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Autonomy and paternalism in quality of life determinations in veterinary practice

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Abstract

Assessments and predictions of patient quality of life (QoL) permeate many veterinary decisions, including (1) whether to perform a procedure due to concurrent QoL issues, (2) whether a procedure will negatively affect QoL in the near or distant future, and (3) whether QoL is poor enough to warrant euthanasia. In order to understand how veterinarians manage decisions relating to patient well-being, interviews with 41 veterinarians and over 100 hours of observations of 10 veterinarians were conducted. Participants held diverse views regarding the type of parameters that should be included when defining QoL. Interestingly, they also held differing views about who should be assessing patient QoL, with some participants believing that animals' owners were better able to assess patient QoL than veterinarians. For these veterinarians, respecting the client's autonomy in deciding what was best for the patient weighed heavily in their decisions. Other veterinarians felt that they, rather than the client, were the best assessors of QoL and felt justified in persuading clients to follow a certain course of action (often considered a paternalistic approach). These findings raise some interesting questions for the profession. What role should veterinarians play when assessing patient QoL? When is paternalism acceptable or even mandatory in veterinary medicine? Does respecting client autonomy also require an evaluation of the client's abilities to make appropriate decisions for the patient? The lack of uniformity in defining and assessing patient QoL highlights the need for increased dialogue with respect to veterinarians' responsibilities to both animals and clients.

Keywords: *animal welfare, decision-making, quality of life, veterinarian–client–patient relationship, veterinary medicine*

Introduction

Compared to colleagues working with food animals, veterinarians in companion animal practice face unique challenges when assessing and predicting quality of life (QoL). Clients of companion animal practitioners may expect a higher QoL for their animals than do farmers, yet they may also tolerate a significantly lower QoL for their animals, particularly near the end of life. As many companion animals are considered family members, questions about patient QoL are inevitably bound to the type of relationship that veterinary clients and patients share.

In veterinary practice, QoL assessments frequently occur following diagnosis of a serious disease, illness, disability, or when clients are considering euthanasia. QoL predictions are made when considering treatments that may have a lasting effect on the patient's lifestyle, for example limb amputations or surgery involving sensory organs (eg eye enucleations, ear ablations). Although assessing and predicting QoL plays a very important role in decision-making in veterinary medicine, only recently have veterinary researchers attempted to develop tools to assist in these assessments (Wiseman-Orr *et al* 1997; Hartman & Kuffer 1998; McMillan 2003; Wojciechowska *et al* 2005a,b).

Veterinarians have a responsibility to both clients and patients to assess QoL adequately and to apply these assessments to veterinary decisions. This paper explores the views of companion animal veterinarians with respect to QoL assessments and the effect assessments have on veterinary decisions. The implications of veterinarians' views about clients as decision-makers will also be addressed in the light of veterinary responsibilities.

Methods

The results presented below are based on a qualitative study of veterinary moral decision-making focussing on situations in which the interests of their patients conflict with the interests of clients. Although the study did not specifically address QoL assessments and predictions, QoL was central to veterinarians' decision-making. Over a 30-month period, 41 interviews with veterinarians, who practice in Western Canada, were conducted. Interview durations ranged from 40 to 150 minutes. Nineteen women and 22 men participated, including 20 companion animal practitioners, one equine practitioner, 15 mixed animal practitioners, and five practitioners specialising in food animal practice. Practice experience levels ranged from less than one year to over 40 years. Eighteen participants were practice associates or locums and the remainder were practice owners. All interviews were audiotaped and transcribed verbatim. To supplement interview data, veterinarians were observed when interacting with patients and

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clients. Over 100 hours of observations included 10 different veterinarians who also participated in personal interviews. Written or audiotaped field notes from observations were transcribed and included in data analysis. The University of British Columbia Behavioural Research Ethics Board approved the study design.

In keeping with a grounded theory research approach (Charmaz 2006), analysis of interview and field note data continued throughout the data-collection period. The data were reviewed and segments categorised according to recurrent ideas, topics, or reasoning processes that participants identified. Qualitative data software QSR N6 facilitated this process.

Representative quotations presented in this paper were edited to enhance ease of reading and understanding. False starts, pauses in conversation, and interjections such as 'um' and 'uh' were removed. In some cases, sections of text were removed to improve readability. In these instances, a series of three dots (…) indicates that text has been removed. Text found inside square brackets [ ] has been added to clarify the quote. Terms such as 'a few', 'some' and 'most' are used to describe relative trends in participant responses.

Results

Quality of life parameters

Parameters mentioned by most veterinarians when considering QoL included basic functioning (eating, drinking, and ambulating) and negative affective states such as pain and suffering.

