experience of giving consent for elective neutering surgery for an animal, remembered that the form had been used to structure the discussion:

“.... the nurse (....)..... – she had a biro in her hand and she actually used certain parts of the form, she didn’t underline anything but she used it as a pointer, and she pointed certain specific things out, to say, sort of, just drawing this to your attention.”

(AO5)

However, this client felt that it was important for a discussion to accompany the form, which had been rather difficult to read:

“But... but... to be fair, however dense the form was, I did have someone who was talking to me and was listening to my responses. I didn’t have the sense that it was just, “sign the form and let’s get going.”

(AO5)

The latter example stresses the importance of the concurrent consent discussion. If clients feel that there has been a conversation based on the content of the form, then the readability and format of the form itself may be less important.

7.5.3 Recording consent in other formats

One participant felt that alternative methods of recording the consent discussion could be considered:

“..... that conversation needs to be recorded in some manner, whether it’s recorded using technology or old-fashioned writing down or typing into a clinical record.”

(PB4)

while highlighting one major limitation of consent forms in current use:

“... the amount of information that the owner has been given is hardly ever indicated on the consent form.”

(PB4)

Interestingly, one of the clients interviewed was quite content with *not* signing a consent form:

“emmm ... to be honest, if there wasn't a consent form, I wouldn't worry, as long as I felt that I'd had that chat, and I'd been fully informed, I'd be happy for them to record like verbal consent or something like that for it, to be honest, yeah.”

(AO7)

I will discuss alternative methods of recording the consent discussion in Chapter 8, Section 8.3.2.

7.5.4 Consent forms as 'evidence' or 'protection'

In summarising this theme, there was broad agreement between veterinary professionals, animal owners and representatives of professional bodies that what was important was the discussion between veterinary professional and client, but from the professional point of view, it was useful to have a written record that such a discussion had taken place, particularly when dealing with subsequent client complaints. Thus, the view of the form as 'protection' against client complaints or, less frequently, litigation, was strongly endorsed by veterinary professionals. Despite a feeling that professional bodies insisted on written consent, this was not reinforced by their representatives, who placed more importance on the consent discussion. They did, however, acknowledge that a signed consent form was useful evidence that some sort of conversation had taken place. However, there was a consensus that current consent forms contain too much information, and that they do not do a very good job of recording the consent discussion. I will therefore consider ways to improve consent forms in Chapter 8.

7.6 Oral consent

Those veterinary professionals who preferred to use oral consent perceived that they are constantly seeking consent, for every treatment proposed or offered, and therefore separate consent for anaesthesia and surgery is perhaps not helpful.

“...and I find that we tend to use the written consents where we don’t have so much of a pre-existing relationship with the client. But I’d say the vast majority of consent would be oral (....).... actually, you are constantly gaining consent from every client, for administration of a vaccine, or for administration of a medication (....).... and you do that all on oral consent.”
(VS2)

This raised the question of how is oral consent confirmed? I asked the same interviewee if there was a standard ‘confirming’ statement used in situations requiring oral consent, with the response that the most important purpose of this statement was to confirm understanding:

“We tend to end the conversation with “Are you happy with everything?” “Do you understand, does that all make sense?” that’s the kind of thing I say.”
(VS2)

Returning briefly to the different levels of consent, which were considered in Chapter 1, Section 1.3, it was proposed that non-therapeutic neutering should require written, informed consent, but procedures such as vaccination could be regarded as requiring ‘simple’ or oral consent.

7.6.1 The consent discussion

The consent discussion provides the information that clients need to make informed decisions about proposed treatment for their animals (see Chapter 6). Thus, the discussion

could have a role in respecting client autonomy and, to a lesser extent, protecting the best interests of the animal. Participants were asked what they thought should be covered during consent discussions, or what they would normally include in consent discussions. The main topics included risk disclosure, estimates of financial costs, and giving options. Several participants steered the interview along an interesting diversion by mentioning other procedures that can be included on consent forms. This included consideration of whether pre-operative blood tests should be offered to clients or should be recommended by the veterinary professional, a topic which is considered in more detail in 7.6.3.

Starting with the 'usual' consent discussion, one veterinary surgeon offered a comprehensive list of what is covered:

“A basic explanation of the journey that that animal will take (....) be that work-up, diagnostics, fluids, blah blah blah, surgery; risks involved; ball-park cost, maybe top-end figures at least ... (....) yeah, checking their understanding of the process, I suppose....”

(VS1)

Although most consent discussions in veterinary practice will include provision of cost estimates, one interviewee was keen to separate consent discussions and financial discussions:

“And then I think the other thing that always gets brought into them is the financial thing. And I think that should be separate, because the consent ends up being consent for whatever the procedure's going to cost, and can you pay for that?”

(VN6)

Another veterinary nurse had experience of designing consent forms to achieve this aim:

“When we’ve looked at sort of designing consent forms, (...) we’ve almost had like an explanation of the procedure, maybe with some diagrams, then the complications and then the financial estimate as a separate consent, so giving financial consent separate to the procedure consent.”

(VN9)

It was noticeable that the veterinary nurses recommended keeping financial and procedural consent separate, yet none of the veterinary surgeons referred to such an approach. The key difference may be that veterinary nurses usually obtain consent once the client has chosen a specific procedure, whereas veterinary surgeons will discuss all the options (and costs) to enable the client to make an informed decision. Therefore, the differing views may be attributable to different professional responsibilities. Veterinary nurses are not responsible for making clinical decisions, therefore they see consent from a slightly different perspective to veterinary surgeons.

Clients seemed less concerned about discussion of costs. However, all clients interviewed had pet insurance. It is, however, important to clarify that most policies will not cover the costs of elective neutering. When asked what a consent discussion prior to neutering should consist of, one owner replied:

“I’d want to know the kind of risks and benefits, like what were the kind of common, like, post-operative problems, and were there any risks, could it change his personality at all emm ... things like that. But it would actually mainly be practical things, because with working, I’d be I’d really want to know, like, how I could plan this to kind of fit in with our family ...”

(A07)

I followed this up by asking if discussion of costs was also important, and this interviewee agreed that it was good to know how much veterinary treatments were going to cost, remembering an instance when the family dog had been ill:

“..... I just felt when they’d been telling me about the different tests he could have, at no point did they say how much they were going to cost ... (....) so I got to the desk and I was thinking oh my goodness – how much is this gonna be? Yeah, I think before neutering, I would want to know how much it was going to cost. Just so that you don’t look so surprised when they tell you the bill!”

(AO7)

Finances were considered an essential part of the discussion by one of the professional body representatives, for reasons arising from cases that they were familiar with. This interviewee argued against separating costs from consent, certainly during the discussion:

“ .. somebody has ... (....) ... gone through all the options, and they want the best, they think, yeah I want that. And then if you start to have completely separate discussion on financials, and they’re finding that actually ... (....) they can’t really afford it, and they then feel pressurised, because they think, well, I’ve got to go for it ... you know, I don’t think having two bits of paper matters, but I think you have to join up the dots in your discussion.”

(PB8)

Thus, there was a general view that costs were an essential component of the consent discussion, may influence the client’s choice of treatment, and should be presented at the same time as options for treatment. There was a difference between separating costs from the rest of the consent discussion and separating the written estimate of costs from the consent form, the view being that the discussion had to be integrated.

7.6.2 Risk disclosure during the discussion

Both veterinary nurses reported that they include the discussion of risks involved with surgery, particularly with general anaesthesia, in their topics to be covered during consent

discussions. These participants considered the topic of risk in detail, particularly highlighting the clear communication of the exact nature of the risks involved, with one commenting:

"I always used the word "death" as well, as one of my risks."

(VN6)

Another veterinary nurse discussed the specific risk of death in response to my sweep-up question, "is there anything else you would like to tell me about consent?" at the end of the interview. If I had not asked this question, I would not have had access to this response, thus demonstrating the important role of effective communication by the interviewer. In this case, the participant offered more thoughts on risk disclosure:

"I think probably my big thing is, and I'm always trying to put this over to student nurses, is the word 'complications', and what that actually means, because they're all so scared of saying the pet could die from the anaesthetic. (.....) It's rare and you can say, it's not very often, but yes, you do actually have to fully explain what the complication is, and don't hide behind the term 'complication'."

(VN9)

It was more difficult to obtain the owners' perspective on risk disclosure. One animal owner did remember that the consent form signed at the time of neutering surgery (several years previously) included reference to the risk of death. I asked whether this risk had been clearly stated on the form, with the response:

"..... and there's always a consent form, and it always sets out clearly things like risks, you know, there's a risk of anaesthetic, there's emm ... you know, there's a risk of bleeding, there's a risk of infection, emmm ... and you know, ultimately, that could ... there's a risk of death."

(AO10)

However, it seems more common to discuss risks in generic terms, both from the recollection of an animal owner remembering the discussion prior to a dog's elective surgery:

"A small amount about risk emm... in that... he said there was always a risk with any surgical procedure, but that it was a very routine process from the veterinary perspective..."

(AO5)

and from the perspective of a veterinary surgeon outlining a 'normal' consent discussion:

"... (be)cause what I would have said is, "with all anaesthetics there's always a risk, and we'll do everything we can to minimise that."

(VS2)

From my experience as a veterinary surgeon and from working with 'simulated' clients in communication skills training sessions, the problem with defining risks in generic terms is that the client may have a false notion of what constitutes 'risk'. For example, they may interpret risks as meaning that the patient will be a bit sleepy after surgery or may vomit post-anaesthetic. Additionally, some risks may matter more to different clients. The importance of defining which risks are involved with the proposed procedure, and what constitutes a 'material risk' when referring to elective neutering surgery are discussed further in Chapter 8.

7.6.3 Offering additional procedures

One topic that seemed to unite the veterinary professionals was the offering of pre-operative blood tests to animal owners, in the guise of improving the safety of general anaesthesia. I was content to explore participants' view on this aspect of consent, especially as this topic provokes controversy amongst veterinary professionals. It is debatable whether

carrying out pre-operative blood tests is justifiable on patient safety grounds.⁴² I did not ask specific questions regarding pre-operative blood testing and its place in the consent process, but it was a topic raised by several interviewees. One veterinary surgeon saw the consent form sometimes being used as a commercial document to promote methods of increasing practice income:

“One of my biggest concerns about consent forms, and I hate using them, but I had to when I was locuming,⁴³ ... consent forms that are sales forms for pre-anaesthetic bloods...”

(VS2)

Two veterinary nurses shared this view, with strong objections to the approach seen in some practices of offering pre-operative blood sampling to all clients whose animals are booked for surgery, regardless of perceived need:

“... I’ve heard people saying, yeah, we do that, it will make the anaesthetic much safer, if we do that. And you know, if we’re doing it properly then that’s what we should do. And always this thing of giving the client the choice as well. And my angle has always been a lot more ... actually, it’s a clinical decision, it’s not a financial decision. It’s not, “oh you can afford an extra forty quid so your pet gets a blood test,” it’s, “does your pet need a blood test?”

(VN6)

“Whew, I have a separate issue with the pre-op bloods, emm ... (be)cause I don’t think clients should ever be asked if they want bloods and to have to

⁴² For example, see M Alef, F Von Praun, G Oechtering, ‘Is Routine Pre-Anaesthetic Haematological and Biochemical Screening Justified in Dogs?’ (2008) 35 *Veterinary Anaesthesia and Analgesia* 132. These authors found that pre-operative blood screening was of little clinical relevance and did not prompt major changes to the anaesthetic technique.

⁴³ A locum veterinary surgeon provides cover for permanent veterinary surgeons when they are on holiday, for example. Most “locum” appointments are short-term.

make that decision, because that's like saying, well it might have kidney failure – do you want bloods? How are they supposed to know?”

(VN9)

One animal owner recalled having made such a decision about blood tests, however, without any apparent pressure or guidance from the person taking consent:

“... (be)cause I do remember at one point where she pointed at the ... the pre-operative blood tests that are an option, that are presented, and I said if she was older, or in any sort of questionable health, I would have opted for those, but because she was so young, and so obviously healthy, I didn't see the need for those, and she said yes, that sounds like a reasonable sort of decision.”

(AO5)

In summary, there are several topics that are generally agreed by all participants as essential components of consent discussions; these are the options, risks and benefits, costs and outcomes of treatment. The veterinary professionals interviewed did not think it was appropriate to try to 'sell' additional procedures to clients during the consent process, either via the discussion or the consent form itself. Indeed, the veterinary nurses were keen to separate consent for the procedure and consent for the financial costs of the procedure.

Such views correlate with the tension between respecting client autonomy, or the 'consumerist' approach, and presenting only the preferred option, or the 'paternalistic' approach.⁴⁴ I thought that this apparent tension was worthy of further investigation, so will now turn to focus on the topic of whether the veterinary professional 'should' influence the client's decision.

⁴⁴ Shaw and others, in 'Veterinarian-Client-Patient Communication Patterns Used During Clinical Appointments in Companion Animal Practice' (2006) 228 *Journal of the American Veterinary Medical Association* 714, describe 3 theoretical models of communication, paternalism, consumerism and relationship-centred.

7.6.4 Informing the client or influencing the decision?

As was shown in Chapter 6, the elective neutering of companion animals is often a procedure that is requested by the animal owner, with little or no alternative options offered by the veterinary professional. Thus, the situation is similar to that found in the studies by Probyn⁴⁵ and Hall,⁴⁶ in that the client has already made the decision for surgery before the consent discussion. It could also be argued that, as neutering is a preventative treatment, it requires shared decision-making, as suggested by Müller-Engelmann's participants.⁴⁷ However, a key component of informed consent is the offering of alternative treatments, and the amount of direction or influence that the healthcare professional provides. In exploring this theme, the interviews deviated temporarily from the study treatment of elective neutering of companion animals. I thought it important to explore the theme as one that arose from the analyses of consent forms and consent discussions, but also as a key finding of previous interviews regarding consent.

I asked all veterinary professionals where they would position themselves on a hypothetical scale that ranged from, at one end, offering only the 'best' option for treatment, to, at the other end, offering clients all the available options and leaving the choice entirely to them. I asked clients where their 'ideal' veterinary surgeon would sit on this scale. In asking this question, I was attempting to work out how much autonomy clients want, and how much autonomy veterinary professionals are prepared to give them. Here, I was not proposing a holistic respect for autonomy that might apply to the treatment of competent human patients, but rather investigating their idea of a 'balanced approach' between those involved in decision-making on behalf of animal patients.

The first key finding was that some veterinary surgeons do not want clients to have any autonomy at all. I had anticipated that a somewhat 'paternalistic' view might exist amongst older veterinary surgeons, a view confirmed by the response from a member of this group:

⁴⁵ Probyn and others (n6)

⁴⁶ Hall and others (n8)

⁴⁷ Müller-Engelmann and others (n13)

“... I really can’t see the point in giving the client the option of things they know absolutely nothing about and probably don’t understand, at each stage of the process.”

(VS3)

I was therefore surprised to find that a younger veterinary surgeon shared this view, with a perception that recently graduated veterinary surgeons are reluctant to give clear recommendations to clients:

“I think how most of the teaching in some of these vet schools is now to say “here’s option A, here’s option B, here’s option C,” and then stand there in silence and say “What would you like?”

(VS2)

In fact, the veterinary surgeons interviewed were keen to recommend or select treatments to offer to clients. If there is only one clear option for treatment, then they are comfortable with offering only their preferred or ‘gold standard’ treatment:

“I can very easily go up to a cow and sort of say, well she’s ketotic,⁴⁸ so we need to treat her with this, it’s not really much of a battle there, it’s very veterinarian-led, cos they’re almost never going to say no to that.”

(VS1)

Where there are several options, they may offer choices to the client, while giving some direction:

⁴⁸ Ketosis is a metabolic disease commonly found in high-yielding dairy cattle. Treatment is fairly straightforward and usually successful.

“...so what I will usually do in situations like that is I’ll often offer three or four options (...) and say, you know, I think she’s a good candidate for surgery therefore we should crack on ...”

(VS1)

Some veterinary professionals are very willing to lead clients, or even offer limited choices:

“... (.....) ... and I will say to them, “Your dog needs a blood test, it needs this, it needs that ...” and I’m very clear on that ... (...) I firmly believe that what the clients are after is guidance.”

(VS2)

This approach is not without danger, however, as this participant recognised.

“I can think of several examples where I’ve led people ... (...) ... and they haven’t appreciated it, because it’s then come back as “well this didn’t go perfectly” and they complain.”

