

THESIS

RESPECT FOR PATIENT AUTONOMY IN VETERINARY MEDICINE:

A RELATIONAL APPROACH

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ABSTRACT

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This thesis considers the prospects for including respect for patient autonomy as a value in veterinary medical ethics. Chapter One considers why philosophers have traditionally denied autonomy to animals and why this is problematic; I also present contemporary accounts of animal ethics that recognize animals' capacity for and exercise of autonomy (or something similar, such as agency) as morally important. In Chapter Two, I review veterinary medical ethics today, finding that respect for patient autonomy is undiscussed or rejected outright as irrelevant. Extrapolating mainstream medical ethics' account of autonomy to veterinary medicine upholds this conclusion, as it would count all patients as "never-competent" and consider determining their autonomous choices impossible; thus welfare alone would be relevant. Chapter Three begins, in Part I, by describing the ways we routinely override patient autonomy in veterinary practice, both in terms of *which* interventions are selected and *how* care is delivered. I also show that some trends in the field suggest a nascent, implicit respect for patient autonomy. Part II of Chapter Three presents feminist criticisms of the mainstream approach to patient autonomy. I argue that the relational approach to autonomy advocated by such critics can be meaningfully applied in the veterinary realm. I advance an approach that conceives respect for patient autonomy in diachronic and dialogic terms, taking the patient as the foremost locus of respect. In Chapter Four, I turn to issues of practical implementation, such as interpreting what constitutes an animal's values and concerns, and assessing the effect of positive reinforcement training on autonomy. The Conclusion offers areas for future research while refuting the objection that a simpler, expanded welfare-based approach would yield the same substantive recommendations as my account.

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INTRODUCTION

In this thesis, I examine the principle of respect for patient autonomy, an important value in human-centered biomedical ethics, and its relevance and usefulness in veterinary medicine. My interest in this topic first arose when, as veterinary director, I was helping to establish a new chimpanzee sanctuary. The chimpanzees were being “retired” from biomedical research after such use of the species was banned in the United States. As a sanctuary, we were committed to putting the chimpanzees and their needs and interests first and foremost. Prior to their transfer to the sanctuary, the chimpanzees’ fates and most aspects of their day-to-day lives had been determined chiefly by human interests and concerns. In recognition of this fact, our team was committed to providing the chimpanzees with many opportunities for personal choice and directing their own lives; in other words, we would strive to maximize their ability to exercise autonomy.

These concerns were to inform all aspects of care-giving and facility planning, and the veterinary department was to be no exception. But, given that veterinary care, however beneficial, was unlikely to be something chimpanzees would choose on their own, how could we respect their autonomy while also meeting or exceeding the highest professional standards, as we aspired? I soon found that I was entering largely uncharted territory in the fields of both veterinary medicine and animal¹ ethics.

In this thesis, I argue that the principle of respect for autonomy can and should be incorporated as a value in veterinary medicine, and that a relational conception of autonomy is needed for the principle to be usefully and meaningfully applied. Over the course of four chapters, I will gradually narrow my discussion from the broader context of autonomy as a general philosophical and ethical topic to the specific case of veterinary patients and the real-world application of respect for patient autonomy, relationally conceived.

¹ Solely for the sake of brevity, this thesis will generally use the term “animal” to refer to animals other than humans. Human beings are of course acknowledged to be a variety of animal.

I review in Chapter One some general arguments for denying autonomy to animals and challenges to these arguments. I present the accounts of several animal ethicists who argue for including respect for autonomy – or something like it – among values important in determining our ethical obligations to animals. In Chapter Two, I survey the existing literature on veterinary ethics to establish what role, if any, might currently be acknowledged for respect for patient autonomy. Concluding that this fails to be an articulated value in veterinary medical ethics, I go on to export to the veterinary case the “mainstream” account of respect for autonomy used in human-centered biomedical ethics. I show that, because of the limited cognitive and linguistic abilities of veterinary patients, such an extrapolation results in the conclusion that respecting patient autonomy is not among the veterinarians’ moral duties.

In Chapter Three, I describe ways in which patient autonomy is routinely overridden in the practice of veterinary medicine, both in terms of *which* veterinary interventions are selected and *how* the resulting necessary care is delivered. I then point to recent trends in veterinary medicine that seem to suggest a nascent but unarticulated move toward respecting the autonomy of veterinary patients. I describe criticisms leveled at the mainstream account of respect for patient autonomy and introduce an alternative conception, namely, a *relational* approach to patient autonomy, that accounts for these criticisms. I show that conceiving of autonomy relationally points the way to meaningfully incorporating respect for patient autonomy as a value in veterinary medicine. Finally, in Chapter Four, I discuss practical applications of this theoretical work, including associated challenges. These challenges include the potential difficulty in interpreting the values or concerns of animals and the effect on animal autonomy of the practice of training animals to voluntarily participate in veterinary procedures.

Why Focus on Autonomy?

Despite my own interest in the subject of respect for patient autonomy in veterinary medicine, one would be right to question whether this is too esoteric an issue to be relevant to ongoing

discussions in animal ethics and veterinary medical ethics. For most of the history of philosophy, animals were considered to “obviously” lack autonomy, a notion so entrenched that many theories explicitly divide human behavior into the contrasting categories of “autonomous action” and “animal behavior.”² Until quite recently, respecting autonomy was not a subject of much concern to animal ethicists, most of whom have placed their emphasis elsewhere, for example, attending to animal suffering. Veterinary medical ethics is quite rudimentary as a discipline and thus offers many areas ripe for philosophical elaboration. So why focus on respect for autonomy as a potential value in veterinary medical ethics?

Exploring this issue is worthwhile for a number of reasons. Recently, several animal ethicists have made compelling cases for considering autonomy or something similar to it – exercising personal choice, exerting some kind of agency – an important capacity of many animals, one which must be given proper consideration and respect in any adequate moral framework. If this is correct, then we should be able apply respect for animal autonomy as a value in the specific case of veterinary medical ethics; after all, respect for patient autonomy is considered central to most accounts in the analogous field of (human) medical ethics. Conversely, if it turns out to be absurd or impossible to respect patient autonomy in veterinary medicine, then this counts against the more general case for counting respect for animal autonomy as ethically important. Thus, veterinary medicine may serve as an important test case for the coherence of more general arguments regarding animal autonomy and the respect it merits.