> "First of all is the animal in pain? Is it suffering? And that's very judgmental but any obvious pain or obstruction to normal … activity. If they have an ulcerating tumour on their foot for instance, and they can't walk — that's obviously an animal welfare issue. If they've got a large mass on their side that's not ulcerated and it doesn't seem to bother them and that doesn't interfere with their function, I guess that would be a different matter. So I guess, the minimum standard of existence is animal welfare. Is the animal getting enough food and water?"

In general, study participants were most concerned with pain and suffering; however, definitions of pain and suffering varied (Morgan 2006). Some individuals felt that suffering was an extension of pain; severe or chronic pain resulted in suffering. Other participants included other presumably non-painful factors when assessing suffering, such as nausea, dyspnea, and malaise. Inclusion of these parameters was not consistent amongst participants, with some explicitly stating that vomiting or dyspnea, even near the end of life, were not parameters they considered when evaluating patient QoL.

Some veterinarians mentioned positive mental states such as happiness as part of QoL assessments.

> "I would say providing a good quality of life for their pet is [a client's] responsibility … Safety, food, shelter, and happiness which is one of the hardest things to measure or evaluate."

Quality of life assessments

In order to assess QoL, veterinarians gather information from their own clinical examinations and the patient history provided by the client. Veterinarians depend on clients for factual information about the animal such as eating, exercise, and voiding patterns. They also rely on their clients for information on how the animal is feeling and whether the animal is coping well. Below, a practitioner describes how a dog did not manage well after becoming blind.

> "He was blind by the time he was eight years old, and just freaked out ... It was a chronic onset of blindness. He just turned into a wing nut. [He] just couldn't handle the blindness. He got very aggressive, very socially intimidated, defecating all over the house. We had to put him to sleep. He just couldn't compensate. His quality of life with his disease was very bad. But you and I both have lots of blind dogs in the practice that have great lives. Same disease, totally different outcome. Their quality of life is different based upon their circumstances. So you base your decisions on whether these guys have good quality of life based on how well they are tolerating their pain. Are they managing their pain? Are they managing their blindness? Are they managing their incontinence? It's different for everybody. You have to have the judgment to know the difference between what's working and what isn't."

In this situation, the practitioner relied on client communication to assess how well the dog was coping with its disease in order to make a decision about euthanasia.

Study participants also used client interpretations to predict how well a patient might respond to treatment. In the following quote, the veterinarian discusses how communicating with the client regarding the animal's preferences aids in QoL assessments and predictions.

> "We often discuss what's important to their pet. What they think their pet likes to do, what it still can do. How would coming in for chemotherapy treatments interfere with that? How frightened is it of being at the doctor's? How does it handle having procedures? So that they can kind of feel that they're making the decision they're most comfortable with. [A decision] dependent on not only the medical side of things but also the side of things that came from their pet … Things like euthanasia, that comes up quite a bit. What does your pet really like to do? … It's not interacting the same or it doesn't get up and move. It just sleeps the whole time. Is that real 'quality of life'? And I think that's probably just as important as physiologic changes."

Discussions with clients about patients' likes and dislikes and how various medical treatments may affect these preferences were common for some participants.

Judges of quality of life

Because the client has much more access to the patient's behaviours and preferences, some participants believed that clients were better judges of patient well-being than were veterinarians.

> "I think owners can judge an animal's quality of life better than anyone can — better than a vet, better than

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anyone. They know when an animal is happy and when it's not so happy."

These veterinarians relied on caregivers to make assessments about well-being. However, many participants agreed that caregivers are sometimes poor judges of QoL. Some clients evaluated their animals' QoL as very poor — poor enough to justify euthanasia. In the following quote, a practitioner relates a story of a client requesting euthanasia for QoL reasons.

"They paid the bill already and [I'm] faced with this dog sitting here, munching on all the treats, running around wagging its tail. I've had [this happen] a number of times. And I find that really hard because you're getting one story from the people. Maybe it's true, maybe they are having problems at home, but it's hard to tell here. And sometimes I don't always believe the story I'm getting either."

The veterinarian is concerned about the disparity between her perception of the patient and that of the client. Her first impression of the dog is so drastically different from the client's report that she has trouble trusting the client's interpretation. Another example of this disparity in QoL assessment can occur when clients believe that an animal's QoL is better than does the veterinarian, and pursue treatments that the veterinarian considers futile.

"A nine-year-old Great Dane that's been in congestive heart failure for literally two years. This animal is horribly cachectic and literally it's getting its chest drained every week for the last two years … I find that absolutely horrendous, absolutely horrendous … An animal that is wobbling and walking around barely. There is no quality of life there."