(VS2)

Another warned against *not* giving clients options, especially in anticipating which treatments or services they would and would not pay for:

“I think you are doing your client a disservice if you assume what they can afford or what they would pay (...) ... I think a lot of us fall down in not offering top notch, “gold standard” tertiary referral⁴⁹ or whatever, because we just assume that they wouldn’t go for it”

(VS1)

⁴⁹ ‘tertiary referral’ is a term that suggests the patient has been referred from general practice to a specialist at another practice, but has then been referred from there to a referral hospital or, more commonly, to a university veterinary hospital

Interestingly, professional body representatives were more circumspect regarding clients making decisions, and were more protective of the veterinary professional's autonomy:

"Without wanting in any way to limit the ability or the need for owners to make informed decisions ... (...) they are not scientists, they are not the patient, and they are not trained to make those sort of decisions....."

(PB4)

"... you can give options, but you have to be careful you don't give too many, ... (...) ... it's very difficult, I mean the reason that people go to a veterinary professional is because they are the professional."

(PB8)

One veterinary nurse found it especially difficult to leave choices to the client when considering decisions that have potential implications for animal welfare, indicating a preference for making decisions based on the animal patient's best interests:

"..... in that situation it's really, really difficult to not react when somebody is being really unreasonable. And they're actually trying to get you to do something that's against your professional principles, against animal welfare, not in the interests of their animal ..."

(VN6)

A professional body representative proposed that the safest thing to do is to aim for a 'middle ground':

" you don't have to give every last thing or side-effect of every last drug ... (...) ... but it has to be real choices."

(PB8)

Both veterinary nurses were strongly in favour of offering clients all the options, with the aim of increasing client adherence to the treatment plan:

"... I personally always feel you should give all the options, and explain why they are the options and why you're recommending, and then discuss that through with the client."

(VN9)

The views of the veterinary nurses fitted with the views of the animal owners, who were keen to do their own research, to be given suitable options and to be given advice where required:

"I do like to know what the pros and cons are. I do usually do some reading up and some, perhaps, verbal checking with people that I know (.....) if I'm struggling to make a decision, I welcome the kind of recommendation that would be sort of "if it were my dog, I would do it for this reason."

(AO5)

"..... you almost don't want to be given too many options; because I don't have any kind of specialist knowledge in this field, and almost I am looking to be guided to a certain extent by the vet and their expertise."

(AO7)

"..... even if I ask the question, "what would you do?" or "what would you recommend?" (.....) ... I like to know all the kind of facts and possibilities and options before I make that decision myself."

(AO10)

When offered the two extremes of decision-making, clients would prefer to have all the options, but they also appreciate some help with decision-making, particularly in stressful situations. This finding resonates with those of the Sinding⁵⁰ and Doherty⁵¹ studies, where patients with serious disease appreciated more direction from their doctors. Advice from professional bodies indicates that clients should be given choices⁵² and that there is no longer a place for offering only the veterinary surgeon's preferred treatment, except where that is the only treatment available. Offering clients choices increases the 'informed'-ness of informed consent.

It is revealing to view this analysis through the influence of doctrinal research, where the underpinning theme of respecting client autonomy has its origins. The contrasting view that the veterinary professional should advocate treatment deemed to be in the best interests of the patient was prevalent among the professionals interviewed. In medicine, this view would be considered as paternalistic. It could be argued that paternalism is not an appropriate term for the treatment of animals. Indeed, it may not be justifiable to use findings from medicine to suggest a way forward for consent in veterinary practice. However, when returning to the focus of this work, the companion animal patient, we must consider that its status is frequently that of a family member (see Chapter 4, Section 4.3.1). Comparisons are inevitable with paediatric decision-making, where a 'best interests' approach predominates (see Chapter 4, Section 4.4). The underpinning theme of respecting client autonomy versus advocating treatment deemed to be in the best interests of the patient is apparent throughout this analysis, so the topic will be discussed further in Chapter 8.

7.7 Demonstrating respect for client autonomy – practical aspects of consent

⁵⁰ Sinding and others (n9)

⁵¹ Doherty and others (n7)

⁵² RCVS (n41) Section 11.2 refers to the client being given a '*range of reasonable treatment options*' as an essential requirement for informed consent

One method of respecting client autonomy involves paying attention to the practical aspects of the consent process, such as giving clients time to consider the information provided and ensuring that the person who provides the information is suitably knowledgeable and trained to do so (see Chapter 3, Section 3.6.4).

7.7.1 Timing of the consent discussion

One topic added to the interview guide following the first couple of interviews was the timing of the consent discussion. In giving clients the information that is needed to make an informed decision, it is important that they then have sufficient time to consider this information and decide whether to proceed.⁵³ Some veterinary professionals favoured the discussion taking place in advance of planned surgery, particularly for elective surgery such as neutering:

“Bringing it forward – if it’s an emergency you can’t but – for neutering. You know, when people book in for neutering, should we not be providing information at that point?”

(VS2)

This veterinary surgeon did not currently have pre-surgery consent discussions, but during the interview we discussed the protocol used by the practice visited for the observational research; this interviewee was keen to implement a similar approach when discussing the benefit of having the discussion in advance of the surgery. The animal owners endorsed this preference:

“I think, in some ways, it might be better to actually do the consent process on a different day to the procedure. Emm, I think when you actually have the

⁵³ See, for example, MG Berry and others, ‘A Comparison of the Views of Patients and Medical Staff in Relation to the Process of Informed Consent’ (2007) 89 *The Annals of The Royal College of Surgeons of England* 368, who found that the majority of patients questioned would prefer to have information in advance of their surgery.

animal in your arms, somehow your focus is pretty much on them, rather than on the 'what might be's' and the probabilities and recommendations."

(AO5)

"I'd wanna ... maybe go in for a pre-consult, like a consultation and then be like, oh we'll book him in like two weeks on Monday, something like that. So we've got a bit of time to kind of get plans in order as well, for like looking after him when he comes home."

(AO7)

"...and in terms of timing, emm ... not feeling rushed, so not having to ... you know, get pushed ... you've got to sign this now, so having an opportunity to go away and think about it and perhaps, you know, research some more information, perhaps having, you know, a leaflet to read about it to take away"

(AO10)

A compelling reason provided for having the consent discussion in advance is that when owners leave their animals for surgery, the emotional impact of this separation affects them:

"I think it's also better if you can do it before people are in a highly stressed situation because when they're in the very highly stressed situation, people don't take in what you're saying"

(PB8)

"I don't think it's ideal, because I think, emm ... the client comes in with a pet, they're having a procedure, they're really nervous, anxious, and then you're giving them all this information at that time, that I don't think they can digest properly."

(VN6)

An important aspect of the timing of the discussion was the amount of time that could be spent with the client. Time is a resource that is often in short supply in a busy clinic, especially in situations where veterinary staff are trying to admit animals for surgery first thing in the morning. Thus, from my previous experience in practice, a situation such as the one described below is common:

“.... you tend to end up doing them first thing in the morning, (....)..... so you’ve got, like, three, four people waiting in the waiting room, and they’ve all got to get to work! ... (....) because I’ve had that a lot of times, you know, it’s all right, just give me the form, I’ll sign it, and I’ll just leave him with you, and I won’t do it.....”

(VN6)

In another participant’s experience, this early morning rush can lead to poor practice regarding consent for elective procedures:

“....and I have seen as well ... (....) the reception – you know, hand the cat over the reception desk, sign here, oh, have we got a daytime telephone number for you, marvellous!(.....)..... I would walk in and the consent form would be on the kennel.”

(VN9)

In the above example, the receptionist, who was not a veterinary professional, had conducted a perfunctory consent process with the client and ‘got the form signed’, an approach that does not fit with the ideal of who should be responsible for gaining consent (see Chapter 3, Section 3.6.4).

In summarising this theme, many participants thought it was a good idea to conduct the consent discussion for elective procedures in advance of the scheduled appointment for the

procedure. Such an approach gives the client time to consider the procedure and ask questions when there is less emotional pressure, while giving the veterinary professional time to go through all the required elements of the consent discussion without unrealistic time constraints.

7.7.2 Person responsible for obtaining consent

I asked animal owners if they would feel comfortable having the consent discussion with any member of the veterinary healthcare team. The answers varied. One client would only be satisfied if the veterinary surgeon who is going to perform the surgery is also responsible for the consent discussion:

“I would expect that conversation with a veterinary surgeon, the person that’s actually going to perform the surgery.”

(AO10)

This interviewee used a one-person veterinary practice, was used to always seeing the same veterinary surgeon, and reported having a good experience regarding continuity of care if that veterinary surgeon was on holiday. For example, when the dog had been ill recently, the usual veterinary surgeon was about to go on holiday:

“..... I can remember coming in to speak to the other girl and I felt like I had to start to explain what had gone on the previous week, and she said oh no, don’t worry I was here when [dog] was here, I had my handover day ... and I know exactly what’s gone on...”

(AO10)

This extract demonstrates good practice in handing over cases from one veterinary surgeon to another, but such continuity of care is rare in many practices. This may have an effect on trust. As will be discussed below, in 7.7.3, trust can be an important influence on client decision-making and on consent.

Other animal owners were content to see either a veterinary surgeon or veterinary nurse. One had particularly good impressions of the nurses in the practice, commenting:

“When we’ve taken him to get weighed for his worming tablets, we’ve always seen a veterinary nurse..... I think that actually maybe they have a bit more time to talk about things and could probably explain it in ways that we can understand better.”

(A07)

Regardless of whether the person taking consent was a veterinary surgeon or a veterinary nurse, it would undoubtedly help if this was communicated to the client, as illustrated by this excerpt:

“I’m not sure whether the person I was talking to was a vet nurse or a vet - I’m guessing a vet nurse, but they didn’t identify themselves as that...”

(A05)

Following the recently updated RCVS supporting guidance on communication and consent, either a veterinary surgeon or a veterinary nurse⁵⁴ would fit with the College’s recommendations on who should take consent. Interestingly, the guidance does not stipulate that the client should be informed of the role of the person to whom they are talking. The RCVS guidance has been formulated along similar lines to the GMC guidance regarding training and suitability of personnel for consent discussions (see Chapter 3, Section 3.6.4).

7.7.3 The influence of trust on consent

⁵⁴ RCVS (n41) Sections 11.3-11.5

Although not asked specifically about trust and its importance, it appeared as a recurring theme in several interviews. Trust can be an influence on consent.⁵⁵ It seems particularly important to animal owners. For example, in discussing decision-making in general, one stated:

“I certainly prefer to make the decision with a vet that I trust and that’s a huge factor in deciding whether to go forward.”

(AO5)

The conversation returned to trust later in the interview, when asked how to approach making the decision in the case of several options for treatment:

“If a vet that I had great trust in, and that I had always seen acting in my pet’s best interests before, I couldn’t fail to consider what they would recommend....”

(AO5)

This client reported having several poor experiences with veterinary practices in the past, but was happy with the current practice, despite saying “they’re not perfect.”

A professional body representative felt that trust is declining:

“The day of that kind of blinding allegiance to the professional, and it’s not just vets, it’s everybody, is gone!”

(PB8)

However, one veterinary surgeon aimed for a practice based on trust:

⁵⁵ See, for example, O’Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press 2002) 12-14

“I think we get good consent, and we involve our clients, but I think we are hugely aided by the fact our business model supports constant communication with the clients and a personal relationship.”

(VS2)

With elective neutering, trust is perhaps not such an important factor, as the procedure is regarded as price-led, and even regarded as a ‘loss leader’ by many practices.⁵⁶ Like vaccinations and other preventative health treatments, practices assume that clients will compare prices between practices, and choose the cheapest option available. However, this ‘price-led’ approach may only apply to specific versions of the client-service provider relationship, as will be explored in Chapter 8, Section 8.4.1. Trust may still play an important role when veterinary professionals recommend neutering to their clients for companion animal patients.

7.8 Conclusion

Analysis of interview data has revealed some key themes that warrant further discussion in Chapter 8, such as the balance between client autonomy and veterinary professional paternalism/beneficence, and the purpose of informed consent.

The veterinary nurses interviewed were more respectful of client autonomy than the veterinary surgeons involved, but also mindful of their perceived role as animal advocates. The veterinary surgeons interviewed gave the impression that they were in favour of varying degrees of paternalistic/beneficent behaviour, a view that was partially reinforced by the representatives of professional associations. None of the veterinary professionals mentioned the role of consent in checking the client’s understanding of the proposed procedure.

⁵⁶ See, for example, J Rothstein ‘A Veterinarian’s Master Class on Pricing’ *Veterinary Economics* (2015) <<http://veterinarybusiness.dvm360.com/veterinarians-master-class-pricing-0>> accessed 18 August 2018

With regards to the purpose of consent in protecting interests, participants viewed those of the veterinary professional as being best served by the consent process. Protection of the client's interests concentrated chiefly on financial interests, while protection of the animal's interests proved more difficult to support. The clients interviewed reflected many of the findings from studies on human patients outlined in 7.1. They wanted to be given options and to be given all of the information required to make a decision, but also wanted support in making the decision when it was a difficult one. They placed emphasis on trust and the continuity of care, wanting to know to whom they were speaking. They also wanted to be informed of costs.

Several practical issues require more in-depth consideration, including recommendations for the consent process itself, for example, timing and personnel involved, suggestions of ways to improve consent forms, and investigating other ways of recording the consent discussion.

Further reflection on this study reveals that the decision to use interviews provided rich data that enabled a higher level of analysis than could be achieved through analysis of forms or observational data alone. Triangulation of the three methods, with the added perspective provided by the findings from legal analysis, has resulted in a holistic view of consent in the specific context of elective neutering of the animal patient. In hindsight, the involvement of veterinary nurses, veterinary surgeons and representatives of professional bodies provided interesting variations in the resulting data, reminding future researchers that a narrow approach to data collection can restrict the variety of responses.

The small numbers of participants involved means that any attempts at generalisation are flawed, but this was never the intention of the study. A larger sample of veterinary surgeons, for example, may have given more of a range of views, but would still have been vulnerable to the same criticism regarding sample size. In choosing my interviewees carefully, I was able to work with rich data from key participants, and to achieve a higher level of analysis. The three sets of participants provided intriguingly different horizons from which to view consent, thus providing valuable data for the final analysis.

In the concluding chapter, I will attempt to bring together the conceptual analyses from the legal and empirical chapters, in order to explore the major findings emanating from the triangulation of the preceding studies. In this final amalgamation of the data analyses from forms, conversations and interviews, I will discuss the 'higher level' concepts, incorporating perspectives from doctrinal study. From these, I will develop both a conceptual model for consent and a practical framework for obtaining consent in veterinary settings, thus returning to practice-based outcomes.

CHAPTER EIGHT: TOWARDS A NEW MODEL OF CONSENT FOR VETERINARY PRACTICE

8.0 Introduction

This thesis has sought to demonstrate the value of a new methodological approach for research on, and in, veterinary practice. It has reported the findings from one of the first empirical projects on informed consent in this setting. The original aims of this research, to investigate the process of consent to the treatment of companion animals in the context of elective surgery, to analyse the current approach to consent, and to suggest improvements to the consent process for practitioners, were pursued through a combination of doctrinal legal research, drawing on developments in human medicine, and triangulation of several empirical studies. In this chapter, I will summarise the key findings, starting with the data analyses.

The analyses resulting from the linked doctrinal and empirical work have been reported in earlier chapters. In this final chapter I will present a holistic view of the research findings. Findings from doctrinal research will provide a legal and, from analysis of relevant guidelines, a professional ethical perspective to each of the resulting areas of debate. My view of consent, influenced by my analysis of all the research that I conducted, is that it *should* act as a means of protecting the animal from unnecessary or inappropriate treatment, it *should* protect the client from unexpected financial costs and from undisclosed risks of an unfavourable outcome, and it *should* protect the veterinary professional by evidencing the discussion and the client's agreement to proceed. In order to achieve these goals, and particularly to protect the interests of the client and patient, I will propose improvements that could be made to some key practical aspects of consent. For example, the design of consent forms, the timing and content of the consent discussion and alternative formats for recording consent will be considered as a means of demonstrating and promoting appropriate respect for client autonomy.