Competing conceptions of autonomy, including relational conceptions which broaden the notion of what it means to respect autonomy, have been found useful in some (human) medical contexts and in addressing (human) social problems, but are only starting to be explored in animal ethics. As some have pointed out, “the ethical dimensions of sanctuaries are undertheorized,”³ and relational conceptions of autonomy are among potentially useful but neglected tools for this work. To my knowledge, veterinary

² See, for example, Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). New York, NY: Oxford UP. (pp. 102-103).

³ Emmerman, K.S. (2014). Sanctuary, Not Remedy: The Problem of Captivity and the Need for Moral Repair. In L. Gruen (Ed.), *The Ethics of Captivity*. New York, NY: Oxford UP. (p. 219).

medicinal ethics has not explicitly considered relational conceptions of autonomy at all. If, as I suggest, a relational approach to autonomy is applicable to both animals and human beings and suggests concrete and feasible ways in which patient autonomy might be respected by veterinary practitioners, this supports the continued use of a relational approach to autonomy in areas of ethics outside of animal ethics and veterinary medical ethics. In addition, both the theoretical understanding and the practical recommendations that spring from such a conception may also be useful in some human cases, when the model of autonomy used by mainstream medical ethics fails to be adequate. Finally, if it turns out that respect for patient autonomy is among the values we ought to incorporate in the day-to-day practice of veterinary medicine, this opens the door to including this value in questions about what practices or institutions veterinary medicine as a profession should support or oppose.

The Relationship between Welfare and Autonomy

Before embarking on this thesis, it is worth briefly touching on the relationship between welfare and autonomy. Given the historical lack of attention to animal autonomy, this issue has been grappled with primarily with regard to humans. Some theories of human welfare consider autonomy to be among capabilities whose development and exercise enhances human welfare. Others, however, distinguish between an individual's welfare and her⁴ autonomy. In human medicine, for example, these are assumed to be separate considerations, as the physician's duty of beneficence, which entails contributing to her patient's welfare, is distinct from her duty to respect her patient's autonomy. The two obligations may conflict, as when an intervention is likely to improve a patient's health or longevity but does not align with her values or preferences.

The term "animal welfare" has traditionally mirrored the narrower, autonomy-excluding conception of human welfare, focusing on measures such as providing for physical needs, like food,

⁴ In the interest of balancing out the historical androcentrism in philosophy, I will, in this thesis, use feminine pronouns (*she, her, or hers*) when generic gendered pronouns are called for.

water, health care, and an appropriate environment, and minimizing aversive states such as fear, pain, and stress.⁵ However, in certain contexts, “exercise of autonomy” is mentioned as a component of animal welfare, at least for some species. In 1985, the Animal Welfare Act was amended to require consideration of the “psychological welfare of primates,” with the ensuing requirement that captive primates in research facilities be provisioned with “environmental enrichment,” i.e., objects, furnishings, food puzzles, and other items that can be manipulated by individuals and permit variation in their daily activity. While the rationale for providing environmental enrichment was the alleviation of unpleasant mental states, such as boredom, Hal Markowitz, the biologist and animal behaviorist considered the “father of environmental enrichment,”⁶ thought a chief function of environmental enrichment to be providing animals with opportunities to “exercise autonomy.” He defined autonomy as control over one’s environment and one’s own life.⁷ Empirical animal welfare research has examined the value to animals of exerting control over aspects of their lives, documenting, for example, that chimpanzees prefer to use enrichment items that can be controlled or manipulated over those that cannot.⁸ Today, many accept that psychological welfare is affected by the degree to which an animal can exercise choice and control over her environment.⁹

This might suggest that autonomy should simply be incorporated as one more animal welfare consideration, alongside nutrition, hydration, etc. However, I believe this may be too simplistic. While Markowitz was surely ahead of his time to include “autonomy” in the discussion at all, merely providing animals with opportunities to control minor aspects of their lives reflects, in my view, an impoverished understanding of what it means to respect autonomy. It seems to suggest that, as long as we provide

⁵ AVMA *Animal Welfare Principles*. (n.d.) Retrieved from <https://www.avma.org/KB/Policies/Pages/AVMA-Animal-Welfare-Principles.aspx>. Accessed on June 28, 2017.

⁶ Maple, T. L., & Perdue, B.M. (2013). *Zoo Animal Welfare*. New York, NY: Springer. (p. 83).

⁷ Wildlife Conservation Society (2007) *Enrichment Workbook*. (p. 7); Maple T.L. & Perdue, B.M. (pp. 81-82).

⁸ Videan , E.N., Fritz, J., Schwandt , M.L., Smith, H.F., & Howell S. (2005). Controllability in Environmental Enrichment for Captive Chimpanzees (*Pan troglodytes*), *Journal of Applied Animal Welfare Science*, 8 (2), 117-130.

⁹ Wildlife Conservation Society. (pp. 2-4).

some manipulable objects, we can check off the “exercise of autonomy” box on our animal welfare checklist. But, as typically understood, respecting autonomy is a much deeper, broader concept, one that implies respecting someone’s freedom to make choices across disparate aspects of their lives. Understood in this way, we can easily imagine conflicts between animal welfare and animal autonomy.

As will be clear by the end of this thesis, I believe that neither animal ethics nor veterinary medical ethics should be limited to conventional welfare considerations, with no role for consideration of autonomy, as doing so would paint an incomplete picture of our ethical obligations to animals. However, I do not take a position as to whether the exercise of autonomy should ultimately be considered a component of welfare or a separate consideration, regardless of whether the subject of discussion is humans or animals. If we utilize a conception of autonomy that is applicable across species lines, then conclusions about the conceptual relationship between autonomy and welfare ought to be similar between humans and animals, so we might expect veterinary medicine to follow human medicine in keeping considerations of welfare separate from those of autonomy. However, the widespread use of the term “animal welfare” as representing an amalgam of all the interests an animal has may militate in favor of incorporating considerations of patient autonomy as a component of animal welfare.