The practitioner in the above quote later expressed frustration that his colleague allowed repeated procedures on a dog with a very poor QoL. Presumably, the owner of the dog felt that the dog's QoL was acceptable enough to warrant continued treatment.

Some participants felt that veterinarians were better judges of QoL and that it is the veterinarians' responsibility to make decisions based on these judgements. Below, one veterinarian describes how she had to convince a client that his dog's QoL was poor enough to warrant euthanasia.

"It took a while to convince him that the dog would be better off in heaven than here suffering. And sometimes I think that's our job. That's a really hard thing … to make them make the right decision."

Disparities between the veterinarian's and the client's assessment of QoL of patients may create uncertainty and tension for veterinarians when making decisions based on these assessments.

Discussion

Veterinarians in this study held their own beliefs about which parameters should count in QoL assessments and predictions. In practice, veterinarians rely, sometimes heavily, on information from clients to make assessments. Some practitioners believe that clients are better judges of QoL than are veterinarians; however, other participants challenged this view, claiming that as animal experts, veterinarians are better judges. Veterinarians also recognised that sometimes clients do not appear to make good assessments about their animals' QoL and subsequently make poor decisions about care. These results highlight problems that veterinarians encounter in practice. Who is the best judge of patient QoL? How should veterinarians incorporate client information into QoL assessments? With many veterinary decisions hinging on QoL assessments and predictions, how should veterinarians incorporate their responsibilities to respect client autonomy at the same time as protecting the well-being of patients?

Before entertaining these questions, a brief detour into medical decision-making may be instructive. It is argued that the ideal for decision-making in medicine is a shared effort between patient and physician (Emanuel & Emanuel 1992). The physician provides factual information about possible therapies, with patients supplying information about their own values and preferences (Charles *et al* 1999; Stevenson *et al* 2000). The situation becomes more complicated when patients are incompetent; that is, they are unable to make their own decisions or provide information regarding their values and preferences. Infants, severely mentally challenged individuals, those suffering from dementia and patients in a persistent vegetative state may all be considered incompetent.

Decision-making for incompetent human patients includes two components: (1) who should decide for the patient; and (2) what standards should guide decisions (Brock 1994). To address the first issue, in the absence of an advance directive, a family member seems an obvious choice, as he/she is likely to identify with patient interest and have intimate knowledge of the patient (Beauchamp & Childress 1989). However, physicians may have to "examine the way in which the proxy decision-makers — usually the next of kin — make the decisions in order to assure themselves that it is the product of reflective consideration and not the offhand result of a hasty reaction" (Kluge 1999). Thus, while the choice of decision-maker may seem obvious in most cases (next of kin), at times the choice may need to be based on the quality of the decision-maker's choices.

Two main principles assist decision-makers in guiding decisions: the Substituted Judgement Principle (SJP) and the Best Interests Principle (BIP) (Brock 1994). The SJP suggests that the decision-maker should choose "as the incompetent individual would choose in the circumstances were he or she competent" (Buchanan & Brock 1989). This principle becomes more difficult to apply for patients who were never competent and/or who will never be competent and has been criticised for this reason (Beauchamp & Childress 1989; Kluge 1999). The quality of evidence used to formulate decisions based on what the patient would have wanted becomes very important. The "previously expressed beliefs, values, and goals" are considered, as well as "previous reactions, statements, or written directives" (Tonelli 1997). On the other hand, the Best Interests Principle (BIP) guides a decision-maker to choose "the alternative that best promotes and protects the patient's

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interests" or "the choice that most competent and reasonable persons would make". The BIP is independent of an individual's preferences and instead focusses on the preferences of a generalised population.

These principles may help to frame questions arising in veterinary medicine about QoL and decision-making. Some participants of this research believe that clients are better able to judge the quality of an animal's life than are veterinarians. This belief comes in part from the fact that clients have prolonged access to the patient and are likely to have more information about changes in behaviour, for example. However, this is only part of the picture. Veterinary clients are also able to evaluate patient preferences. Although veterinary patients are incompetent to make medical decisions, they are able to express preferences. This quasi-autonomy, expressed through individual patient preferences, should influence QoL assessments or predictions. For example, a decision to proceed with surgical removal of a large portion of the mandible to treat neoplasia should be influenced by predictions of the dog's QoL. The animal caregiver may have information about how well the patient may tolerate the surgery based on the dog's preferences. This type of surgery may have disastrous consequences for a dog strongly motivated by food, for example. The SJP suggests that surrogate decision-makers should make decisions based on the values, beliefs, and preferences of the patient. As the patient may prefer to spend his time eating or chewing, this surgery may affect this individual's QoL more dramatically than it would that of the average dog. Veterinary clients may have superior knowledge of what a veterinary patient might prefer and thus be better judges with respect to applying the SJP.