I will then expand the discussion to consider the best means of achieving a balance between autonomy and beneficence. I will advocate that the latter is worth valuing if we sever its (perhaps unfair) links with the accepted version of 'strong' paternalism, especially in situations where the patient cannot give consent. I propose that this 'balanced' approach provides a suitable basis for consent in the context of veterinary treatment. Based on this approach, I will propose a theoretical model for informed consent to the treatment of companion animal patients. This model will incorporate key findings from the empirical work and will be influenced by legal analysis. In presenting this model, key differences from the medical approach to consent will be highlighted and justified. One key difference is the triadic relationship involved in the consent process for veterinary treatment. Building on previous work on different types of owner-companion animal-veterinary professional relationship by Rötze-meier-Keuper and others,¹ I will then adapt the proposed model for use with differing versions of this triadic relationship.

Next, I will consider the limitations of my work, by examining the methodology and methods used, the areas of veterinary practice chosen for the study, and my own position as the researcher, before evaluating their effects on the outcomes of the studies

Finally, I will suggest some potential areas for future research. Starting with the potential for using interpretive description methodology in other areas of socio-legal research, I then focus on consent in the veterinary context, expanding the suggestions for future research to other areas of veterinary ethics and law, social scientific studies of the veterinary profession and wider human-animal studies. I will consider the implications for consent in healthcare more generally, and for professional regulation, ending with specific recommendations for the RCVS and for veterinary education.

8.1 Conceptualising the combined data analyses

¹Rötze-meier-Keuper J and others, 'Triadic Relationships in the Context of Services for Animal Companions' (2018) 85 *Journal of Business Research* 295

In Chapter 3, analysis of case law involving a failure to disclose risks to patients documented the gradual move from a paternalistic approach to consent ('doctor knows best') to a consent involving respect for patient autonomy. The question of the appropriateness of autonomy (in this case, the animal owner's) was briefly considered for its suitability as an underpinning principle to consent in the veterinary context. The analysis highlighted the very different approaches taken to the treatment of the competent adult patient and the treatment of the young child. The former is regarded as having an autonomy that is worthy of protection when deciding on treatment. The decision for the child patient is based on calculation of 'best interests' in cases where parents disagree or are considered to have made decisions that may cause serious harm to the child. The use of the 'best interests' calculation for medical decision-making when the patient cannot give consent, was explored in Chapter 4, specifically exploring the process in those cases decided in the courts. Healthcare decision-making for babies and very young children was compared with decision-making for animals. There are major differences between the two types of patient, for example, their respective legal rights and the resolutions applied in cases of disagreement between carers and healthcare professionals. However, there were some similarities, such as the permitted interference with bodily integrity. Doctrinal analysis clarified the legal basis of consent which, in combination with its professional ethical basis, enabled conceptual analysis of the findings from my empirical studies.

In Chapter 5, the content and purpose of consent forms used in veterinary practice were evaluated, in order to answer the research questions:

RQ1 Which topics are included in the text of consent forms used in veterinary practice?

RQ2 What part does the consent form play in the process of informed consent?

Many of the problems identified with the consent forms from veterinary practice (in 5.6) were similar to those found with consent forms used in human medicine, for example, an

over-reliance on complicated terminology and lack of reference to the accompanying discussion.² However, some areas identified for improvement were unique to the veterinary consent form. These included the provision for recording financial estimates in varying formats (5.6.7), and the intention for some forms to be used as 'shopping lists' or 'order forms' for additional procedures and purchases (5.6.2). These findings support the conclusion that there is a commercial aspect to consent in veterinary practice. In this final chapter, consideration will be given to improving consent forms for veterinary treatment, using a format that demonstrates greater respect for client autonomy, where appropriate.

The analysis of observed consent discussions in Chapter 6 revealed an unexpected finding, namely that veterinary surgeons in the case study practice neither used nor produced a copy of the consent form during these discussions. This study originally set out to answer the following research questions:

RQ3 Which topics are covered during consent discussions between veterinary professionals and clients?

RQ4 How does the consent discussion expand on the topics included on consent forms?

However, it proved impossible to answer the latter question from the study that I conducted, as this would have required observation of how the two components of the consent process are used together. With this in mind, I make recommendations for improving the consent protocol in this practice, intending that these may prove useful to other practices, individual veterinary professionals and the RCVS.

Three aspects of the importance of respecting client autonomy emanated from my analysis of the observed consent discussions. The first was how an appropriate balance between

² JML Williamson, AG Martin, 'Assessing the Readability Statistics of National Consent Forms in the UK' (2010) 64 *International Journal of Clinical Practice* 322

autonomy and beneficence was achieved, the second was how respect for client autonomy was demonstrated and the third was how the client's financial autonomy was recognised.

Respect for client autonomy was demonstrated through the level of risk communicated to clients (Section 6.3.7). The nature of the risks involved in surgery and how these should be disclosed to clients were subjects raised by several participants in the subsequent interview study. Therefore, this chapter will consider what constitutes a 'material risk' in the context of planned, non-therapeutic procedures, drawing on current medico-legal thinking on the definition of a material risk, as outlined in Chapter 3. As full disclosure of risks is recognised in more recent case law to be an important component of respecting patient autonomy, I will argue that it should also be regarded as an essential component of consent discussions between veterinary professionals and clients.

In Chapter 7, analysis of the data obtained from interviewing key participants aimed to answer the following questions:

RQ5 How would participants define informed consent, its purpose and how it should be obtained?

RQ6 How would participants describe the "ideal" consent protocol?

Interpretation of the data led to several areas for further discussion in this chapter. Regarding the purpose of consent, the views of the participants concurred with previous medical and veterinary research in holding that its primary purpose is to 'protect' the professionals involved.³ Turning to the practicalities of the consent process itself, issues such as the timing of the discussion, the personnel involved in leading this discussion and ways of improving consent forms were raised. Participants suggested that consent conversations

³ A Akkad and others, 'Patients' Perceptions of Written Consent: Questionnaire Study' (2006) 333 *BMJ* 528; A Akkad and others, 'Informed Consent for Elective and Emergency Surgery: Questionnaire Study' (2004) 111 *BJOG: An International Journal of Obstetrics and Gynaecology* 1133; MC Whiting and others, 'Survey of Veterinary Clients' Perceptions of Informed Consent at a Referral Hospital' (2017) 180 *Veterinary Record* 20

should include disclosure of specific risks, although there were differing opinions regarding the balance between ‘paternalism’ (or beneficence, as I propose renaming it in the veterinary context) and client autonomy, with trust identified as a potential influence on consent (Section 7.7.3). Finally, representatives of professional bodies were somewhat sceptical about how closely veterinary medicine should follow in the footsteps of its human counterpart. I will address this concern in 8.5. I now turn to my recommendations regarding consent for veterinary practice.

8.2 Recommendations for practice

When trying to make decisions in the context of veterinary healthcare, and specifically when seeking consent to non-therapeutic neutering, I propose that the ideal situation involves finding an appropriate balance between client autonomy (with its associated constraints) and beneficence.⁴ In discussing the best interests of the animal patient, I focus on the interests of the individual animal, rather than the interests of the animal population (see Chapter 1, Section 1.3.1 and Chapter 4, Section 4.5 for more detail regarding population-based arguments). In striving to achieve this balance, there are implications for practice regarding the consent process, specifically its timing, content (risk disclosure, financial estimates), personnel involved and purpose, and finally, the design of the consent form to facilitate its role as a record of the consent discussion.

8.2.1 Balancing respect for client autonomy and protection of the animal’s best interests

I will start by considering the achievement of an appropriate balance between autonomy and beneficence. Consent to the treatment of the animal patient requires careful balancing of respect for the client’s wishes with protection of the best interests of the animal patient. As discussed in Chapter 4, there are sound reasons for respecting the autonomy of the animal owner where appropriate, while ensuring that the animal’s interests are protected

⁴ In this chapter, I use the term ‘beneficence’ in preference to ‘paternalism’ when referring to consent being given by someone other than the patient

and, where possible, promoted. In the contract-based and commercial market of veterinary practice, clients can be considered to be exemplary “*consumers exercising choices*” as described by Lord Kerr and Lord Reed in *Montgomery*.⁵ Thus, animal owners retain financial autonomy over whether, and which, treatment is given to their animal ‘property’. To balance this autonomy, and to prevent owners making decisions that are contrary to animals’ interests, veterinary professionals are tasked with making decisions that prioritise the welfare of animal patients “*committed to [their] care.*”⁶

Nevertheless, owners may be the most suitable candidates to decide on the animal’s best interests. In most cases, it is the animal owner who knows and has a unique bond with the individual companion animal,⁷ and therefore the owner may be best placed to interpret the animal’s preferences and desires. It is the owner who will bear most of the emotional and relational burden resulting from any decision regarding the animal.⁸ Such arguments resemble those made on behalf of parents as the most suitable decision-makers for children,⁹ but there are major differences, some of which were highlighted in section 4.2. However, comparison of pets with children invites accusations of anthropomorphism, including the failure to recognise the specific natures of animals.¹⁰ Such comparisons also fail to incorporate the differing outlooks on treatment when the person giving consent has property rights over the patient, rather than the patient also being the holder of rights.¹¹ Thus, to qualify as the most suitable decision-maker for the animal patient, an owner must recognise the specific needs and interests of the animal, prioritising these as the basis for decision-making over the right to do as they wish with their property. I will refer to the type

⁵ Per Lord Reed and Lord Kerr in *Montgomery v Lanarkshire Health Board* at 75

⁶ RCVS ‘Declaration on professional registration’ <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/#declaration>> accessed 1 September 2018

⁷ J Yeates and J Savulescu, ‘Companion Animal Ethics: a Special Area of Moral Theory and Practice?’ (2017) 20 *Ethical Theory and Moral Practice* 347, at 351

⁸ Although I acknowledge the effect on the veterinary professional involved, see, for example, CEM Batchelor and DEF McKeegan, ‘Survey of the Frequency and Perceived Stressfulness of Ethical Dilemmas Encountered in UK Veterinary Practice’ (2012) 170 *Veterinary Record* 19

⁹ EK Salter ‘Deciding for a child: a comprehensive analysis of the best interest standard’ (2012) 33 *Theoretical Medicine and Bioethics* 179

¹⁰ Yeates and Savulescu (n7) at 353

¹¹ *ibid*, at 354

of autonomy that I have described as ‘constrained owner autonomy’.¹² This autonomy incorporates ‘unconstrained financial autonomy’. In choosing this terminology, I also accept that financial considerations may act as a form of constraint, in that an owner may wish to choose a treatment that is in the animal’s best interests but be unable to afford it. Financial autonomy is thus inevitably balanced with an awareness of the welfare needs of the animal and its known preferences and desires, with the result that beneficence, or putting the animal’s ‘best interests’ above the client’s preferred wishes, also acts to constrain client autonomy.

The primary role of the veterinary professional in treatment decision-making may therefore be to provide the owner with the information about proposed treatment(s) with a view to maintaining the ideal human-animal relationship, for example, enabling the animal to “participate within a companion relationship between owner and animal where both derive a significant benefit.”¹³ Here, the veterinary professional will inevitably focus on the health-related interests of the animal patient, although in the context of neutering, there are also population-based interests involved. To enable the owner to reach a decision that also incorporates the wider interests of the animal will therefore require the provision of information about the risks, benefits, side-effects, costs and long-term outcomes of each of the treatment options. These health-related aspects can then be combined with the client’s knowledge of the individual animal’s preferences to produce a genuinely ‘best interests’-based decision.

In Chapter 4, Section 4.7, I attempted to construct a ‘best interests’-based argument for non-therapeutic neutering of companion animals, primarily based on health-related interests. In this example, I offered the veterinary evidence that is available to all veterinary professionals, and that should therefore be communicated to clients. The information

¹² I have borrowed this term from Lainie Friedman Ross. *Children, Families and Healthcare Decision-Making*, (Oxford University Press 1998) See Chapter 1, replacing “parent” with “owner”.

¹³ S Schnobel ‘Regulating the veterinary profession: taking seriously the best interests of the animal.’ (2017) 33 *Professional Negligence* 239, 253

provided by clients to widen the interests-based calculation might include the individual animal's behaviour, preferences (which could include, for example, lying out in the garden whenever possible, or being able to free range freely outside and mix with other animals of the same species, as illustrated in Chapter 6, Section 6.3.3) and dislikes; for example, a dislike of taking pills, or visiting the veterinary practice at all, may influence choice of treatment.

Much of the previous research into calculating an animal's 'best interests' focuses on the assessment of quality of life.¹⁴ However, such an approach proves challenging in view of the lack of standardised and objective measures for this assessment.¹⁵ It is less common to find proposals for a more comprehensive calculation of 'best interests' for animals. One proposed list includes quality of life, the ability to function naturally and the ability to participate in a mutually beneficial companion relationship with the owner, together with the veterinary professional's knowledge of the individual animal and its lifestyle.¹⁶ This list does appear to assign more weight to the veterinary professional's assessment of the animal's best interests. The measurement of best interests is difficult for both infant and animal patients. The patient is unable to express any wishes in either case, although the difficulty of interpreting behaviour in another species exacerbates the problem with animal patients. As Baines proposes, the difficulty with calculating best interests may be ontological or epistemological,¹⁷ however until more work is invested in attempting to resolve this problem, I propose that Schnobel's list provides a reasonable starting point for calculating the best interests of companion animal patients. One important caveat is that both the animal owner and the veterinary professional should have equal input to the discussion.

8.2.2 How respect for client autonomy is demonstrated via the consent process

¹⁴ KK Vøls and others, 'Quality of Life Assessment in Dogs and Cats Receiving Chemotherapy - a Review of Current Methods' (2016) 15 *Veterinary and Comparative Oncology* 684

¹⁵ S Mullan, 'Assessment of Quality of Life in Veterinary Practice: Developing Tools for Companion Animal Carers and Veterinarians' (2015) *Veterinary Medicine: Research and Reports* 203

¹⁶ Schnobel (n13) at 253

¹⁷ P Baines, 'Death and best interests: a response to the legal challenge' (2010) 5 *Clinical Ethics* 195 at 196.

Achieving a balance between client autonomy and patient best interests requires an unhurried consent discussion between the animal owner and the veterinary professional. I will now translate respect for client autonomy into practical aspects of consent, starting with the timing and content of this discussion.

The veterinary practice used for the observational study followed the 'gold standard' recommendations for surgical consent; the discussion took place in advance of the day of surgery, and it was conducted in a more relaxed and unhurried environment.¹⁸ The allocation of 15 minutes for the discussion seemed to be appropriate, as none of the ten observed consultations exceeded this time. Interviewees were, in general, in favour of conducting the consent discussion in advance of planned elective surgery. They also acknowledged the importance of allocating sufficient time for the discussion, and not being under time pressure due to the timing of the consent process.

The GMC advises doctors that, when obtaining consent, "You should ...encourage.... [patients] to ask questions..."¹⁹ This requirement is endorsed by the RCVS: "Veterinary surgeons and veterinary nurses should make sure that clients have sufficient time to ask questions and to make decisions."²⁰ During the consent discussion, therefore, it is important that the client is given the opportunity to ask questions. First, this requires that the person participating in the consent process has the professional skills and knowledge to provide this opportunity, to listen and to be able to answer these questions.

In the practice used for the case study, the person obtaining consent from the client was a veterinary surgeon, therefore appropriately qualified to do so, according to RCVS guidance

¹⁸ OA Anderson, IMJ Wearne, 'Informed Consent for Elective Surgery - What Is Best Practice?' (2007) 100 *Journal of the Royal Society of Medicine* 97. See also MG Berry and others, 'A Comparison of the Views of Patients and Medical Staff in Relation to the Process of Informed Consent' (2007) 89 *The Annals of The Royal College of Surgeons of England* 368 and RCSE 'Consent: Supported Decision Making - a guide to good practice' (2016) <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/> at 17

¹⁹ GMC 'Consent: Patients and Doctors Making Decisions Together' <<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent>> at 10

²⁰ RCVS 'Supporting Guidance' <<https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/>> at 11.14

on which practice personnel should assume responsibility for obtaining consent.²¹ Two out of three clients interviewed would also regard a veterinary nurse as an appropriate person to conduct the consent process, therefore agreeing with the RCVS guidance, but one client would expect that the veterinary surgeon who was going to perform the surgery would also be responsible for consent. This view introduced the influence of trust on consent, and in two of the observed discussions, the clients wanted to know who would perform the surgery. When clients are paying for a service, it seems logical that they should also know who is providing the service.