CHAPTER ONE

Introduction

As authors on the subject frequently observe, the term “autonomy” is used in many different ways across the literature.¹⁰ The term itself may be defined as “self-rule,” as opposed to heteronomy, or rule by other, external forces.¹¹ As an adjective, “autonomous” may describe a choice someone makes, or may describe the agent whose makes choices or takes actions, e.g., an “autonomous person.” In the latter case, it may indicate either that the individual has a *capacity* for making autonomous decisions or that her actions or choices are frequently substantially autonomous.¹² As we shall see, what makes a decision or action autonomous is also contentious, with necessary conditions ranging from very stringent to very permissive. Historically, animals were assumed to lack the capacity to make autonomous decisions, making them (and any actions they might take) non-autonomous. This remains the predominant view today.

While an in-depth discussion of arguments for and against animal autonomy and the moral consideration it deserves is beyond the scope of this thesis, I will use this chapter to briefly outline some of the reasons animals have historically been considered nonautonomous and describe challenges to these conceptions. I will then review some newer accounts that conceive animals as being able to make autonomous choices and that consider respect for animal autonomy an important value in animal ethics.

¹⁰ For example, Natalie Thomas describes eight different “kinds” of autonomy. Thomas, N. (2016). *Animal Ethics and the Autonomous Animal Self*. London: Springer Nature. (p. 72).

¹¹ Wardrope, A. (2015). Liberal Individualism, Relational Autonomy, and the Social Dimension of Respect. *International Journal of Feminist Approaches to Bioethics*, 8 (1), 39.

¹² Friedman, M. (2003). *Autonomy, Gender, Politics*. New York, NY: Oxford UP. (p. 4).

Animals and Kant's Conception of Autonomy

One classic argument that denies all animals autonomy while attributing it to (many) humans originates with Immanuel Kant. For Kant, autonomy is a property of the will of a *rational* being.¹³ In his understanding of the term, *rationality* involves being aware of the grounds for a potential action or end, evaluating these grounds, and then deciding to act or pursue an end only if they are adequate.¹⁴ Another central feature of rational beings, in Kant's view, is the ability to understand and act in accordance with *principles*, or "universal and necessary laws."¹⁵ That is, in deliberating about what action to undertake, a rational being can articulate the rule, or *maxim*, that would underlie the decision to act in that way, and consider whether it could be universalized, or made to apply across all situations, without generating a contradiction or inconsistency.¹⁶ For Kant, morality emerges through rationality, for one can determine the moral status of a potential action through rational reflection, by examining the potential action's underlying maxim, and whether it could be universalized into a principle followed by all without contradiction. Rational agents must have the ability to judge things as good, right, or justified, and must have the capacity to be guided by such normative judgments.¹⁷

It's not difficult to see why Kant holds animals do not qualify as rational and therefore fail to even be candidates for autonomy. Kant seems to believe that animals' actions are guided by nature, rather than deliberation about the grounds for acting. Kant assumes animals lack the capacity for abstraction necessary for appreciating and acting in accordance with principles. Without language, it is difficult to see how a being could hold or consider concepts like *universality*, or applying in all times and places, and *necessity*, or the impossibility of things being otherwise. Or, if non-linguistic beings *could*

¹³ Hill, T.E. (1984). Autonomy and Benevolent Lies. *Journal of Value Inquiry*. 18, 255.

¹⁴ Korsgaard, C.M. (2012) "A Kantian Case for Animal Rights." In M. Michel, D. Kühne, & J. Hänni (Eds.) *Animal Law – Developments and Perspectives in the 21st Century*. Zürich: Dike. (pp. 7-8).

¹⁵ Rollin, B.E. (1976). There is Only One Categorical Imperative. *Kant-Studien*, 67 (1), 63.

¹⁶ *Ibid.*, 63-64.

¹⁷ Sayre-McCord, G. (2015 – draft). Rational Agency and the Nature of Normative Concepts. (p. 1).

somehow consider such concepts, it seems difficult to see how we would know this is the case, for they would be unable to articulate their understanding to us.

Autonomy, for Kant, involves being committed to principles in such a way that one can set and pursue ends in accord with them, regardless of one's desires or other factors such as tradition, instinct, or fear of punishment.¹⁸ That is, one is free to act, rather than being determined by some outside force, and can choose to act in accordance with one's normative judgments.¹⁹ Autonomous beings can respond to reasons, where a *reason* is understood narrowly as a statement invoking universal and necessary principles.²⁰ For Kant, autonomy and morality are inextricably linked, because the principles with which an agent, as an autonomous being, acts in accordance turn out to be principles of morality.²¹

The requirement to respect other rational beings' autonomy is a direct result of the connection between universal principles and morality. The rational nature of another individual is fundamentally the same as mine, the argument goes, and my own rational nature and functioning is of value to me, so failure to respect another's rational nature by subjugating her to my will would result in a contradiction.²² As rational beings ourselves, we are required to respect the autonomous choices of other rational beings, both in allowing them to decide their own actions and in regarding their ends as worthwhile.²³ This means that, if we disagree with someone regarding her choice of action or end, we may use reason to try to sway her, but we cannot force or trick her into adopting our ends instead. To undermine the choice someone has adopted for themselves would be to treat them as a means to our own ends.

Given Kant's account of autonomy and the roots of respect for autonomy, we can see additional reasons why animals do not qualify for either. Animals cannot give abstract, universal principles as their

¹⁸ Thomas (p. 139); Hill 255.

¹⁹ Sayre-McCord 2.

²⁰ Thomas (p. 73).

²¹ Hill 255.

²² Rollin (1976) 68. Hill 255.

²³ Korsgaard (p. 6).

reasons for acting; rather, animals seem to act to achieve ends because they desire them, because they are driven by emotions, or because they are causally determined via biological mechanisms.²⁴ And if they lack the type of rational nature that Kant has in mind, then there is no contradiction in failing to respect their chosen ends or actions, as these have not arisen from the same rational nature that underlies our own ends and action. On the contrary, animals are properly considered merely means to an end on Kant's account, meaning we can use them in order to further the projects, desires, and efforts that we, as rational autonomous beings, have.²⁵

Challenges to and Re-interpretations of Kant's Account

Despite its continued relevance, Kant's account of autonomy has been criticized from multiple different angles. In this section, I will first review Christine Korsgaard's argument that Kant misidentified one of the presuppositions of rational choice. Correctly conceived, she argues, this presupposition leads to the conclusion that animals, even if not rational by Kant's definition, are ends in themselves. Her argument, I suggest, can be extended to show that animals' decisions and actions *prima facie* merit our respect. I then use Geoffrey Sayre-McCord's analysis of Kantian "rational agency" to examine how Kant's underestimation of the mental abilities of animals leads him to postulate, of human and animal decision-making, a difference in kind where there is really only one of degree. Recognizing this lack of an unbridgeable gulf challenges Kant's conclusions that humans but not animals are capable of autonomy.²⁶ Finally, I note the difference between Kantian autonomy and the type of autonomy that (human) medical ethicists are concerned to protect.