In human medicine, surrogate decision-makers are also able to make decisions using the BIP, which adheres to criteria and preferences of a generalised population. Surrogates are purportedly able to judge what a reasonable person would do in similar circumstances. Is this also true in veterinary medicine? Although veterinary clients may be familiar with their pets, they may be less able to make judgements about the patient's best interests under this principle. Veterinary clients may lack specific knowledge about a species or breed, or interpret animal behaviour uncritically. Veterinarians are familiar with how well, in general, animals may tolerate a certain procedure or treatment. For example, a client may request euthanasia because their dog suffers from chronic pain resulting from arthritis. Under the SJP, the client may recognise that the animal will no longer play with a ball, an activity the animal seemed to enjoy in the past. Based on the client's knowledge of the dog's preferences, the client may conclude that euthanasia is in the animal's interests. However, because of their experience with the way arthritic patients often respond to therapy, veterinarians are more able to assess and predict QoL. Thus, veterinarians may be better judges when considering the BIP.

Both veterinarians and clients are able to offer information in assessing and predicting QoL. Tools aimed at assessing QoL and facilitating decision-making in a clinical setting should account for information from both the veterinarian and the client. The manner in which information from both sources is combined presents a larger challenge. As noted above, medical decisions for animals are necessarily paternalistic. To what degree should the preferences of an animal influence decisions about best interests? In order to treat a readily curable condition such as a wound or a fractured limb, an animal's movement may need to be temporarily restricted. Decision-makers may need to override the patient's preference to run freely. However, treating a chronic condition such as diabetes in a difficult and fearful patient might present a more difficult decision.

Moreover, decision-makers are likely to be influenced by personal beliefs, values, and preferences. Companion animal practitioners in this study used different criteria to assess QoL, with many focussing on pain and suffering. Indeed, even within these domains, definitions of pain and suffering were not uniform. Even in human QoL evaluations, where there is no species barrier, healthcare workers and lay caregivers and nurses assess QoL differently (Addington-Hall & Kalra 2001). Both veterinarians and clients should consider how their own beliefs, values, and preferences might influence QoL assessments. More research is needed to compare veterinary assessments and client assessments of QoL and to explore the impact of assessors' personal values on assessments and predictions. QoL assessment tools may include a self-evaluation for assessors to mitigate these influences.

Apart from questions regarding who is the best judge of animal QoL and how to incorporate patient interests and preferences into decision-making, this research raises some questions about veterinarians' responsibilities to patients. As noted above, physicians are responsible for evaluating the decisions made by surrogates and for intervening when appropriate. Do veterinarians have a similar responsibility? In Canada, with the exception of cruelty or neglect, clients are legally entitled to make decisions regarding the care and treatment of their animals. However, from an ethical standpoint, the justification for deferring to clients' decisions is questionable. In veterinary medicine, great emphasis is placed on respect for client autonomy. This principle has strong foundations in professional and medical ethics and it is carried into veterinary medicine and reinforced by the fact that animals are considered property in many jurisdictions (Flemming & Scott 2004). Although veterinary decisions should account for patient preferences, these decisions are usually made paternalistically; that is, they are made *for* the patient in *their* best interests. Under what circumstances should a veterinarian intervene when clients are making poor decisions about animal care?

Rollin (2002) suggests that veterinarians should invoke their Aesculapian authority for the benefit of the animal to prevent convenience euthanasia and encourage euthanasia in cases where continued life is unfair. The circumstances under which veterinarians invoke this authority and the appropriateness of invoking this authority deserve attention.

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Veterinarians seeking to advance the interests of their patients may resort to coercive or manipulative strategies to 'encourage' clients to make good choices (Morgan 2006). Although these strategies cannot be classified as paternalism because their aim is not to benefit the client, they suffer from the same criticisms as paternalism because they undermine client autonomy. The idea that veterinarians should override client autonomy in order to benefit a patient should be differentiated from medical paternalism as it carries ethical problems that are unique to the veterinary profession. A different term such as veterinary 'maternalism' or veterinary 'directiveness' may be useful in identifying instances in which veterinarians are compelled to override client autonomy in order to advance the interests of the patient.

Conclusion

QoL is an important element in veterinary decision-making. As veterinary medicine becomes more technologically advanced and the human–animal bond strengthens, clients are more likely to choose treatments or procedures that will have an impact on patient QoL in both the short term and the long term. Jointly, veterinarians and veterinary clients can provide information to assist in assessing or predicting patient QoL. Assessment tools aimed at accounting for information from both parties as well as assessor biases may provide improved structure for assessments and subsequently for decision-making. Furthermore, the profession should consider how to respond in situations when veterinarians are suspicious of the inadequacy or inappropriateness of client decisions.

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