Some interviewees suggested that clients could use trust as a reason to leave the decision to the veterinary surgeon, a situation that may lead to difficulty in the event of unsuccessful surgery or escalating costs, where the client could claim that there was no informed consent. However, as is the case in human medicine, clients can distance themselves from decision-making, an approach known as “voluntary diminished autonomy.”²² If client autonomy is respected where appropriate, then a client’s wish to let others make the decision should also be respected. In these situations, however, it is advisable to give the client the information used to make the decision, to explain the risks and benefits, to discuss the costs of the selected procedure, and to give plenty of opportunity for the client to ask questions.

Although there were no apparent examples of voluntary diminished autonomy in the observed consultations, the client was not always given an explicit opportunity to ask questions. Where clients did ask questions, many of these concerned the post-operative care of the patient and other practical aspects of recovery from the surgery. However, when clients expressed concern or asked questions about the risks of general anaesthesia or the potential long-term health effects of neutering, these did not always invoke appropriate responses. In one case, the client revealed that she had gained the information from the

²¹ RCVS (n20) at 11.3-11.5

²² NI Cherny, ‘Controversies in Oncologist-Patient Communication: a Nuanced Approach to Autonomy, Culture, and Paternalism.’ (2012) 26 *Oncology* 37, 38

internet. The response to this question, which did not directly address the concerns raised, may illustrate some veterinary professionals' negative views towards clients who research information on-line prior to consultations.²³ The solution may require practices to do two things: first, to maintain a list of websites containing information aimed at clients, and to publicise these, and second, to expect that clients will seek their own information, and therefore to ensure that clients are asked if they have any questions about what they have read.

Additionally, client questions may reveal which risks are important to them. However, as illustrated in *Montgomery*, relying on patient/client questions to identify which risks should be disclosed is fraught with problems, as the following excerpt from the judgments of Lord Kerr and Lord Reed, in dismissing *Bolam* as precedent for risk disclosure, illustrates:

“There is something unreal about placing the onus of asking on a patient who may not know that there is anything to ask about (...).... but it is those who lack such knowledge, and who are in consequence unable to pose such questions and instead express their anxiety in more general terms, who are in the greatest need of information.”²⁴

Thus, the recommendations for practice are that *the consent discussion should be scheduled to allow sufficient length of time for information to be shared and to ensure the availability of an appropriate member of practice staff to conduct the conversation. The client should be given plenty of opportunity to ask questions or express concerns.*

Although client questions should be answered truthfully and appropriately, there is also a need to disclose risks to all clients, whether they ask questions or not. Such a requirement

²³ LR Kogan and others, 'United Kingdom Veterinarians' Perceptions of Clients' Internet Use and the Perceived Impact on the Client–Vet Relationship' (2017) 4 *Frontiers in Veterinary Science* 1860. This study found that over half of vets surveyed thought that their clients' use of the internet to research animal health information negatively impacted on the vet-client relationship.

²⁴ Per Lord Kerr and Lord Reed, in *Montgomery v Lanarkshire Health Board* at 58

should be added to the RCVS supporting guidance on consent. I will now examine the types of risk that need to be disclosed.

8.2.3 Respect for client autonomy involves disclosing significant risks

If the veterinary profession follows at least some of the latest legal and professional ethical developments in human medicine, and the findings from the three triangulated empirical studies reported in this thesis, respect for client autonomy involves the disclosure of significant risks. The current wording of veterinary professional ethical guidance does not include reference to material risks, although the latest consent guidance refers to providing clients with “a clear indication of both common and serious risks.”²⁵

It would be interesting to investigate how the RCVS would define a ‘common and serious’ risk, and who would decide on the risks for a particular procedure. One interpretation of this phrase suggests that the College might rely on an evidence-based approach to risk, which may mean that only those reaching a specified level of occurrence, as, for example, the 10% figure quoted in *Sidaway*,²⁶ would be considered as either common or serious risks.

An alternative definition of ‘serious’ could be a risk that, even if uncommon, has devastating consequences for the animal patient and/or the client, in which case, it seems to be similar to a ‘material’ risk. For the non-therapeutic neutering procedures that were the focus of my consent studies, then the serious/material risk involved is death. I think that there is room for the inclusion of material risks in veterinary consent discussions, and certainly in those prior to elective neutering. The recent *Montgomery* ruling’s definition of a material risk, as being a risk to which a reasonable person would be likely to attach significance,²⁷ could therefore be taken to include the risk of death in a healthy animal undergoing a non-therapeutic procedure. A ‘particular client’ interpretation of this risk would reinforce the

²⁵ RCVS (n20) at 11.2b

²⁶ Per Lord Bridge in *Sidaway v Board of Governors of the Bethlem Royal Hospital* at 900F

²⁷ *Montgomery* (n24) per Lord Kerr and Lord Reed at 87. The definition of a material risk extends to a risk ‘to which the ‘particular patient’ may attach significance, if the doctor is or should be aware of this.’

materiality of the risk of death in cases where there is a very strong attachment between owner and animal, or, for example, where the animal has been highly trained to provide specific forms of assistance to the owner.

However, the risk of death under general anaesthesia was only specifically mentioned in some of the observed consultations. The GMC advises doctors that: “You must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is very small.”²⁸ The finding that not all discussions contained a reference to the risk of death is backed up by the analysis of consent forms, which found that only 24% included specific risks such as death. However, even if the risk of death is pre-printed on the form, this neither guarantees that the client will read about it, nor that the person obtaining consent will refer to it during the discussion. It may also be relevant which member of the practice team is responsible for the discussion. Although numbers are small, analysis of data from the interview study suggested some differences between the two veterinary professions in their approach to risk disclosure, with veterinary nurses being keen to ensure that clients were informed of death as a potential risk, but veterinary surgeons seemingly content to be more generic in their presentation of risks. My recommendation for practice is that *for procedures requiring general anaesthesia, the risk of death should always be specified.*

Material risks associated with elective neutering include more than just the risk of death. For owners of female dogs of certain breeds, the risk of urinary incontinence subsequent to neutering is another risk that should be discussed, being one that is evidenced in the literature²⁹ and that may negatively affect the dog-owner relationship. The evidence for other long-term health and behaviour problems is less robust. However, if clients ask specific questions about effects on growth, and types of cancer that seem more common in

²⁸ GMC (n19) at 32, p17

²⁹ DG O'Neill and others, 'Urinary Incontinence in Bitches Under Primary Veterinary Care in England: Prevalence and Risk Factors' (2017) 58 *Journal of Small Animal Practice* 685. These authors found that neutered bitches were more than twice as likely to suffer from this condition as un-neutered bitches of the same age, with certain larger breeds being particularly susceptible.

neutered animals, then the veterinary professional involved in the discussion should provide information about these. Any other risks that become apparent during the discussion as being 'material' for a particular client should be included; for example, if the reason for neutering is an attempt to modify the animal's behaviour, the risk of the procedure having no effect on behaviour would be material to that client. If it becomes apparent that neutering would not be in the animal's 'best interests', for example, due to a pre-existing condition, or a higher risk of urinary incontinence, or because the owner wanted to use neutering to modify behaviour that is not under hormonal influence, then the veterinary professional should advocate for the animal patient's best interests. My recommendation for practice is that *the risks and benefits of neutering for the individual animal should be explained and discussed.*

8.2.4 Respect for client autonomy involves offering alternative treatments

As has been demonstrated in several medical negligence cases (see Chapter 3, Section 3.5), full disclosure requires the offering of alternative treatment, together with associated risks and benefits. The RCVS advises that the client should be given "a range of reasonable treatment options."³⁰ In the observed discussions, clients were not presented with any alternative options to surgical neutering. In the case of elective neutering surgery, there are perhaps fewer alternatives, but, at least in the case of male dogs, there are non-surgical alternatives to castration, involving hormone implants.³¹ For female dog neutering, the practice offered two alternative methods, the traditional midline incision and a laparoscopic technique. However, during the observed consultations, clients were not offered a choice between the two methods of performing the procedure. Where a client had requested a laparoscopic spay prior to the consultation, there was no discussion about the pros and cons of this technique. Conversely, where a client had not indicated a choice, the veterinary surgeon made a recommendation, giving reasons for recommending one technique over another. I consider that all clients should be offered the alternative of laparoscopic

³⁰ RCVS (n20) at 11.2

³¹ X Lucas, 'Clinical Use of Deslorelin (GnRH Agonist) in Companion Animals: a Review' (2014) 49 *Reproduction in Domestic Animals* 64

(‘keyhole’) surgery for neutering female dogs (if available in the practice, or at a neighbouring practice if the individual patient would benefit from this procedure). Consent consultations that are designed to maximise client autonomy should therefore include discussion of both techniques for the spay procedure and presentation of the risks and benefits to the client, who can then make an informed decision.

More generally, the client should be provided with the risks and benefits of neutering and should be advised on the risks and/or benefits for the individual animal. Thus, the client would be provided with the information necessary to make the decision whether to neuter the animal at all, and if so, at which age. This suggestion does not align with the views of some of the veterinary surgeons interviewed, who felt that the client may not understand the information if given it, and that veterinary surgeons should only recommend the best treatment for the animal. Rather, I find that I am in agreement with the opinions of the veterinary nurse participants, who were enthusiastic proponents of giving clients all of the options. Some of this enthusiasm was the result of having been in the position of clients themselves, and not having been given all options. Regarding the possibility that the client may not understand, the onus falls on the veterinary professional to ensure that the information is given in a way that the client can understand. Therefore, my recommendation for practice is that *clients should be offered alternative treatment options, where these exist*.

8.2.5 Respect for client autonomy includes financial autonomy

In general, clients in the case study practice were informed about the costs of neutering procedures, although there were several areas for potential improvement. First, there was no reference during the discussions to the responsibility for post-operative costs to deal with complications. This financial responsibility is divided between the practice and the client, depending on timing, and is clearly indicated on the practice’s consent form. Second, one veterinary surgeon assumed that a non-insured client would not consider referral of the dog to a specialist surgeon for removal of a lump while being neutered (Chapter 6, Section 6.5.1).

Whether a client has insurance or not, respecting client financial autonomy should involve presenting all of the available treatment options and allowing the client to decide. As illustrated in 8.2.4, professional ethical guidance refers to offering reasonable options for treatment.³² The definition of 'reasonable' is, of course, open to debate, but the views of those representatives of professional bodies interviewed were that there is a balance to be achieved, between giving clients too many options and not giving any options, and that the costs of each option are an essential part of the consent discussion. Reasonable treatment options would include treatments available at the practice, in view of current personnel and equipment, and the offer of referral to another practice if an alternative treatment, unavailable at the current practice, would be in the animal's best interests. The question of how far animal owners should be prepared to stretch themselves financially to cover the costs of veterinary treatment is controversial. Yeates and Main suggest that they should be prepared to cover the costs of "reasonably necessary" treatment.³³ Again, there is the problem of defining 'reasonable' in this context, but there is an implication that there are limits to owners' obligations to fund treatment. I concur that such a proviso is necessary as more complicated and expensive surgeries become available for animals. Therefore, my recommendation for practice is that *clients should be offered all reasonable treatment options and given clear indications of costs for each, together with any potential future costs involved.*

In conclusion, my list of recommendations for practice regarding the consent conversation with the client for non-therapeutic neutering procedures, but with potential application to other treatments, consists of the following 7 specific actions:

1. The consent discussion should be scheduled to allow sufficient length of time (e.g., 15 minutes) for information to be shared. For elective procedures, it should be in advance of the day of surgery

³² RCVS (n20) at 11.2

³³ JW Yeates and DCJ Main 'The ethics of influencing clients' (2010) 237 *Journal of the American Veterinary Medical Association* 263, at 266

2. The consent discussion should be scheduled to ensure the availability of an appropriate member of practice staff to conduct the conversation
3. The client should be given plenty of opportunity to ask questions or express concerns
4. For procedures requiring general anaesthesia, the risk of death should always be specified
5. The risks and benefits of neutering for the individual animal should be explained and discussed.
6. Clients should be offered alternative treatment options, where these exist
7. Clients should be offered all reasonable treatment options and given clear indications of costs for each, together with any potential future costs involved

Some of these recommendations incorporate current RCVS guidance on communication and consent to produce a more detailed protocol for practice. In making suggestions regarding the conversation, it is now essential to consider how this conversation might be recorded, in order to ensure that both parties are clear on the procedures and costs that have been agreed.

8.3 How the consent form could be used to record the consent conversation

One area for improvement of the consent process in the 'case study' practice involved my finding that the consent form was not completed at the time of the consent discussion, contrary to recommendations from the RCVS and the RCSE.³⁴ The RCVS also advises that the client should receive a copy of the form to take away, read and review.³⁵ The first recommendation for improvement of this issue therefore involves *ensuring that a consent form is completed during the consent discussion, and that a copy is provided to the client afterwards*. This would specifically enable the client's attention to be drawn to the financial responsibilities related to the planned surgery and any aftercare required. It would also

³⁴ RCVS (n20) at 11.6; RCSE (n18) p22

³⁵ RCVS (n20) at 11.11

provide an extra opportunity for the client to identify any areas of uncertainty and prepare any remaining questions for the day of surgery.

However, in using the consent form as evidence of the accompanying discussion, the quality of that evidence depends on the design of the form, and how much of the discussion can be recorded in the space provided. The form is also required to act as an agreement to proceed with the proposed treatment, and as a contract for the payment of fees.

The RCVS provides a suggested template for consent forms, available for download from its website.³⁶ From the variety of consent forms submitted to me for the study, it was apparent that some practices use this form with only minor modifications, whereas others have taken sections of the template and combined it with their own versions.

Forms are often generated and printed directly from electronic patient records, meaning that details such as patient and client identification and contact details are pre-printed. Therefore, suggestions for improving the forms concern areas such as the details of the procedure, alternatives, risks and benefits, and financial costs.

8.3.1 Recommendations for modifying the consent form to record the discussion

The consent form is a record of the consent discussion, requiring sufficient blank space to record the main points of that conversation. The forms analysed rarely provided sufficient space to record a consent discussion, with most of the layout occupied by text. Here, veterinary practices could learn from human medicine. For example, the form used by the NHS in England to evidence parental consent to the treatment of a child³⁷ provides adequate space for listing the intended benefits of the treatment, together with “serious or frequently

³⁶ RCVS, ‘Specimen Form of Consent for Anaesthesia and Surgical Procedures’ <<https://www.rcvs.org.uk/document-library/specimen-form-of-consent-for-anaesthesia-and-surgical-procedures/>>

³⁷ North Devon Healthcare NHS Trust, ‘Parental agreement to investigation, treatment or procedure for a child or young person’ <<https://www.northdevonhealth.nhs.uk/wp-content/uploads/2010/09/Consent-form2.pdf>> accessed 29 September 2018.

occurring risks”³⁸ (this form is dated 2012, therefore pre-*Montgomery*). Only one of the consent forms submitted provided space to document the procedure-specific risks that were discussed during the consultation.

The NHS form requires the person taking consent to confirm that they have discussed:

“what the procedure is likely to involve; the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient and his/her parents”³⁹

In addition to describing the planned procedure, therefore, it provides evidence that alternative treatments have been discussed. While discussion of alternatives may not apply to all examples of routine neutering, as discussed earlier there are some alternative surgical techniques and alternatives to the surgery available for dogs. Therefore, the form should provide space to record those alternatives. My recommendation for consent forms in veterinary practice is therefore that the form should record the specific risks associated with the treatment, the benefits of the proposed treatment (this is particularly important for non-therapeutic procedures), and any alternative treatments that have been discussed with the owner. In summary, my recommendation for consent forms is *the provision of more “free text” space for documenting the discussion between the veterinary professional and the client.*

8.3.2 A proposal to record the conversation via alternative means

One alternative to recording the discussion on a consent form is to record the discussion by other means, for example, video- or audio-recording, as has been suggested by previous authors.⁴⁰ As I observed and recorded consent discussions in practice, I had access to one

³⁸ *ibid*

³⁹ *ibid*

⁴⁰ See, for example, V Ali, ‘Consent Forms as Part of the Informed Consent Process: Moving Away From “Medical *Miranda*”’ (2003) 54 *Hastings Law Journal* 1575, at 1588

alternative version of recording consent, via audio-recording. One participant in the interview study (PB4, Chapter 7, Section 7.5.3) did remark that alternative methods of recording the discussion may be used in the future. Paper forms may become less useful as practices move to 'paperless' practice management systems, and as more patient records are kept in electronic formats. As most veterinary professionals now have smartphones, audio-recording the consent discussion becomes more achievable, subject to disclosure and consent. Although there is no research available on whether veterinary clients ever record consultations, it is known that human patients frequently make surreptitious recordings of medical consultations. Although this behaviour can negatively affect the trust between doctors and patients,⁴¹ and has led to intense debate over whether it should be encouraged or not, some maintain that doctors should encourage patients to record consultations. Proponents argue that this will maximise shared decision-making, conversely, others fear that it may lead to the practice of defensive medicine.⁴² I consider that, as veterinary surgeons are not currently used to having their consultations recorded by anyone (unlike physicians, who are often recorded for training and assessment purposes), the fear of promoting defensive practice is a valid one. However, encouraging clients to record consultations would promote a 'shared decision making' approach and may gradually produce a culture shift in veterinary practice.