²⁴ Hill 255.

²⁵ Thomas (p. 130).

²⁶ In his master's thesis, my fellow graduate student, Eric Easley, makes a related argument. He defends the claim that our current state of knowledge about animal cognition suggests that many animals possess sufficient degrees of reason, autonomy, and self-consciousness, the cognitive capacities underlying "dignity and the ability to meaningfully set ends," to warrant extending direct moral considerability to them. Easley, W.E. (2014). *Of Mice and Kant: Re-examining Moral Considerability to Non-Human Animals on Kant's Cognitive Grounds*.

Korsgaard begins by describing a common interpretation of Kant, one which she argues deeply misunderstands his philosophy.²⁷ Under this interpretation, Kant identifies rationality or autonomy as properties which confer a kind of intrinsic value on their bearers, one which entitles them to be respected. Since humans, but not animals, have these properties, they alone are entitled to this respect, namely, being treated always as an end and never as merely a means. Importantly, this is a type of metaphysical claim: property *x* bestows intrinsic value on being who have it.²⁸

This interpretation is flawed, Korsgaard argues, because one of Kant's major claims is that we, as humans, don't have access to such "metaphysical knowledge" and shouldn't pretend that we do.

Instead,

"Kant thinks that claims that go beyond the realm of empirical or scientific knowledge must be established as necessary presuppositions of rational activity – that is, as presuppositions of thinking in general, or of constructing a theoretical understanding of the world, or of making rational choices. His philosophical strategy is to identify the presuppositions of rational activity and then to try to validate those presuppositions through what he called <<critique>>."²⁹

In this way, Kant thought we could "construct an objective moral system" without having metaphysical knowledge that is out of the grasp of human beings.³⁰ If we remember this, Korsgaard argues, then we will see that Kant is proposing that people, in making rational choices, *necessarily presuppose* their own value – that is, our value as beings worthy of respect is established by the necessity of presupposing it, *not* by our possession of a given property.³¹ What sets us apart as rational beings is our capacity to be guided by what we judge as good;³² since much of what we choose is good *for us*, we must presuppose that *we* ourselves are ends. More generally, Kant thought the "we" referenced here meant *rational beings*; thus the claim that "rational beings are ends in themselves" is a presupposition of rational

²⁷ Korsgaard (p. 6-7).

²⁸ Korsgaard (p. 6).

²⁹ Korsgaard (p. 7).

³⁰ Korsgaard (p. 6).

³¹ Korsgaard (p. 7).

³² Sayre-McCord 1-2.

choice.³³ He suggests that in making rational choices we “presuppose our value only insofar as we are beings who are capable of willing our principles as laws.”³⁴

However, Korsgaard believes this is a flawed conclusion. While rational choice does involve presupposing we are ends in ourselves, this differs from presupposing that “*rational beings* are ends in themselves, for we are not merely rational beings.”³⁵ In other words, Kant mistakenly identified to whom the term “we” refers. In making a rational choice, we only “presuppose our value as beings *for whom* things can be good or bad.”³⁶ But the class of beings for which things can be good or bad is *sentient animals*, not rational beings. Since it is by virtue of our sentience that things can be good or bad for us, the correct presupposition of rational choice is that sentient animals are ends in themselves.³⁷

Korsgaard’s focus is showing that, by Kant’s own lights and correcting for his error in identifying a presupposition of rational choice, animals are ends in themselves because they have a certain kind of subjective experience, specifically one that can be good or bad. She does not address the question of animal autonomy, though, and since she does seem to find the type of rational agency found among humans to be unique, she probably would not argue that her reinterpretation of Kant supports “respect for animal autonomy.” However, if humans’ status as ends is part of the source of our obligation to respect their pursuit of their chosen ends, then considering an animal as an end would also logically entail respecting her choice of what to pursue as an end.

The objection could be made, however, that while rational agency is not necessary for being considered an end, it is essential to the concept of autonomy. That is, autonomy, as the freedom to determine one’s actions, has meaning only for those who can guide their behavior via normative judgments (i.e., rational agents), for otherwise their behavior is already being determined by “non-self”

³³ Korsgaard (pp. 8-11).

³⁴ Korsgaard (p. 11).

³⁵ Korsgaard (p. 1).

³⁶ Korsgaard (p. 11).

³⁷ Korsgaard (pp. 13-14).

forces. Without having an ability to decide what is right and wrong, good and bad, justified or unjustified, directing one's own actions fails to be an exercise of autonomy.

Sayre-McCord tries to bring out exactly what Kant finds unique about rational agents by presenting a series of "successive approximations" of rational agency that show "just how sophisticated an agent might be without being a rational agent in the sense that Kant specifies."³⁸ While he purposely avoids discussing Kant's account of autonomy *per se*, I will argue that his account suggests that the freedom to determine one's actions might be valuable even for those who do not qualify as rational agents. Although Sayre-McCord seems to agree with Kant that the ability to guide one's behavior by one's normative judgments is a uniquely human capacity,³⁹ I question whether this conclusion is at odds with observations of some types of animal behavior and argue that it exaggerates the difference between the everyday decision-making of ordinary humans and that of (some) other species.

Sayre-McCord identifies the ability to act on the basis of representations as a core capacity of rational agents – a necessary, but not a sufficient, condition for Kantian rational agency. Within the class of beings that has this capacity, he identifies four increasingly sophisticated types of agents:⁴⁰

- Stimulus-response agents respond directly to their representations without looking ahead to the future or representing other possible responses, and their representations need not be conscious; robots, plants, and amoebas would likely be relegated to this category, but humans probably also behave as stimulus-response agents at times, such as when we reflexively pull our hand away from a hot stove.
- Planning agents can represent both their current world and how the world might be different as the result of their own intervention; they can represent and choose among different possible courses of action, selecting the most attractive or least repellent course. Many "simple" animals

³⁸ Sayre-McCord 2.

³⁹ Sayre-McCord 1.

⁴⁰ Sayre-McCord 2-6. Note that most of the specific examples are my own.

seem to fall into this category, as they continually make choices about how to satisfy their basic needs for food, shelter, mates, etc. Planning agents, Sayre-McCord notes, “satisfy the principles of standard decision theory,” so would be considered rational by some non-Kantian accounts.

- The strategic agent is distinguished by her ability to represent how others will likely respond to their own representations of her actions, the actions of others, and their own prospective options. Sayre-McCord identifies this level of sophistication with lying or deception, since “lying involves trying to get others to represent things as being a way in which one thinks they are not, and this requires seeing others as representing the world and (presumably) responding to those representations.” This class of agent seems to include at least apes, who effectively alter the behaviors of other individuals by deception; they hide or suppress certain behaviors and communicatory signals (e.g., erections, mating vocalizations, food barks) and feign reactions to redirect another's attention (e.g., staring intently or “alarm barking” at nonexistent stimuli).⁴¹
- The Kantian rational agent is one who represents in normative terms, i.e., an agent who, when judging representations, uses normative concepts such as being good/bad, right/wrong, or justified/unjustified and who has the capacity to be guided by such normative judgments. This capacity is what differentiates acting in a certain way because one believes it is right or good from acting that way for other reasons, like blind acceptance of norms or fear of punishment. Sayre-McCord notes that normative concepts can be moral or nonmoral.

I suspect that Kant, presented with this classification scheme and unacquainted with modern-day advances in cognitive sciences, ethology, and other disciplines, would likely classify animals as stimulus-response agents. He seems to believe that all animals’ actions are guided by instinct, their existence

⁴¹ De Waal, F.B. (1992). Intentional deception in primates. *Evolutionary Anthropology*, 1 (3), 86-92. Retrieved from: <http://onlinelibrary.wiley.com/doi/10.1002/evan.1360010306/abstract>; Personal communication with chimpanzee socialization expert, Michael Seres.

resting “on nature” rather than on their wills.⁴² Were this true, postulating autonomy as an exclusively human capacity would make sense, for choosing cannot be valuable for an agent who does not choose.

However, today the validity and usefulness of the concept of “instinct” is increasingly questioned, as it seems to block inquiry which might lead to a deeper understanding of the causes of behavior. Explanations that stop with a reference to the vague concept of instinct tend to have less robust explanatory and predictive power than those that incorporate learning, cultural transmission of knowledge and skills,⁴³ information the animal has gleaned from highly-attuned sensory modalities, individual preferences and idiosyncrasies, and means-end rationality. Though he seems to want to retain Kantian rational agent status as uniquely human, Sayre-McCord suggests that animals exhibit very sophisticated rational abilities and are far from automatons following each new impulse mindlessly. If animals are planning agents and strategic agents, then we need to reevaluate the idea that their ability to direct their own lives is unworthy of being considered autonomy or of meriting respect.

Besides this, although he seems convinced that humans alone are rational agents, Sayre-McCord’s account of what constitutes a normative concept suggests to me that some animals should also be considered rational agents because they have the capacity to guide their behavior by (at least) nonmoral normative judgments. To show why this is true, I will examine the specific criteria Sayre-McCord puts forth for determining whether a concept is a normative concept and look for examples from the animal world. However, first a brief discussion of the concept of abstraction is needed.

The ability to abstract is necessary for considering actions, norms, etc. under normative concepts, because making normative judgments involves manipulating a specific representation in the

⁴² Korsgaard (p. 3).

⁴³ Johnson, E.M. (2001). Cultural Transmission in Chimpanzees. *Scientific American*. Retrieved from: <https://blogs.scientificamerican.com/primate-diaries/cultural-transmission-in-chimpanzees/>
Gruber, T., Muller, M.N., Strimling, P., Wrangham, R. & Zuberbuehler, K. (2009). Wild Chimpanzees Rely on Cultural Knowledge to Solve an Experimental Honey Acquisition Task. *Current Biology* 19, 1806–1810.

abstract.⁴⁴ To use a classic example, if you are considering falsely telling your teacher that your dog ate your homework so she will not count your assignment as late, one of the first steps in normatively evaluating this possible action (i.e., deciding if it is right or wrong, justified or unjustified) is abstracting it. For example, you can think about “telling a lie to get out of trouble” and see how that squares with your normative concepts. Kant believed that all substantive ethical prescriptions could be deduced via a process of abstraction and checking for universalizability, but we need not go this far to agree that some degree of abstraction is necessary for employing normative concepts.

Humans are very skilled at abstracting, so it is not surprising that Kant assumed the ability to abstract was uniquely human. However, it turns out that many animals have at least some capacity for abstraction. Experimental investigation has shown that a variety of bird and primate species can form abstract concepts and identify novel instantiations of a concept.⁴⁵ For example, pigeons who have been taught to identify which paintings in a set are by Picasso and which are by Monet go on to correctly identify novel paintings by these artists, and even generalize these categories to correctly identify painting by other artists as cubist or impressionist.⁴⁶ To the extent that human language requires and permits abstraction, apes who communicate in sign language and with lexigrams have the ability to abstract. A more everyday example might be salient to parents with both dogs and young children: once the child or the dog has abstracted from her toys to develop the concept of “toy,” the difficult – but achievable, I am told – challenge is to further specify the concepts of “dog toy” and “child toy.”

In any case, we cannot point to universal lack of ability to abstract as a reason to conclude that no animal can employ normative concepts. Sayre-McCord holds that we have grounds for thinking

⁴⁴ Thanks to Katie McShane for clarifying this for me in conversation.

⁴⁵ Daniel, T.A., Wright A.A., Katz J.S. (2015) Abstract-concept learning of difference in pigeons. *Animal Cognition*, 18(4), 831-837.

Magnotti J.F., Wright A.A., Leonard K, Katz J.S., Kelly D.M. (2017). Abstract-concept learning in Black-billed magpies (*Pica hudsonia*). *Psychonomic Bulletin & Review*, 24(2), 431-435.