A major obstacle to recording any consultation, provided it is done with the full knowledge of both participants, is the requirement to obtain consent for the recording. This could be achieved through inclusion of a statement from both participants at the start of the recording. The resulting audio file could be emailed to the client and attached to the patient's electronic health record in the practice, although this would require additional staff input. Financial aspects could be confirmed via the production of a printed estimate for consideration and signature by the client. Providing an audio recording of the consent discussion is a way of maximising respect for client autonomy, as it can then form a basis for

⁴¹ M Tsulukidze and others, 'Patients Covertly Recording Clinical Encounters: Threat or Opportunity? a Qualitative Analysis of Online Texts.' (2015) 10 *PLoS ONE* e0125824

⁴² G Elwyn and L Buckman, 'Should Doctors Encourage Patients to Record Consultations?' (2014) 350 *BMJ* g7645

client questions and research. In order to gather views from the profession on the way forward for recording consent, I propose that the RCVS should consider opening a consultation on the subject of using audio- and/or video-recording as a method of documenting consent in practice. Meanwhile, I will return to my recommendations regarding consent forms and their use as records of the consent conversation.

8.3.3 Using the consent form to provide a menu of additional purchases

The similarity of some consent forms to 'shopping lists' of additional procedures raised some concerns amongst interview participants (Chapter 7, Section 7.6.3) about the 'informedness' of any decisions regarding these procedures. However, an alternative viewpoint regards giving the client free choice of these options as a means of maximising client autonomy. The type of additional purchase offered ranged from post-operative recovery food, nail clipping, and the insertion of a microchip, to medical treatment such as intravenous fluid therapy, extra pain relief and pre-operative blood tests. I will focus on the latter as it was a procedure that was mentioned during consent discussions and several interviewees also introduced it as a topic. Different perspectives are therefore provided through the triangulation of the three studies.

When considering whether to have pre-operative blood tests performed, analysis of the forms resulted in a clear distinction between practices. Some apparently offered these tests routinely to all clients, leaving the client with the decision whether or not to accept the offer. Other practices recommended pre-operative blood tests, either for all patients, or only for patients falling into specific categories (e.g., older patients, or those with pre-existing disease), while still providing the client with a means to 'opt-out'. It is not known how these additional tests were presented to clients in all of the practices concerned. However, during some consent discussions in the case study practice, clients were made aware of the availability of pre-operative blood tests but were given a strong recommendation by the veterinary surgeon regarding their necessity. The case study practice's consent form did not include any reference to pre-operative blood tests.

The veterinary professionals interviewed were unanimous in expressing the view that clients should not be left to make this decision, regarding it as a clinical decision that the veterinary professional should make for the individual patient. Similar views were expressed by the veterinary nurses interviewed regarding intravenous fluid therapy and additional pain relief. Although this view suggests 'paternalism' on the part of the veterinary professional, it is more correctly described as beneficence, as I have previously argued that paternalism is not an appropriate term when consent is given on behalf of another (see Chapter 3, Section 3.1.4). A decision based on the patient's clinical status avoids unnecessary procedures or drug administration for the patient, and unnecessary financial outlay for the client.

However, when considering 'non-clinical' additional purchases, such as nail clipping or buying tins of a special recovery diet, there is no reason to prevent these decisions being made solely by the client. This leads to my recommendation that only non-clinical items should be listed on the consent form, leaving decisions regarding 'extra' clinical procedures and additional medication to be recorded by the veterinary professional obtaining consent. Additionally, the client should be advised regarding the necessity of the procedure for the individual patient, a requirement that is now included in the RCVS updated guidance on consent.⁴³ My recommendations for consent forms in practice are therefore that *options for selecting additional purchases are limited to non-clinical procedures or items* and that there should be *provision for recording discussions regarding pre-operative blood tests and other additional clinical procedures*.

8.3.4 Using the consent form as evidence of a contract

Some forms contained a statement of confirmation that the person signing the form had the authority to do so and was at least 18 years of age. It is desirable to confirm these details in terms of the financial contract that is created between the practice and the client. This also requires clear discussion of costs.

⁴³ RCVS (n20) 11.8

Respect for the financial autonomy of the client requires that the consent form should record the financial discussion that has taken place, with estimated fees either recorded on the form itself or on a separate written estimate. In light of the requirement to view consent as an ongoing process, any increase in these estimated fees should require contact with the client before proceeding. Some forms, however, contained a generic phrase implying that the veterinary surgeon would do anything deemed necessary, with the client liable to pay for any resulting costs. Terms such as these seem unfair on clients, demonstrating a lack of respect for their financial autonomy. Extra costs arising should require extra consent, and therefore a new discussion with the client. This requirement is outlined in the RCVS guidance, which states that “If, during the course of treatment, it becomes evident that an estimate or a limit set by the client is likely to be exceeded..... consent to the increase (should) be obtained. This should be recorded in writing by the veterinary surgeon.”⁴⁴ Such an approach ensures that consent is maintained as treatment changes and costs increase. I consider that it is important to require veterinary practices to contact clients for specific consent before performing additional procedures.

My recommendations to allow the consent form to fulfil its role as evidence of a financial contract are that there should be *provision for recording financial estimates*, that there should be *no reference to proceeding without consent, to performing additional procedures without consent and expecting the client to pay*, and that there should be *confirmation that the person giving consent has the authority to do so, in terms of age and ownership of the patient*.

8.3.5 Using the consent form to confirm client understanding

Some forms that were analysed required the client to sign to confirm understanding of the information given. It is difficult to see how a signature on the consent form could prove understanding.⁴⁵ Although it was apparent from the consent discussions (Chapter 6) that

⁴⁴ RCVS (n20) 11.25

⁴⁵ Indeed, consent ‘in form only’ is no consent. See *Chatterton v Gerson*, per Bristow J at 265

clients had often requested elective neutering surgery for their animals, it was also apparent that they did not always understand exactly what this entailed. Their understanding depended on the clarity of the explanation given regarding the surgical procedure.

Some consent forms included in the analysis required the signature of the person taking consent, reflecting usual procedure in human medicine. However, such forms were in the minority, with only one form also including confirmation that the client had received a copy. Both of these inclusions reflect good practice. Accordingly, further recommendations are that *the signature of the person obtaining consent is required*, and confirmation is provided that *a copy has been given to the client*.

One interesting alternative to informed consent that has been proposed in human medicine is 'request for treatment'. This approach is based on giving the patient responsibility for completing the consent form in advance of the procedure, defining the treatment, what it involves, the risks and the benefits, with any misconceptions clarified at the appointment prior to surgery.⁴⁶ Request for treatment maximises patient autonomy, requiring greater patient understanding of the planned treatment in order that patients can complete sections of the form that were traditionally completed by doctors.⁴⁷ However, critics question whether patients have access to sufficiently good information to fulfil their roles as equal partners in 'request for treatment' scenarios, as they often depend on information given to them by the healthcare provider. This information may be provided via 'procedure-specific' information brochures.⁴⁸ Before considering an 'informed request' approach to consent in veterinary medicine, a comprehensive redesign of current forms would be required. Financial costs of each available option would need to be available, better on-line resources for clients would be essential,⁴⁹ and it would require a wholesale shift in attitude on the part

⁴⁶ K Shokrollahi, 'Request for Treatment: the evolution of consent' (2010) 92 *Ann R Coll Surg Engl* 93

⁴⁷ *Ibid*, at 97

⁴⁸ JC Oosthuizen, P Burns, C Timon, 'The changing face of informed consent' (2012) 126 *The Journal of Laryngology & Otology* 236

⁴⁹ A similar request for better on-line resources for clients is contained in a paper by Z Belshaw and others, 'Owners and Veterinary Surgeons in the United Kingdom Disagree About What Should Happen During a Small Animal Vaccination Consultation' (2018) 5 *Veterinary Sciences* 7 at 9

of veterinary professionals towards 'informed' clients.⁵⁰ Incentive to change any of these factors may be minimal, meaning that there is little chance of the adoption of a 'request for treatment' approach in the veterinary world in the near future. However, as a means of ensuring understanding, and therefore maximising client autonomy, it is worthy of consideration. Notwithstanding the possibility of a move towards a consent based on 'request for treatment', I will now consider ways to improve the design of current consent forms by proposing 8 specific changes.

8.3.6 Recommendations for consent form design

In view of the diverse roles of the consent form, and its underlying purpose as a means of recording the conversation between the veterinary professional and the client, the list below collates the previous recommendations for the redesign of consent forms currently used in veterinary practice. The suggestions incorporate some ideas from the forms that I analysed for this study, and some ideas from consent forms used in human medicine.

My recommendations for consent forms include:

1. provision of more 'free text' space for documenting the discussion between the veterinary professional and the client, and ensuring that the form and discussion are linked
2. limiting the options for selecting additional purchases to non-clinical procedures or items
3. provision of free text space for recording discussions regarding pre-operative blood tests and other additional clinical procedures
4. provision for recording financial estimates
5. the removal of phrases that imply that additional procedures can be performed without specific client consent
6. confirmation of the authority of the person giving consent in terms of age and ownership of the patient

⁵⁰ Kogan and others (n23)

7. requiring the signatures of both parties to the consent process
8. confirmation that the client has received a copy in advance of the day of surgery

In order to provide a more practical version of these recommendations, I have modified the RCVS approved consent form to reflect them; the amended form is included in Appendix 11.

8.4 A new model of consent for veterinary practice

By making practical recommendations for consent in each section of this chapter, I have attempted to produce outcomes that are translatable and achievable for general veterinary practitioners in the UK. However, concentration on practical outcomes may lead to an inadvertent neglect of normative ethical consent guidance. In this section, therefore, I will attempt to provide a more holistic view of the nature and purpose of consent to the treatment of companion animals. In order to achieve the goals outlined in 8.0, of protecting all three participants, consent must consist of a balance between the autonomy of the client, the professionalism of the veterinary surgeon or veterinary nurse, and the best interests of the animal patient.

This balance may be achieved through a combination of “constrained owner autonomy”⁵¹ and “utility beneficence.”⁵² I have balanced the responsibilities of the human participants between the veterinary professional and the animal owner. I will start with those of the veterinary professional, who, in view of the findings in 8.2.1-8.2.5, can demonstrate respect for the autonomy of the animal owner through:

- a) presenting all ‘reasonable’ treatment options (see 8.2.4 for further discussion on these)
- b) providing scientific expertise and knowledge of the evidence of risks and benefits of each treatment option

⁵¹ Based on Ross (n12)

⁵² TL Beauchamp, JF Childress, *Principles of Biomedical Ethics* (7th edn., Oxford University Press 2013) at 202

c) presenting this information in a format that is understandable to the animal owner

I now turn to the animal owner, who can demonstrate their knowledge of the 'best interests' of the individual animal through providing evidence of the animal's temperament, preferences, and lifestyle,⁵³ thus acting as an advocate for the animal patient. However, the owner is also responsible for payment for treatment and for the provision of ongoing care, so must contribute to the shared decision-making conversation by

d) identifying any individual constraints to the decision-making process, such as finances available, personal values and beliefs, and time available for ongoing care

In situations where the options offered have no differential effects on the welfare of the animal, I consider that the decision should be based on the financial autonomy of the client and should be made principally by the client with support from the veterinary professional. Where welfare differentials exist, I propose that the veterinary professional should prioritise the options that are in the best interests of the animal patient, assisting the animal owner to make a decision that maintains positive welfare for the patient, but is achievable for that individual owner. Where there is agreement between the veterinary professional and the animal owner regarding the chosen option, the treatment should proceed. Where there is disagreement, the animal's best interests should take priority, and the discussion should continue, perhaps involving other parties who may be brought in to give additional opinions.

Applying this model to elective, non-therapeutic neutering surgery means that the best interests of the individual animal patient should take priority over the veterinary professional's opinion about the benefits of neutering in general. The animal owner may have made the decision to neuter the animal through societal and professional pressure to do so. In recognising this, the veterinary professional should ensure that a form of 'relational

⁵³ These criteria may affect the choice of treatment, for example, the animal may be too aggressive for the owner to attempt administration of pills without risk of injury

autonomy' (see Chapter 3, Section 3.1.3) is utilised to encourage the client to explore whether this is the best decision for the individual client and the individual animal. Such an approach fits with the BSAVA's policy statement on neutering, which states that "options should be discussed between the owner and veterinary surgeon when making decisions for an individual animal,"⁵⁴ rather than recommending neutering for every animal registered as a patient.

The proposed model of consent requires two assumptions, the first being that animals' interests do matter. The limiting of recommendations to companion animals means that the comparison with decision-making for non-competent children is appropriate, although it may seem difficult to sustain in view of the difference in legal status. Ensuring that the comparison is valid depends on companion animals being regarded as family members, which is not always the case. The second assumption is that the increasing emphasis on animal welfare in the veterinary profession⁵⁵ will be sustained and enforced by professional regulation. The RCVS, as the profession's regulator, could take the lead in promoting a "best interests" basis for consent to treatment of animal patients, perhaps by subscribing to the BVA's view that, "Promoting a patient's best interests sometimes requires ethically appropriate influencing of animal owners."⁵⁶

Returning to the point regarding the animal's position as a family member, I will illustrate this by providing a practical example of how the model could be used in practice. This involves describing its use with various forms of the triadic relationship.

8.4.1 Using the model with differing triadic relationships

The different forms of triadic relationship discussed by Rötzmeier-Keuper and others, and briefly mentioned in Chapter 1.4, are based on these authors' interpretation of a specific

⁵⁴ BSAVA, 'Neutering' <<https://www.bsava.com/Resources/Veterinary-resources/Position-statements/Neutering> >

⁵⁵ As evidenced by the publication of the BVA's 'Vets speaking up for animal welfare: BVA animal welfare strategy' (BVA 2016)

⁵⁶ *Ibid*, 20

type of relationship, involving a “professional relationship between provider and owner, an intimate relationship between owner and animal companion, and a service-accomplishing relationship between provider and animal companion.”⁵⁷ Based on interviews with owners and service providers, with the resulting analyses evaluated according to balance theory, their study categorises four types of triadic relationship in the context of service provision for companion animals.

In *harmonious* triads, owners regard their animal companions as family members or friends, and choose service providers according to the animal’s needs, rather than basing their choice on costs or the effort involved in using the provider. The animal is described as a “reliable partner,”⁵⁸ with the relationship between provider and owner based on trust and shared values. This triad is regarded as balanced. In owner-companion animal relationships where this applies, the proposed model of consent, where a balance is achieved between owner autonomy and animal best interests, should work in most situations. The owner in this triad will make decisions based on the animal’s best interests, and the owner’s financial autonomy should be respected by the veterinary professional.

In *dysfunctional* triads, owners regard the animals as easily replaceable, with the relationship between them viewed as somewhat detached. The animals in this triad are described as “often submissive,”⁵⁹ owners seek only basic services and are reluctant to take up any recommendations by providers, resulting in a similarly distant relationship between owner and provider that is based on cost and convenience. The relationship between provider and animal is also affected, as the animal may be presented too late for treatment, or the provider may feel an obligation to advocate for the animal’s best interests, resulting in conflict with the owner. These triads are unbalanced, as are *challenging* triads, where owners view their companion animals as ‘child substitutes.’ Here, the animals focus on their owners, showing distress and being uncooperative when separated from them. These

⁵⁷ Rötzeimer-Keuper and others (n1) 296

⁵⁸ Ibid, 299

⁵⁹ Ibid, 299

owners demand excessive support from service providers, frequently showing strong emotions. This demand for support diverts attention from the animal, as the service provider also has to care for the owner, resulting in an unbalanced triad. However, in this triad, the owner will make decisions based on the animal's best interests, so the balance can be allowed to swing towards the owner's autonomy, even though the triad is unbalanced.