⁴⁶ Watanabe S., Sakamoto, J., & Wakita M. (1995). Pigeons' Discrimination of Paintings by Monet and Picasso. *J of the Experimental Analysis of Behavior*, 63 (2), 165 – 174.

someone uses a concept when we have reason to believe that “their representations are appropriately sensitive to the evidence they have that the concept in question is satisfied.”⁴⁷ He describes several criteria for determining that a given concept is a normative concept. These are: (1) the standards for applying the concept (representing something is right or good) are always open to evaluation;⁴⁸ (2) when such a standard is met, the agent automatically has a reason for doing (or not doing) something;⁴⁹ and (3) when the concept is in place, the distinction between a “better theory of X” and a “theory of a better X” becomes blurred or disappears.⁵⁰

Based on his account, it seems possible to make the case that animals have at least some normative concepts, for example, *good/bad* and *right/wrong*. Watching an eagle meticulously arrange sticks into a large nest⁵¹ suggests she has in mind a “right” way for the nest to be built. A chimpanzee watching a younger family member attempt to termite fish with the “wrong” tool will sometimes remove it from her hand and replace it with the “right” kind of tool.⁵² Noting that nest building is a behavior that improves with practice,⁵³ and observing a chimpanzee seemingly modify her concept of what qualifies as “good tool” for nut-cracking,⁵⁴ suggests that animals’ behavior-guiding concepts are open to modification. Their concepts provide them with reasons for acting one way and not another. And better theory of termite-fishing tools seems to be a theory of better termite-fishing tools. The ability to critically reflect on one’s actions is not where we will find a decisive difference between (most) humans and all nonhumans.

⁴⁷ Sayre-McCord 7.

⁴⁸ *Ibid.*, 11.

⁴⁹ *Ibid.*, 12.

⁵⁰ *Ibid.*, 15.

⁵¹ Eagle Nest Building – video. Retrieved from <https://www.youtube.com/watch?v=WILDyvS6pY4>

⁵² Jane Goodall Institute. Learning – video. Retrieved from <https://www.youtube.com/watch?v=qyy2ko191s0>

⁵³ Healy, S., Walsh, P., & Hansell, M. (2008). Nest building by birds. *Current Biology*, 18 (7). R271-R273. Retrieved from [http://www.cell.com/current-biology/pdf/S0960-9822\(08\)00066-3.pdf](http://www.cell.com/current-biology/pdf/S0960-9822(08)00066-3.pdf)

⁵⁴ Baby Chimp Learning How to use sticks and stone – video. Retrieved from <https://www.youtube.com/watch?v=LA17w-3MaMQ>

If we are intent to find, between humans and other animals, a difference in kind rather than in degree, Sayre-McCord's account does suggest two possible candidates: (1) the capacity to make and be guided by *moral* normative judgments, and/or (2) the capacity to reason about normative judgements *linguistically*. Even these I am not sure are on completely secure footing. For one thing, at least some apes in human-language studies have employed terms like "good" and "bad."⁵⁵

While these seem to have been used in a nonmoral context, the assumption that animals do not and cannot make moral normative judgments is increasingly questioned.⁵⁶ This is especially true when we compare animal behavior and its apparent motivations with the moral psychology of ordinary humans, rather than idealized versions of moral reasoning such as Kant's. In practice, the type of critical reflection humans use in moral decision-making seems to be less about normative concepts and more about empathy, considering potential harmfulness to ourselves or others, and the background norms that constitute the context of our decisions – all abilities expected of an empathetic "strategic agent." Furthermore, while Kant's account claims that a perfect rational agent would guide her behavior exclusively by reason and not emotion, we now know that humans *require* emotional input for making decisions; destruction of brain centers associated with emotional processing results in an inability to make decisions, moral or otherwise, even when brain centers associated with reasoning are left intact.⁵⁷ Thus, using reason alone to determine one's actions turns out to be impossible.

Carol Gilligan's research on moral psychology shows that reliance on abstraction and universality is more common in men's approach to ethical issues, while women attend more to

⁵⁵ Boehm, C. (2012). *Moral Origins: The Evolution of Virtue, Altruism, and Shame*. New York, NY: Basic Books. Pp. 120-128. Retrieved from: <https://books.google.com/books?id=R7xaq1r0GwAC&pg=PA123&lpg=PA123&dq=kanzi+good+bad&source=bl&ots=mCddivgenD&sig=ksW79ZZWdN4mwBwvPKNeMiwaQKg&hl=en&sa=X&ved=0ahUKEwjT6pOz5ejWAhWj34MKHWVABN0Q6AEISDAF#v=onepage&q=kanzi%20good%20bad&f=false>

⁵⁶ see Frans de Waal's books *Good Natured: The Origins of Right and Wrong in Humans and Other Animals*, *Peacemaking among Primates*, and *Primates and Philosopher: How Morality Evolved*; as well as Marc Bekoff and Jessica Pierce's *Wild Justice: The Moral Lives of Animals*.

⁵⁷ Damasio, A. (2007) Neuroscience and Ethics: Intersections. *American Journal of Bioethics*, 7(1): 3-7.

contextual detail, seeking to resolve issues by looking to the particular details of an ethical conflict.⁵⁸

Equating morality with abstraction-derived prescriptions may thus reflect male bias and the exclusion of women from philosophy, rather than universal truth. When we *do* identify abstract ideals to which people from diverse cultures seek to conform their behavior, we find norms like reciprocity, community cohesion, and fairness,⁵⁹ which are also recognized as behavior- and emotion-guiding in other primate species.^{60,61}

In any case, my purpose here is not to attempt to locate a “uniquely human” capacity, but rather to point out that even if we accept that the ability to be guided by normative judgments is what is essential to autonomy, attributing autonomy to some animals is still justified. More importantly, even if we grant that humans alone can have a special “Kantian autonomy” arising from the capacity of rational agency, it appears that this is *not* the sort of autonomy that (human) bioethicists are concerned with protecting. The autonomy of bioethics, as we will see in the next chapter, does not revolve around whether an agent invokes normative concepts in arriving at her decisions. It may be an interesting question to what degree she acts as a Kantian rational agent, but whether this is her predominant mode of decision-making or whether she relies more on emotions, desires, or societal norms does not factor into whether she qualifies as an autonomous patient. Bioethicists are intent to protect a much broader type of autonomy, basically a patient’s ability to have control over, and adequate understanding of, their health care. Using this kind of conception of autonomy, rather than a highly demanding one like Kant’s, means that ordinary patients are entitled to respect for autonomy and that physicians are not in the business of assessing whether or not a patient’s decision-making involved appeal to normative concepts.