Finally, *doubtful* triads involve a dysfunctional owner-companion animal relationship, where the animal is viewed as "a status symbol or a social mediator"⁶⁰ for the owner. The relationship between owner and service provider is loyal and profitable for as long as the provider goes along with the owner's wishes but is ultimately subject to the owner's whims. The authors refer to this triad as 'balanced' but point out that it may cause moral stress for the service provider. Again, the veterinary professional will need to advocate for the best interests of the animal and may find that these conflict with the owner's wishes.

Applying an approach that promotes the best interests of the animal to the 'dysfunctional' and 'doubtful' forms of triadic relationship, would require the veterinary professional to act as the advocate for the animal in preference to respecting the owner's autonomy. Although the balanced triad is the ideal situation, many owner-animal-service provider relationships fall into one of the other definitions. These require more advocacy for the animal's interests from the veterinary service provider and, consequently, less respect for the autonomy of the owner. The unbalanced triad therefore causes an imbalance in the owner autonomy – animal 'best interests' equation. This imbalance can be challenging for veterinary professionals, who may find that not only do they have to identify the type of triadic relationship in which they find themselves, but they also need to calculate the amount of restraint that should be placed on the autonomy of the client.

If animal interests matter and animal welfare continues to be prioritised, as it should, by the profession, a beneficence-based consent may deliver the vision of animal advocacy that is

⁶⁰ Ibid, 300

desired by most veterinary professionals. Recognising that the 'best interests' of the animal patient should foreground veterinary consent discussions allows the veterinary profession to fulfil its overarching duty to animal welfare. It also transmits a strong message to animal owners regarding their duties to their animals. Where animal owners are cognisant of these duties, then the autonomy-'best interests' equilibrium should be perfectly balanced; in these cases, the owner's financial autonomy can be fully respected. Where animal owners request or refuse treatment resulting in welfare implications, then the balance should swing in favour of beneficence, and the veterinary professional should advocate on behalf of the animal's 'best interests', utilising evidence, additional opinions and regulatory authorities where necessary.

8.5 Limitations of the study and study design

In providing an overview of the findings from this work, I acknowledge that these are confined to a very small section of the veterinary medical world. When originally planning this research, my intention was to include three main types of veterinary practice settings, i.e., farm animal, equine and small animal, as all three types of practice routinely perform elective (non-therapeutic) neutering procedures on animal patients. Realising that time constituted the most pressing constraint, to study the topic in sufficient depth I had to rein in these ambitions and instead concentrate on one practice setting. I chose small animal practice (treating mainly cats and dogs) because it was the setting with which I was most familiar, the patient in this setting has a 'privileged' position, and it is the most common type of veterinary practice in the UK.⁶¹ However, the selection of small animal practice did not make recruitment any easier, either for submission of forms, for conducting observations or for enlisting key participants. Due to problems with recruitment of veterinary surgeons for

⁶¹ RCVS 'RCVS Facts (2016)' <<https://www.rcvs.org.uk/news-and-views/publications/rcvs-facts-2016/?destination=%2Fnews-and-views%2Fpublications%2F>> Of 2975 practices registered in the Practice Standards Scheme, 45% are small animal practices. The rest comprise equine and small animal hospitals, farm and equine practices, mixed practices and emergency only practices.

interview, I included one farm animal veterinary surgeon in the final analysis of interview data.⁶²

The recruitment of practices for observation of discussions proved equally problematic. After exhausting practices in the local area to where I live, I was fortunate to find a practice that was willing to participate, although it was located some distance from home. The frequent travel to and from this practice, together with some appointments that were cancelled while I was in transit, limited the number of consent discussions that could be observed. For those planning to undertake similar research in future, I would recommend developing key contacts at several practices to facilitate introductions to these practices.

In Chapter 1, I explained the reasons for choosing to set this work in the United Kingdom, and therefore the limitations that this imposed. By restricting the work to a culture that values companion animals,⁶³ often views them as family members,⁶⁴ and spends considerable amounts of money on their care (including healthcare),⁶⁵ I have limited its application to other settings. For example, I have emphasised the best interests of the animal as being a fundamentally important aspect of veterinary decision-making, which is appropriate in the UK, in other EU countries with good records in animal welfare,⁶⁶ and in the USA and Canada where the companion animal also tends to be regarded as a family member.⁶⁷ I acknowledge that such views may be less valid in other settings, for example in Asiatic countries, where there is less of a tradition of keeping animals as companions.

⁶² This interview was the first one conducted, intended as a pilot for the interview guide. The inclusion of a farm vet did not reveal any major differences with companion animal vets.

⁶³ K Hens, 'Ethical Responsibilities Towards Dogs: an Inquiry Into the Dog–Human Relationship' (2008) 22 *Journal of Agricultural and Environmental Ethics* 3

⁶⁴ F Walsh, 'Human-Animal Bonds 1: the Relational Significance of Companion Animals' (2009) 48 *Family Process* 462

⁶⁵ TW Lue, DP Pantenburg, PM Crawford, 'Impact of the Owner-Pet and Client-Veterinarian Bond on the Care That Pets Receive' (2008) 232 *Journal of the American Veterinary Medical Association* 531

⁶⁶ LJ Keeling and others, 'Designing Animal Welfare Policies and Monitoring Progress' (2012) 21 *Animal Welfare* 95

⁶⁷ See, for example, this US-based account of owner grief to euthanasia, P Morris, 'Managing Pet Owners' Guilt and Grief in Veterinary Euthanasia Encounters' (2012) 41 *Journal of Contemporary Ethnography* 337

The choice of companion animals, cats, dogs and rabbits, as the species considered by this research brings its own restrictions on the applicability of the findings to other areas of veterinary practice. The transferability of the recommendations from this study to veterinary treatment of other animal patients, such as those used for food, sport or working performance, or for research, may not be appropriate, even though in these contexts, various versions of the human-animal relationship are found. Indeed, I have not explored the varieties of relationship between humans and animals beyond those involving companion animals. Next, the choice of an elective, non-therapeutic procedure for the study brings further concerns about transferability of findings to other areas of veterinary treatment, such as emergency surgery or treatment of chronic illness. However, I consider that the components of consent are universally applicable, and that my recommendations can be adapted for most practice situations, including the treatment of other species, and the performance of other procedures.

The selected methodology of interpretive description took the research down a very applied path, with constant references to how the consent process could be changed in practice. In doing this, it may have missed some of the more philosophical aspects of consent, such as what it means to an owner to agree to medical treatment on behalf of the animal. The methods used were selected to answer the initial research questions, reflecting the interdisciplinary nature of socio-legal studies, while facilitating the thematic analysis that underpins interpretive descriptive methodology.⁶⁸ The integration of doctrinal legal research with three separate but triangulated empirical studies presented several challenges to me, as the researcher. First, the difficulty of deciding on a logical structure for the thesis and each chapter. This involved several attempts at each of the results chapters, with decisions regarding the final order made according to trial and error. Second, the level of weighting afforded to the legal, ethical and empirical aspects of consent. The space devoted to each of these topics was determined by its practical application to consent in practice. Finally, the

⁶⁸ As pointed out by N Hyett, A Kenny and V Dickson-Swift, in 'Methodology or Method? a Critical Review of Qualitative Case Study Reports' (2014) 9 *International Journal of Qualitative Studies on Health and Well-Being* 1, case study design requires the collection of 'multiple sources of information'.

time available for each study was a constraint on what could be achieved. Larger numbers of participants and a wider selection of practices may have produced different findings, but I have tried to ensure the ‘ecological validity’⁶⁹ of my findings by obtaining data from real world contexts, through triangulation of three types of data collection and analysis, and through explicit discussion of my views and prejudices throughout this thesis.

I have referred to the influence of my veterinary background on the research in Chapter 2, where the methodology and selection of methods are explained. However, it is possible that there is a wider aspect to the influence of this background. In holding the personal view that, overall, non-therapeutic neutering is usually in a companion animal’s best interests, I have perhaps not engaged fully with the debate over whether humans should have the right to interfere with an animal’s bodily integrity in this way.⁷⁰ By focusing on a more practice – based and less theoretical programme of research, I may have omitted some aspects of the wider philosophical debate.

Inevitably, the dearth of reported veterinary negligence cases posed the problem of a lack of specific case law. Therefore, analysis of the key medical cases addressing information disclosure formed the greater part of the doctrinal legal research, although the few veterinary cases examined included reference to some of the key medical cases, at least in part. Undoubtedly, there are arguments to be made for and against the view that veterinary medicine should follow in the footsteps of its human counterpart. The increased interest in “one health” as a concept⁷¹ and as an area for research⁷² implies that valid comparisons can be drawn between veterinary and human healthcare. Nevertheless, several interviewees urged caution in this implied transferability between settings. One opined that the

⁶⁹ Ecological validity refers to the similarity between real life and the research, see V Braun and V Clarke, *Successful Qualitative Research* (Sage 2013) at 280

⁷⁰ See, for example, K Burgess-Jackson, ‘Doing Right by Our Animal Companions’ (1998) 2 *The Journal of Ethics* 159, on the duties we have towards companion animals

⁷¹ See, for example, BGM Eussen and others, ‘Stimulating Collaboration Between Human and Veterinary Health Care Professionals’ (2017) 13 *BMC Veterinary Research* 111

⁷² MF Davis and others, ‘Checklist for One Health Epidemiological Reporting of Evidence (COHERE)’ (2017) 4 *One Health* 14
In this paper, the authors propose a framework for reporting ‘one health’ research

differences in management and funding made direct comparison impossible, and that to expect “[the same] form of excellence that may be possible within a highly controlled health service ... (...) ... but (which) doesn’t take into account the difficulty of treating animals under the sort of circumstances that some people have to treat them”⁷³ was unrealistic, while another pointed out the differences between presenting risks directly to a patient, “(where) you’re taking into account the psychology of the patient,”⁷⁴ and to a proxy decision-maker. These are valid criticisms of directly applying the standards for consent in medicine to veterinary medicine. However, I personally do not agree with these opinions. I propose that, as service providers, veterinary practices need to ensure that they offer a professional service to their clients, and I argue that this entails adopting ‘best practice’ from other health professions, so that clients know what to expect and to what standard. There is still an opinion amongst some veterinary professionals that clients should not be ‘informed’ and that the veterinary professional should make all the decisions.⁷⁵ In disputing this, I argue that even if clients wish to delegate decision-making to the veterinary surgeon, choosing to voluntarily reduce their autonomy,⁷⁶ there is still a need to discuss risks and financial costs to fulfil the requirements of a contract. I therefore maintain that the requirements for informed consent in medicine broadly transfer to its veterinary counterpart.

8.6 Areas for future research

Undertaking empirical research into informed consent in veterinary practice has revealed just how much there is left to study. First, I will consider the need for continuing consent research. The widening of this research to other companion animal veterinary settings, for example, emergency service providers, charity clinics and referral hospitals, would provide valuable opportunities to compare and contrast consent to a variety of treatments and

⁷³ Excerpt from interview with a representative of a professional body, PB4

⁷⁴ Excerpt from interview with a representative of a professional body, PB8

⁷⁵ See, for example, the quotes from participant VS3 in 7.6.4

⁷⁶ See 8.2.2 for an explanation of *voluntary diminished autonomy*

procedures in these settings with this study's evaluation of consent to neutering procedures in first opinion private veterinary practice.

Importantly, it is essential to explore consent in other human-animal interaction scenarios, such as with the owners of farmed animals giving consent for treatment in situations where the economics of the proposed treatment need to be balanced with the potential return of that animal to productive use, or with trainers of sport horses, who often give consent as agents of their owners. Following Scantlebury and others'⁷⁷ description of the varied types of horse owner, a study that differentiates approaches to consent in these hugely variable situations would provide valuable insight into how consent processes are adapted for differing triadic relationships with other species.

Consent to euthanasia is a separate area for research, as it involves a very strong professional ethical requirement to act in the 'best interests' of the animal. This context may offer an opportunity to further demonstrate the tension between client autonomy and patient best interests in a highly charged situation, and therefore it is worthy of consideration for future research, building on the work already undertaken on decision-making for euthanasia in animal patients.⁷⁸ This is a scenario where financial aspects may be key to decision-making. Similar comments apply to 'hi-tech' and innovative medical and surgical treatments for animal patients, another potential area for this type of research.

From a wider perspective, the initial use of interpretive description as a methodology for socio-legal studies, or for social science studies of the veterinary profession could lead to more research based on a similar approach. Its ability to incorporate doctrinal research with empirical research may encourage its use in future investigations regarding veterinary ethics

⁷⁷ In CE Scantlebury and others, 'Could It Be Colic? Horse-Owner Decision Making and Practices in Response to Equine Colic' (2014) 10 *BMC Veterinary Research* 51

⁷⁸ See, for example, LJ Nogueira Borden and others, 'Use of the Measure of Patient-Centered Communication to Analyze Euthanasia Discussions in Companion Animal Practice' (2010) 237 *Journal of the American Veterinary Medical Association* 1275 and SB Christiansen and others, 'Veterinarians' Role in Clients' Decision-Making Regarding Seriously Ill Companion Animal Patients' (2016) 58 *Acta Veterinaria Scandinavica* 30

and law in a practice context. The use of non-therapeutic neutering as the focal procedure for this study revealed more ethical aspects than could be answered here, surrounding the status of the companion animal, the attitude towards interference with the animal's bodily integrity for non-therapeutic reasons, and the power dynamic between professional, patient and client. Therefore, areas for future research extend to the wider ethics of human-companion animal interactions, to professional responsibility for animal welfare and to professional regulation.

Finally, research could investigate the wider application of the findings from this study to medical consent, particularly consent given by parents on behalf of children. Investigation of a beneficence-based consent could be relevant in such circumstances, and its application to non-therapeutic treatment such as vaccination, cosmetic surgery and male circumcision could yield valuable results.

8.7 Recommendations for professional regulation and veterinary education

When considering the application of the findings from this study to professional regulation, I am pleased to note that some of the recommendations from this thesis have already been included in the RCVS's revised guidance on informed consent, which includes appropriate personnel, timing of the discussion and the requirement to advise the client about the necessity of additional tests.

I was invited to submit my preliminary findings to the RCVS Standards Committee for consideration when they were revising their guidance on consent in December 2017.⁷⁹ The revised guidance was published in March 2018. As my initial report to the RCVS was based on preliminary and therefore mainly descriptive findings, further recommendations for the RCVS would now be to:

⁷⁹ See RCVS news item (n367); also see RCVS, March 2018 Council meeting minutes, section 7c, (Standards Committee meeting minutes, 24 Jan 2018, p2, point 12). <https://www.rcvs.org.uk/document-library/rcvs-march-2018-unclassified-papers/> accessed 7 November 2018. A summarized version of the report provided to the RCVS is included in Appendix 12.

- 1) acknowledge the move to respect for autonomy in the field of human medical treatment, by including reference to appropriate respect for the 'constrained' version of client autonomy in its professional guidance;*
- 2) incorporate explicit definition of material risks, decided on a 'particular client' basis;*
- 3) advocate sufficient time for discussion and an approach based on shared decision-making, and*
- 4) explicitly prioritise the best interests of the animal in treatment decisions involving a welfare component.*

Finally, as an adjunct to the recommendations for professional regulation, I will propose some lessons for veterinary education, which is also overseen by the RCVS. Many of the recommendations for professional education involve the provision of more training in communication skills. Both undergraduate and postgraduate training providers should recognise the value in developing the essential skills of shared decision-making. These skills comprise listening, appreciating the client's perspective and valuing the client's contribution, asking appropriate questions and providing information in a form that is useful to the client. Adding in an ethical understanding of the tension between autonomy and beneficence, and how to use shared decision-making skills to ameliorate this tension, would result in a training programme in specific communication skills that would prepare learners to achieve consent that is informed, valid and appropriate for the situation. I now feel that I have come full circle from my initial interest in consent as a dilemma for veterinary communication – of course it is, and undoubtedly will remain so, but the development of the communication skills specified above would go some way to addressing the ongoing dilemma of how to achieve the ultimate aim of informed client consent.

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APPENDIX 1: RCVS SAMPLE CONSENT FORM

SPECIMEN FORM OF CONSENT FOR ANAESTHESIA, CLINICAL AND SURGICAL PROCEDURES

Owner's Name _____

Address _____

Telephone: Home _____ Work _____

Mobile _____

NB: Please complete the section below if you have authority to act on behalf of the owner

Name _____

Address _____

Telephone: Home _____ Work _____

Mobile _____

Species and Breed _____

Name _____ Colour _____

Age _____ Sex M _____ F _____

Neutered M _____ Neutered F _____

Microchip/Tattoo/Brand _____

Details of the Operation/Procedure _____

- I hereby give permission for the administration of an anaesthetic to the above animal and to the surgical or other procedures detailed on this form together with any other procedures which may prove necessary.
- The nature of these procedures and of other such procedures as might prove necessary has been explained to me.
- I understand that there are some risks involved in all anaesthetic techniques and surgical procedures.
- I accept that the likely cost will be as detailed on the [attached] estimate and that in the event of further treatment being required or of complications occurring which will give rise to additional costs, I shall be contacted as soon as practicable so that my consent to such additional treatment and costs may be obtained.
- In the event that the veterinary surgeon is unable to contact me on the numbers provided, I understand the veterinary surgeon will act in the best interests of my animal.
- In order to protect the welfare of my animal, in the unlikely event of an emergency, or where additional pain relief or sedation may be required, I understand the veterinary surgeon may decide to use medicines that are not authorised for use in [state species].'

Notes and Instructions: _____

The cost of the procedures described above (tick as appropriate)

/ will be: £_____ OR

/ will be within the range: £_____ to £_____

Inclusive of: VAT _____

If you are NOT the owner, please tick the box to confirm you have the authority to act on behalf of the owner of the animal described above

Please tick the box if you are UNDER the age of 18

*Signature _____

Date of Signature _____

*A copy of the form should be provided to the person signing and the original retained by the practice

APPENDIX 2: CONSENT FORM STUDY FORUM POST ON VETSURGEON.ORG

Desperately seeking blank consent forms!



Carol Gray

forum
NEWBIE

5 posts

Thu, Aug 4 2016 10:07 AM

Agree (0) | Disagree (0) | Thank You (0) | Like (0)



Hello everyone.

I am a veterinary surgeon and a full time PhD student at the University of Birmingham, currently investigating protocols followed in veterinary practice for admission of animals for routine general anaesthesia and surgery. The study has received approval from the Research Ethics Committee of the University of Birmingham, reference number ERN_16-0077

I am trying to collect examples of consent forms used in practice. Any forms sent to me will have identifying features (name of practice etc.) removed, and will be anonymised so that they cannot be linked with any particular practice. I am going to undertake content analysis to compare themes and language used.

Please would you be kind enough to email a blank copy of your current consent form to

[REDACTED]

Submission will imply that consent has been given for its use (with all identifying features removed) in my thesis and any resulting publications.

All participating practices will be strictly anonymous and your data will remain confidential.

You are free to withdraw from the study at any time until the form has been anonymised, by contacting me at the above email address.

Thank you in anticipation!

 Edit tags

Tangent

Reply

APPENDIX 3a: INFORMATION SHEET (CLIENTS) OBSERVED CONSULTATIONS

Admissions procedures for veterinary surgical patients

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and veterinary surgeon if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of the study is to look at the process of informed consent for veterinary treatment of animals. I am trying to find out the factors that are important to clients when making decisions about whether to agree to proposed veterinary treatment or surgery for their pets.

2. Why have I been chosen to take part?

You have been invited to take part because you have an appointment for your pet to have a surgical procedure, a routine (planned) neutering operation.

3. Do I have to take part?

No, certainly not. Participation is voluntary and, even if you decide to take part, you are free to withdraw at any time, without explanation, up to 6 months after the recording of your consultation. Whether you choose to take part or not, or decide to withdraw at a later date, will not affect your pet's treatment at the veterinary practice in any way.

4. What will happen if I take part?

If you agree to take part, the researcher (Carol Gray) will observe the consultation between you and the veterinary surgeon. I will make notes during the consultation but will be as unobtrusive as possible. I will also audio record the consultation. This will be transcribed by me, and the original recording deleted as soon as this is done. You will be given a number to identify you anonymously in any reports published as a result of the research, and anything that you say that may identify you will not be used.

5. Are there any risks in taking part?

There should be no risks involved, as it will be a normal consultation with the veterinary surgeon, and I will not be involved in the consultation at all.

6. Are there any benefits in taking part?

There will be no direct benefits to you or your pet. However, a better understanding of how pet owners make decisions about proposed veterinary treatment may improve the experience for future clients.

7. What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the researcher, Carol Gray, on [REDACTED], or via email at cag501@bham.ac.uk or her supervisor, Professor Marie Fox, via email at [REDACTED] and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with, then you should contact the Research Ethics Officer at s.l.cottam@bham.ac.uk. When contacting the Research Ethics Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

8. Will my participation be kept confidential?

Yes. All personal data will be stored securely. Consent forms will be stored in a locked filing cabinet in a locked office at the University of Birmingham. Transcribed interviews will be anonymous, and any link with your personal details will be held, by the researcher only, in a secure file on a password protected computer. All personal records will be deleted after 10 years.

9. What will happen to the results of the study?

It is hoped that publication of the results will be possible, most likely in veterinary journals. If you would like to receive a summary of the findings of the study, please indicate this on the consent form and supply an email address.

10. What will happen if I want to stop taking part?

You can withdraw at any time, without explanation, up to 6 months from the date of your observed consultation. You can do this by informing the researcher of your study number. Results up to the period of withdrawal may be used, if you are happy for this to be done. Otherwise you may request that they are destroyed and no further use is made of them.

11. Who can I contact if I have further questions?

Please contact the researcher, Carol Gray, on [REDACTED], or by email cag501@bham.ac.uk or her supervisor, Professor Marie Fox

APPENDIX 3b: INFORMATION SHEET (VETS) OBSERVED CONSULTATIONS

Participant information sheet for veterinary surgeons – pre-op consultations

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with other members of the veterinary team. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of the study is to look at the admissions process for veterinary surgical procedures. I am trying to find out the factors that are important to clients when making decisions about whether to agree to proposed surgery for their pets.

2. Why have I been chosen to take part?

You have been invited to take part because you will be doing a pre-op consultation with a client who has agreed to take part in this study.

3. Do I have to take part?

No, certainly not. Participation is voluntary and, even if you decide to take part, you are free to withdraw at any time without explanation, up to 6 months after the recording of your consultation.

4. What will happen if I take part?

If you agree to take part, the researcher (Carol Gray) will observe the consultation between you and the client. I will make notes during the consultation but will be as unobtrusive as possible. I will also audio record the consultation. This will be transcribed by me, and the original recording deleted as soon as this is done. You will be given a number to identify you anonymously in any reports published as a result of the research, and anything that you say that may identify you will not be used.

5. Are there any risks in taking part?

There should be no risks involved, as it will be a normal consultation with the client, and I will not be involved in the consultation at all.

6. Are there any benefits in taking part?

There will be no direct benefits to you. However, if you wish some feedback from me on your communication techniques, I will be very happy to provide this. I have 12 years' experience as a veterinary communication educator. This is of course optional and there is no pressure to have any feedback at all.

7. What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the researcher, Carol Gray, on 07543 660588, or via email at cag501@bham.ac.uk or her supervisor, Professor Marie Fox, at [REDACTED] and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with, then you should contact the Research Ethics Officer at s.l.cottam@bham.ac.uk. When contacting the Research Ethics Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

8. Will my participation be kept confidential?

Yes. All personal data will be stored securely. Consent forms will be stored in a locked filing cabinet in a locked office at the University of Birmingham. Transcribed interviews will be anonymous, and any link with your personal details will be held, by the researcher only, in a secure file on a password protected computer. All personal records will be deleted after 10 years.

9. What will happen to the results of the study?

It is hoped that publication of the results will be possible, most likely in veterinary journals. If you would like to receive a summary of the findings of the study, please indicate this on the consent form and supply an email address.

10. What will happen if I want to stop taking part?

You can withdraw at any time, without explanation, up to 6 months from the date of your observed consultation. You can do this by informing the researcher of your study number. Results up to the period of withdrawal may be used, if you are happy for this to be done. Otherwise you may request that they are destroyed and no further use is made of them.

11. Who can I contact if I have further questions?

Please contact the researcher, Carol Gray, on [REDACTED], or by email cag501@bham.ac.uk or her supervisor, Professor Marie Fox

APPENDIX 4: CONSENT FORM for OBSERVED CONSULTATIONS

Title of Research: Admissions procedures for veterinary surgical patients

Researcher: Carol Gray

Please
initial
box

- 1. I confirm that I have read and have understood the information sheet dated August 2016 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

- 2. I understand that my participation is voluntary and that I am free to withdraw within 6 months of the date of observation and recording of my consultation, without giving any reason, without my rights being affected.

- 3. I understand that, under the Data Protection Act 1998, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish, within the 6 month limit described in (2).

- 4. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications

- 5. I agree for the data collected from me to be used in this research and understand that any such use of my data will have been reviewed and approved by the University of Birmingham Humanities and Social Sciences Research Ethics Committee.

- 6. I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings for the following purposes: the consultation will be transcribed by the researcher, and direct quotations from this may be used in the final publication. Any identifying features will be removed from these quotations. All data will be stored on a password protected desktop computer.

- 7. I agree to take part in the above study.

Participant name:	Signature:	Date:
Researcher name:	Signature:	Date:

**APPENDIX 5: WEB ARTICLE SEEKING VETERINARY PROFESSIONAL INTERVIEW
PARTICIPANTS (on www.oncoreepd.co.uk)**



PROFESSION REQUESTED TO PARTICIPATE IN STUDY ON INFORMED CONSENT

Veterinary Surgeon Carol Gray, undertaking her PhD in informed consent at Birmingham University, is requesting interviewees to help her obtain more information in this vital area of professional practice.

Experiences of obtaining consent

Veterinary Surgeon Carol, who previously worked as a communication skills educator at the University of Liverpool, has already completed parts of the study that looked at consent forms and observations of consent discussions in practice.

For the third part of the study, she would like to interview veterinary surgeons and veterinary nurses to ask them about their experiences of obtaining consent for elective (routine, non-therapeutic) neutering procedures, and to canvass their opinions on what the consent process should include.

How can you take part?

Interviews will take place either face-to-face, or via Skype, depending on the interviewee's situation and preference. She will then arrange to chat to you about the study, including details about confidentiality and data protection. You can find more information about the study by following the link (see paragraph below).

If you would like to volunteer, please contact Carol on the following email address:
consent2018phd@gmail.com

JM 13th Jan 2016

APPENDIX 6: SOCIAL MEDIA FORUM POST SEEKING VET INTERVIEW PARTICIPANTS

Life In Practice

More help with informed consent research



Carol Gray
forum
NEWBIE
5 posts

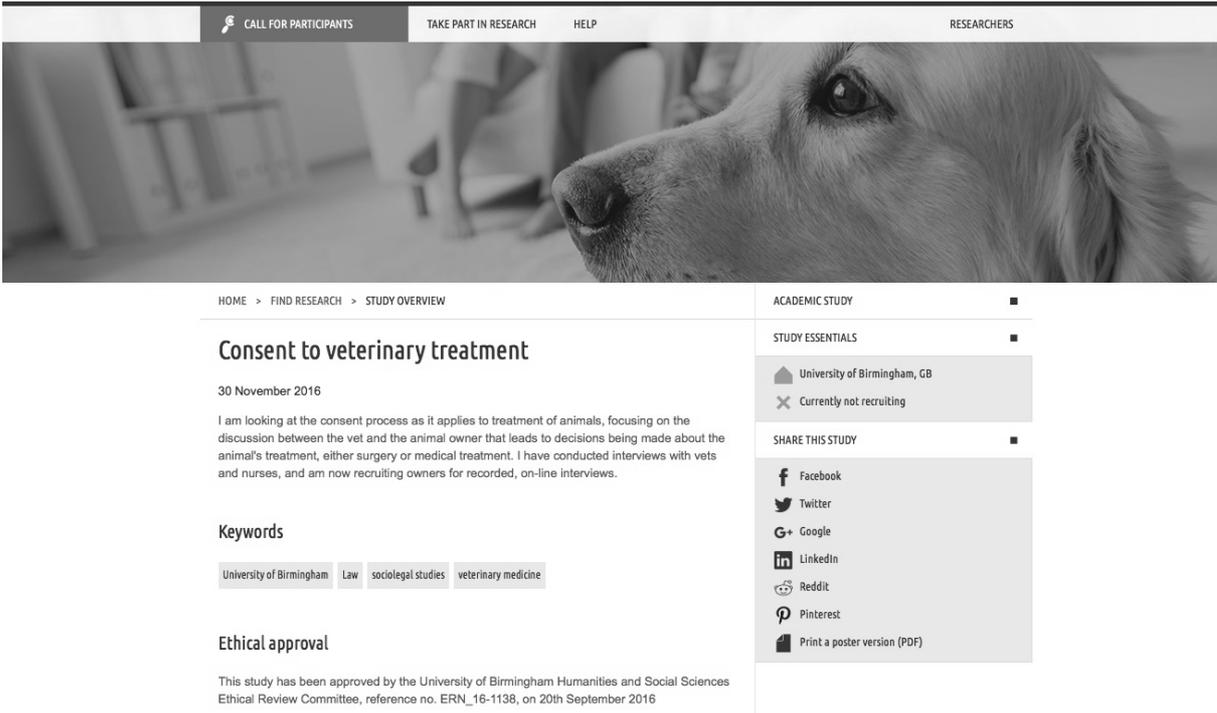
Sat, Jan 7 2017 12:16 PM ▼
Agree (0) | Disagree (0) | Thank You (0) | Like (0)

Thanks to everyone who responded to previous requests (you know who you are!).
The informed consent PhD project is entering its third and final phase of data collection, and now I am seeking YOUR opinions about informed consent. I plan to interview up to 10 vets about this important topic, and can do interviews via Skype, or can travel to interview you in person, whichever is easier.
Information at the following site: <https://veterinaryconsent.blogspot.co.uk/p/recruiting-participants-veterinary.html> If interested, contact me via email and I will send information and consent form.
Thanks again,
Carol

 Edit tags

Tangent **Reply**

APPENDIX 7: 'CALL FOR PARTICIPANTS' WEB PAGE SEEKING CLIENT INTERVIEW PARTICIPANTS



The screenshot shows a web page with a navigation bar at the top containing 'CALL FOR PARTICIPANTS', 'TAKE PART IN RESEARCH', 'HELP', and 'RESEARCHERS'. Below the navigation bar is a large image of a dog's face. The main content area has a breadcrumb trail 'HOME > FIND RESEARCH > STUDY OVERVIEW' and a title 'Consent to veterinary treatment'. The text below the title states the date '30 November 2016' and describes the research focus on the consent process for animal treatment. A 'Keywords' section lists 'University of Birmingham', 'Law', 'sociolegal studies', and 'veterinary medicine'. An 'Ethical approval' section mentions approval by the University of Birmingham's ethics committee. On the right side, there is a sidebar with sections for 'ACADEMIC STUDY', 'STUDY ESSENTIALS' (listing 'University of Birmingham, GB' and 'Currently not recruiting'), and 'SHARE THIS STUDY' (with social media icons for Facebook, Twitter, Google+, LinkedIn, and Reddit, plus a 'Print a poster version (PDF)' option).

CALL FOR PARTICIPANTS TAKE PART IN RESEARCH HELP RESEARCHERS

HOME > FIND RESEARCH > STUDY OVERVIEW

Consent to veterinary treatment

30 November 2016

I am looking at the consent process as it applies to treatment of animals, focusing on the discussion between the vet and the animal owner that leads to decisions being made about the animal's treatment, either surgery or medical treatment. I have conducted interviews with vets and nurses, and am now recruiting owners for recorded, on-line interviews.

Keywords

University of Birmingham Law sociolegal studies veterinary medicine

Ethical approval

This study has been approved by the University of Birmingham Humanities and Social Sciences Ethical Review Committee, reference no. ERN_16-1138, on 20th September 2016

ACADEMIC STUDY

STUDY ESSENTIALS

University of Birmingham, GB

Currently not recruiting

SHARE THIS STUDY

Facebook

Twitter

Google+

LinkedIn

Reddit

Pinterest

Print a poster version (PDF)

APPENDIX 8: INFORMATION SHEET FOR INTERVIEW PARTICIPANTS

Informed consent in veterinary practice

Researcher: Carol Gray
Contact: cag501@bham.ac.uk

Supervisor: Professor Robert Lee
Contact: r.g.lee@bham.ac.uk

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with other people. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

1. What is the purpose of the study?

The purpose of the study is to examine the nature and content of informed consent to veterinary treatment.