⁵⁸ Friedman, M. (2000). “Feminism in ethics and Conceptions of autonomy.” In M. Fricker & J. Hornsby (Eds.) *Cambridge Companion to Feminism in Philosophy*. Cambridge: Cambridge UP. (p. 206).

Sherwin, S. (1989). Feminist and Medical Ethics: Two Different Approaches to Contextual Ethics, *Hypatia*, 4 (2), 58.

⁵⁹ Intro to Ethics course, Boston University, 1998.

⁶⁰ De Waal, F. (2006). *Primates and Philosophers*. Princeton, NJ: Princeton UP. (pp. 42-49).

⁶¹ *Ibid.*, (pp. 169-173).

Thus, animals' prospects for autonomy on a Kantian account do not bear on whether respect for patient autonomy ought to be a value in veterinary ethics.

Split-Level Accounts of Autonomy

Suffice it to say that, while Kant's view has influenced our current understanding of autonomy, his account is not one that most today would ascribe to, as it circumscribes too narrowly what counts as autonomy and as rationality. Another, more widely accepted account of autonomy is described in the following way by David Richards:

"Autonomy ... is a complex assumption about the capacities, developed or undeveloped, of persons, which enable them to develop, want to act on, and act on higher-order plans of action which take as their self-critical object one's life and the way it is lived...."⁶²

Such an account is sometimes referred to as a "split-level" or hierarchical theory, as it involves two levels of desires: *first-order* or basic desires, which are simple desires to do or avoid something, and *second-order* or higher level desires, which take first order desires as their object. Under such an account, there is autonomy in an act only if the first-order volition motivating it is endorsed by a second-order desire.⁶³ We "rule ourselves" to a lesser degree when our actions or decisions run counter to how we would like to direct them, or when we follow impulses without reflecting on whether we *really* want to do so. Animals are typically presumed to lack the cognitive capacities necessary to take an evaluative stance on their desires, cultivate or otherwise change their desires, or form a conception of the good life that is necessary for assessing one's first-order desires.⁶⁴ Thus, it is argued, they have only first-order desires and therefore fail to qualify as autonomous. In fact, a human's autonomous actions are often contrasted with her "animal behavior," or actions rooted in non-endorsed first-order desires.⁶⁵

⁶² Richards, D.A. (1989). Rights and Autonomy. In J.P. Christman (Ed.) *The Inner Citadel: Essays on Individual Autonomy*. New York, NY: Oxford UP. (p. 205).

⁶³ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (pp. 102-103).

Dryden, J. Autonomy. *Internet Encyclopedia of Philosophy*. Retrieved from: <http://www.iep.utm.edu/autonomy/>

⁶⁴ Frankfurt, H. "Freedom of the Will," quoted in Richards, (P. 205).

⁶⁵ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 103).

However, is this truly a distinction in kind between humans and other animals? It is easy to make assumptions when superficially observing animal behavior or engaging in armchair reflection. Yet, when cognitive scientists, ethologists, and behaviorists observe animals carefully, they often witness animals making seemingly rational choices between competing desires. Many animals appear to be able to suppress even a strong desire when it conflicts with a more important desire. Consider, for example, a mother animal's sacrifice of her own desire for food or rest when it conflicts with protection or care for her young. The actions she undertakes to protect her young are often quite complex, rather than being "programmed" or reflex-like. Primatologists studying apes have identified fairly long range goals, such as accession to power or expanding territory, which seem to underlie many of an individual's choices.⁶⁶ Two chimpanzees living in the same social group and environment will often choose very different lives for themselves, with one individual relentlessly pursuing a leadership position in a group while another apparently takes on the role of peacemaker.⁶⁷ The same individual may also make opposite choices in the same situation because of the social context, like suppressing the desire to mate when a higher-ranking competitor is nearby.⁶⁸ Despite these examples, some critics reply that, at best, they show that animals select between competing first-order desires, rather than suppressing a first-order desire due to a conflicting second-order desire; that is, animals can't *decide* that their desires aren't as they want them to be and then aim to change them.⁶⁹

This question may be open to empirical investigation. It is a type of metacognition, and cognitive scientists have performed studies on other types of metacognition; for example, studies suggest that some animals evaluate their beliefs with regard to their level of certainty.⁷⁰ While cognitive monitoring

⁶⁶ See various works by Frans de Wall, Jane Goodall, and Richard Wrangham.

⁶⁷ De Waal, F. (2000). *Chimpanzee Politics* (revised ed). Baltimore, MD: Johns Hopkins UP. (pp. 106-108).

⁶⁸ Personal Communication, Dr. Jess Hartel, primatologist.

⁶⁹ Streiffer, R. (2014). The Confinement of Animals Used in Laboratory Research: Conceptual and Ethical Issues. In L. Gruen (Ed.), *The Ethics of Captivity*. New York, NY: Oxford UP. (p. 187).

⁷⁰ Smith, J.D. (2009). The Study of Animal Metacognition. *Trends in Cognitive Sciences*, 13 (9), 389-396.

is not identical to cognitive control, this type of evaluation would seem to involve the same type of hierarchal structure of the mind and self-awareness presumably necessary for hierarchal autonomy.

Regardless of whether hierarchal autonomy is a feature of some animals, this conception of autonomy has also been challenged as too demanding as a minimal requirement for autonomy in bioethics. For one, such a conception seems to deny autonomy to actions we typically consider autonomous but which we take despite being aware that they conflict with our “higher level desires” – one author offers the example of cheating on a spouse, despite having a “deeper” desire to honor one’s monogamous commitments⁷¹ – as well as actions that are undertaken by intuition or passion, without rational reflection.⁷² In addition, very strong first-order desires can sometimes generate second-order desires (consider cases of addiction), in which case identifying with the second-order desire fails to be a way of distinguishing autonomous from nonautonomous behavior.⁷³

Marilyn Friedman puts forth a feminist version of a hierarchal theory of autonomy which is less rigid with regard to the type of evaluation an individual must undertake for decisions or action to be considered autonomous. She lists four requirements for a choice or action to be autonomous: (1) it must be partly caused by self-reflection, or the actor’s “reflective consideration of wants and values” that are sustained even in the face of some minimal opposition, (2) it must “mirror” these desires or values, (3) the desires and values must matter to the actor, and (4) her actions and choices must be relatively unobstructed by deception, coercion, and the like.⁷⁴

Friedman’s use of the term “human” and lack of discussion of animals suggests she is not counting animals as candidates for autonomy.⁷⁵ However, examined through an animal ethics lens, her account appears to allow the possibility that at least some behaviors by some animals could count as

⁷¹ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 103).