2. Why have I been chosen to take part?

You have been invited to take part because you are a veterinary professional (veterinary surgeon or veterinary nurse), a representative of a veterinary association, or an animal owner

3. Do I have to take part?

No, certainly not. Participation is voluntary and, even if you decide to take part, you are free to withdraw at any time during the interview without explanation. You can either decide to allow me to use any data collected up until you withdraw, or you can request destruction of all of your data.

4. What will happen if I take part?

If you agree to take part, we will decide whether an interview in person, or via email or telephone is more convenient for you, and will arrange it to suit you. The interview will be recorded if it is carried out face-to-face or via telephone.

5. Are there any risks in taking part?

There should be no risks involved, although in discussing consent to treatment, some negative emotions may be involved in recalling past experiences. In this case, the interviewer will stop the interview, and if appropriate, will suggest suitable support contacts. You will then be asked if you are willing to continue the interview, or whether you wish to end it.

6. Are there any benefits in taking part?

There will be no direct benefits to you. However, the study aims to clarify the discussion that should take place between veterinary staff and animal owners when deciding on the treatment of an animal patient. It should produce a protocol based on evidence of what is “best practice” for gaining consent to veterinary treatment, that can be used by practices, and therefore it will benefit veterinary surgeons, veterinary nurses and animal owners in the future.

7. What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the researcher, Carol Gray, on [REDACTED], or via email at cag501@bham.ac.uk or her supervisor, Professor Robert Lee, on [REDACTED], or via email at r.g.lee@bham.ac.uk and we will try to help. If you remain unhappy or have a complaint which you feel you cannot bring to us, then you should contact the Research Governance Officer at ethics@bham.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

8. Will my participation be kept confidential?

Yes. All personal data will be stored securely. Consent forms will be stored in a locked filing cabinet in a locked office at the University of Birmingham. Transcribed interviews will be anonymous, any responses that may reveal your identity will be removed. Your interview will be given a unique ID number, and any link with your personal details will be held, by the researcher only, in a secure file on a password protected computer. All personal records will be deleted after 10 years.

9. What will happen to the results of the study?

It is hoped that the results will be published in veterinary journals. If you would like to receive a summary of the findings of the study, please indicate this on the consent form and supply an email address.

10. What will happen if I want to stop taking part?

You can withdraw from the study at any time, without explanation, up until 6 months from the date of your interview. Results produced from your data, up to the point of withdrawal, may be used if you are happy for this to be done. Otherwise you may request that they are destroyed and no further use is made of them.

11. Who can I contact if I have further questions?

Please contact the researcher, Carol Gray, [REDACTED], or by email cag501@bham.ac.uk or her supervisor, Professor Robert Lee, at r.g.lee@bham.ac.uk or on [REDACTED]

APPENDIX 9: CONSENT FORM FOR INTERVIEW PARTICIPANTS

Title of Research Project: Informed consent in veterinary practice

Researcher: Carol Gray

PLEASE INITIAL BOX

1. I confirm that I have read and have understood the information sheet dated
2. August 2016 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
3. I understand that my participation is voluntary and that I am free to withdraw within 6 months from the date of interview without giving any reason, without my rights being affected.
4. I understand that, under the Data Protection Act 1998, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish, within the 6 month limit described in (2).
5. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications
6. I agree for the data collected from me to be used in this research and understand that any such use of my data will have been reviewed and approved by the University of Birmingham Humanities and Social Sciences Research Ethics Committee.
7. I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings for the following purposes: my interview with the researcher will be transcribed by the researcher, and direct quotations from this may be used in the final publication. Any identifying features will be removed from these quotations. All data will be stored on a password protected desktop computer.
8. I agree to take part in the above study.

Participant name:	Signature:	Date:
Researcher name:	Signature:	Date:

APPENDIX 10: INTERVIEW TOPIC GUIDE

Interview questions (topic guide) – essentially a semi-structured approach, but hoping that each question leads to more sub-topics.

Question 1: Can you tell me about your experiences involving

- a) obtaining informed consent from clients (for veterinary professionals VPs)
- b) giving consent for surgery or treatment for one of your animals (for animal owners AOs)**
- c) giving advice on informed consent to veterinary professionals (for stakeholders SHs)

(Prompts – can you describe one consent process that went well and one that didn't go so well?)

Question 2: What do you regard as the essential components of consent to veterinary treatment? (VPs and SHs)

What information do you think you need before making a decision to give consent for treatment for one of your animals? (AOs)

(Prompts – information about options, risks, benefits, financial aspects)

Question 3: How involved should veterinary professionals be in helping owners to decide about treatment? (VPs and SHs)

How involved do you wish your vet/vet nurse to be in helping you to decide whether to consent to treatment for one of your animals? (AOs)

(Prompts – VP as information provider, VP as decision maker, VP as guide. For SHs only – how important is client autonomy?)

Question 4: **What is your opinion on consent forms? How could they be made better?**

(Prompts – for AOs – how often do you read them? Why do you think they are necessary? For VPs – how well do you think clients read them? Why do you think we need them? Improvements – eg personalisation, room for discussion notes)

Question 5: **Please describe your ideal consent process.**

(eg record of discussion – how? Copies to all participants? Information and decision aids?)

Question 6: **Do you have any other comments or opinions on consent in veterinary practice?**

APPENDIX 11: SPECIMEN FORM OF CONSENT FOR ANAESTHESIA, CLINICAL AND SURGICAL PROCEDURES, BASED ON RCVS VERSION

Owner details

Printed from client records

Patient details

Printed patient records

To be completed by person taking consent:

Details of the **Operation/Procedure** _____

Alternatives discussed _____

Risks discussed _____

Benefits to the patient of having this procedure

Pre-operative blood tests recommended for this patient, **YES/NO**: cost explained

Client agrees to blood tests Client declines blood tests

Any other procedures requested by client, with costs

The **cost** of the procedures described above (tick as appropriate)

will be: £_____ OR

will be within the range: £_____ to £_____

Inclusive of: VAT _____

Any financial limit placed by owner? **YES/NO** Amount:

To be completed by owner or authorised agent:

In order to protect the welfare of my animal, in the unlikely event of an emergency, or where additional pain relief or sedation may be required, I understand the veterinary surgeon may decide to use medicines that are not authorised for use in _____ (state species).

Contact number in case of emergency : _____

- I accept this estimate of costs and agree to pay on collection of the animal.

- I agree that the proposed procedures have been explained to me, as detailed above. I have had the opportunity to ask questions, and I understand and accept the risks involved.

- I give my consent to the treatment agreed

- I am the owner of this animal OR

- I am not the owner, but I have the authority to act on behalf of the owner of the animal described above

- I confirm that I am over the age of 18

Signature of person giving consent:

Date:

I confirm that I have explained the proposed procedure, alternatives, risks and benefits

Signature of person obtaining consent:

Date:

Copy given to client:

APPENDIX 12: PRELIMINARY REPORT ON CONSENT FOR RCVS (SUMMARY, WITH MANY QUOTES REMOVED AS ALREADY PRESENT IN THESIS CHAPTERS)

This report summarises the preliminary findings from the empirical studies conducted as part of an ESRC-funded PhD in informed consent as it applies to the treatment of animal patients. The empirical work consisted of three separate studies: analysis of consent forms, observation of consent discussions and interviews with key participants and stakeholders in the veterinary informed consent process. The findings reported here are those resulting from an initial thematic analysis of data and tend to be mainly descriptive. Further work is currently under way to theorise and produce conceptual analysis. Ethical approval was granted by the University of Birmingham Research Ethics Committee, reference ERN_16-0077. Informed consent was obtained from all participants, with permission to use their anonymised quotes in publications.

1. Findings from consent form study

A total of 60 forms were submitted following requests on social media and in a veterinary newsletter. Following removal of those which would not be suitable for consent to surgical treatment of small animal patients (e.g. forms for euthanasia, “off licence” drug use, equine surgery or in-patient treatment), a total of 41 forms were analysed.

a. Quantitative analysis

A simple yes/no system was used to record the presence or absence of key features of obtaining valid consent, utilising RCVS guidance.

A summary of the main results was included.

b. Qualitative analysis

There was a clear difference between the forms that were apparently designed to be relied on as stand-alone consent, and perhaps presented to the client for completion and signature, and those that recorded the discussion that had taken place between the client and the veterinary professional (VP) and therefore provided evidence of a more informed consent process.

Some forms looked more like “shopping lists” from which the client could choose additional procedures, goods or services. The forms that provided more spaces for the VP to record the content of the discussion were a good example of best practice regarding consent.

Several forms required the client to sign to say that they understood the procedure etc., but only two forms required counter-signature by the VP involved in the discussion to confirm that they had

explained the procedure in terms that the client could understand, thus incorporating both sides of the consent process.

Main recommendations for consent forms:

- a. The provision of free text boxes or lines for completion by the person taking consent is good evidence that there has been a discussion between the veterinary professional and the client, and this format should be encouraged.
- b. Clients should not be left to decide whether their animal receives fluid therapy during a surgical procedure – that is a clinical decision. A similar argument could be put forward regarding pre-operative blood tests (*see interview data*).
- c. The (statistically low, but material) risk of death should be stated on every consent form for a general anaesthetic, OR should be written in a free text summary of the consent discussion. (*see interview data*)
- d. There should be provision for signature by the VP taking consent, perhaps including a statement that they have explained the procedure and associated risks to the client in a way that promoted understanding?
- e. The client should always receive a copy of the form (already in current RCVS guidance).

2. Findings from observations of consent discussions

This study was based in one large practice. Ten “consent for elective neutering” discussions were observed, which involved eight different veterinary surgeons. In this practice, a pre-operative consultation was required before a patient was admitted for an elective neutering operation. The transcripts of the consultations were analysed thematically to code elements of consent.

a. Description of procedure

A description of the procedure was included in six of the ten consultations. The first example is a comprehensive description offered by the veterinary surgeon:

“... Wound – you’re probably looking around this sort of size of a wound (demonstrates with hands) – just depends on who does it but roughly that sort of size – remove both the ovaries and the uterus through that one incision, and then stitched up a layer of muscle, layer of fat and the skin layer.”

The second example demonstrates a conversation between the vet and the client:

“V: I don’t know if you’ve had dogs before, if you’ve had any spayed

C: Is it like the full?

V: Yes, a midline incision, removing the uterus and the ovaries

C: You take the ovaries out?

V: Yes, we take the ovaries because it's the ovaries that produce the hormones that can cause the problems, the infections and mammary cancers and things like that, so we have to take the whole lot."

and the third example is for a dog castration, where a description of the wound is given but there is no clear explanation of exactly what is removed during the procedure:

"So, we do an incision here (demonstrates) just here, between the testicles and the penis, okay? Most of the vets are going to close with intradermal sutures, okay? So you are probably not going to be able to see anything."

b. Discussion of risks involved

Regarding discussion of risk, there were differences in how this risk was presented. Some of the veterinary surgeons did specifically mention death as a risk, whereas others either referred to risks in a generic and rather abstract way.

In three consultations, the veterinary surgeon did not mention risks of general anaesthesia at all, although one of these was for charity neutering and the volunteer accompanying the animals had been through the consent discussion many times before.

The risks of surgery were mentioned in most consultations and were emphasised in the female dog neutering consultations. The primary intra-operative risk referred to was that of haemorrhage, which was explained in more detail. Post-operative complications were also mentioned, and these included wound breakdown and infection. Preventative measures included the provision of a collar to stop the patient from interfering with the wound immediately after surgery.

c. Giving estimates of costs

In most consultations, the estimate for costs was carefully worked out, based on the patient's weight, including any additional procedures, or in some cases, the veterinary surgeon checked that the client had been given an estimate in a previous consultation.

d. Offering extra procedures

The offer of extra procedures was only done with a strong recommendation from the veterinary surgeon. Clients were not left to decide on things such as pre-operative blood tests without any guidance. In a few consultations, the client was informed about the availability of pre-operative blood tests, but these were not pushed for the specific patient. The veterinary surgeons gave reasons why they were not strongly recommending the blood tests.

e. Written consent

Written consent was not sought during any of the observed consultations, although, in one consultation, the veterinary surgeon explained that consent would be obtained on the day of the procedure.

In one other consultation, the animals were being admitted for the surgery on the same day, as they came from a charity organisation, but during the other 8 consultations, there was no reference to a consent form, although every client would be requested to sign a consent form on admission of the patient for surgery. A copy of the form was never given to the client in advance of the surgical appointment.

3. Findings from interview study

Ten interviews were conducted, with five veterinary surgeons or veterinary nurses (VPs), three animal owners (AOs) and two representatives of professional bodies (PBs). Transcripts of the interviews were coded thematically, as for the consultations.

a. The place of the consent form

The first aspect of consent on which interviewees' opinions were sought was the place of the consent form in the consent process. The use of the consent form as an "aide-memoire" for the content of the consent discussion was also mentioned by one of the clients interviewed.

However, there was a strong feeling amongst these interviewees that the form alone was not enough to obtain consent, especially when recalling examples of poor consent processes.

b. Offering extra procedures and services

There were strong opinions about the inclusion of "additional services" on consent forms, ranging from views on offering pre-operative blood tests on the form, offering other services, to the question of whose decision it should be regarding pre-operative blood testing.

c. The timing of the consent process

The timing of the consent process, both in terms of when it happens and how long it should take, was mentioned by several participants, both by veterinary professional, by representatives of professional bodies and by clients.

d. The financial aspects of consent

The importance of clear financial consent was raised by several participants, e.g. VP9 commented that it was better to have *“the financial estimate as a separate consent, so giving financial consent separate to the procedure consent”* while VP2 explained that finances are a driving force for updating consent, The suggestion of separate consent for financial aspects and procedure was not endorsed by interviewee PB8, who felt that the two are inextricably linked, especially from the client’s perspective. Clients were perhaps more pragmatic about the financial aspects of consent. Interviewee AO5 recalled, *“To my best recollection, the financial thing was on a separate form, because I don’t recall seeing it all on the one form. I think there was something on the consent form that said if you opted for certain things, that were options, there was an extra cost to those.”*

Another client recalled that when her dog was ill, she was not informed of the costs.

This view was reinforced by interviewee AO10, who observed, *“There was a verbal conversation, but nothing in writing, no.... Ours doesn’t tend to put anything about fees in writing. Just thinking about, just generally when I’m dealing with them, you only get any information about the cost if you specifically ask the question.”*

e. Disclosure of risk

The final aspect of consent investigated with interviewees was the level of risk that should be disclosed. This evoked some strong opinions amongst the veterinary professionals. Some agreed that discussion of risks tended to be vague, e.g. VP1, who said, *“Sometimes we will write “discussed risks” but might not actually stipulate those risks on that piece of paper.”*

Others wanted to be much more specific, for example VP6, who said, *“..... if you don’t use the word “death” as one of the risks, you’re not actually being overt enough that that is one of the risks.”* while VP9 gave an example of the danger of not expanding on risks.

Clients varied in their recall of specific risks. For example, AO5 stated, *“There were things like, sort of, the risks of anaesthesia, emm ... and that ... you know, surgical outcomes weren’t guaranteed. But to be honest, there was so much that was on it, to actually remember all the prose, perhaps I should have brought a copy of it with me. But, and to be perfectly honest, seeing I was holding [dog] at the time, I think I read the bits that she pointed at.”*

Client A07, who was intending to neuter her pet, remarked on the “routineness” of neutering and therefore perhaps the lack of emphasis on discussion of risks, *“I think because so many people have it done. I don’t think I’d have too many questions about risks and benefits.”*

Main Recommendations for consent process:

- a. Consent forms should be viewed as an aid to consent, in conjunction with a discussion with a veterinary professional (not a receptionist).
- b. Consent forms should not include “shopping lists”/tick box lists of additional procedures. If required, these should be individually documented in the free text space for “procedures” after the consent discussion.
- c. For non-urgent procedures, it would be good practice to schedule the consent discussion in advance of the day of surgery, which would allow adequate time for the process.
- d. The consent discussion should include financial estimates, and an agreement on any financial limits, which should also be documented on the consent form, or on an attached detailed estimate.
- e. There should be explicit discussion of the risks of surgery and anaesthesia, with a clear indication that the most serious risk is death.