⁷² Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 101).

⁷³ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 103).

⁷⁴ Friedman, M. (2003). *Autonomy, Gender, Politics*. (p. 14).

⁷⁵ For example, on p 8, she makes reference to “human” self-determination.

autonomous. It is not difficult to see how the latter three requirements might be satisfied by animals. Their actions and choices clearly reflect their desires and what they value, with the connection between the two often being more direct and straightforward than in the human case. An animal's desire for a favorite food or activity certainly matters to them, as evidenced by their often enthusiastic emotional expressions in anticipation of and upon securing the desired thing; Friedman makes it a point to note that connections among emotional responses are enough to "manifest a rational pattern of caring about or valuing something. It is not necessary ... [to] consciously articulate judgments... about the value or importance to her of what she cares about."⁷⁶ Finally, we can easily find some examples in which an animal is deceived into acting in a certain way and others in which she is not.

Showing that animals are capable of self-reflection in the requisite sense may be more challenging. However, a careful reading of Friedman suggests that her understanding of self-reflection is within the grasp of some animals. The necessary type of reflection, she writes, need not be conscious, extensive, or cognitive in the narrow sense – it may also be "affective or volitional and cognitive in a broad sense."⁷⁷ In fact, Friedman's description suggests that an animal who repeatedly pursues or avoids certain things, especially in the face of barriers or other types of opposition, is autonomously choosing these things:

"What matters ... is that emotions and desires ... can constitute a kind of reflection on or attention to objects or values of concern. They can involve evaluations of those objects. In so doing, they can thereby contribute to the autonomy of a person's choices. Reflection is consideration that can involve an attitude of some valenced sort, either positive or negative. When someone's consideration, of whatever mental sort, involves reaffirming what she wants or values as something important to her, and the reaffirmed commitment motivates her behavior, then... she realizes some degree of autonomy."⁷⁸

In recognition of the role of social factors in determining both one's desires and commitments, and one's ability to exercise autonomy, Friedman requires only that the self *partly* determine what one

⁷⁶ *Ibid.*, 9.

⁷⁷ *Ibid.*, (p. 14).

⁷⁸ *Ibid.*, (p. 10).

does and chooses;⁷⁹ it is not possible for choices or actions to be completely self-originating because we all develop in a social setting of some kind which in part shapes what we desire and care about. To satisfy the criterion of being minimally self-reflective, it is sufficient that one's "actions reflect and issue from the deeper, stable, overarching concerns that constitute who she is."⁸⁰ And animals *do* exhibit stable and guiding preferences and patterns in what they value – dog lovers might imagine their dog's joyous expression when they return home, and her deep, contented sigh when she curls up to sleep beside them – so their actions in pursuit of these preferences and values would qualify as autonomous.

As we have seen from the above discussion, the blanket denial of animals' capacity for autonomy is at least questionable. Accounts of autonomy like Kant's and split-level theories that restrict autonomy to only humans (only *some* humans, to be more exact) seem to make false assumptions about the cognitive abilities of animals. They also seem to exclude from the realm of the autonomous many human actions and decisions that we typically consider and respect as autonomous. As we will see, mainstream medical ethics tends to set a fairly low bar for counting decisions as rational and autonomous: a patient's decision is typically considered autonomous and worthy of respect as long as it is intentional, reasonably well-informed, and not coerced, regardless of whether the deliberation that went into it involved abstraction, the consideration of universal and necessary principles, consideration of one's higher order preferences, or self-reflection about one's desires and values. Using a less stringent definition of autonomy, such as governing one's choices and behaviors based on desires, preferences, or emotions originating within oneself, many animals seem to qualify as at least partially autonomy.

⁷⁹ *Ibid.*, (p. 4).

⁸⁰ *Ibid.*, (p. 7).

Accounts of Respect for Animal Autonomy (or Something like It)

Before narrowing in on the issue of autonomy in veterinary medical ethics and (human) bioethics, I will review three recent theories in animal ethics that identify autonomy, or something similar to it, as a capacity that animals can and do exercise, one worthy of ethical consideration. First is Natalie Thomas's argument that a basic level of self-awareness coupled with agency is sufficient to establish a minimal level of autonomy, one which most animals have and which entitles them to moral considerability. The second and third accounts are Josephine Donovan's feminist animal care ethic perspective and Sue Donaldson and Will Kymlicka's citizenship theory, respectively. These latter two accounts do not refer to "respect for animal autonomy" *per se*, but they point to something along the same lines, that is, respecting animal choice and what matters to individual animals, such that animal ethics is not limited to traditional considerations such as decreasing suffering and increasing opportunities for enjoyment. While I believe that each of these accounts offers important insights, the case for incorporating respect for patient autonomy as a value in veterinary medicine does not rest on accepting any one of these views in particular.

Thomas argues that many animals are self-aware agents who can direct their actions toward certain goals. They are *self-aware* in the sense that they have phenomenal awareness, in at least a minimal sense, of both what happens to their bodies and their own beliefs, desires, interests, and preferences – evaluative factors that in turn ground their choices.⁸¹ They are *agents* in that they are selves who are able to make choices, often in ways that are *rational*, or based on reasons – perhaps minimally complex reasons, but reasons nonetheless.⁸² These reasons may encompass an individual's beliefs, desires, and preferences. Like self-awareness, rationality can vary along a continuum; reasons can be more or less complex and can affect

⁸¹ Thomas (p. 37).

⁸² *Ibid.*, (pp. 7-8, 136).

actions to a greater or lesser degree.⁸³ Any being that can control her own actions and pursue her own ends, for her own reasons, values the freedom to self-govern, and this basic self-governance is what Thomas means by a minimal level of autonomy.⁸⁴

Thomas accepts that autonomy exists on a continuum and concedes that (many) humans, by virtue of their complex mental capacities, may be capable of a “richer” sense of autonomy, one which at times involves deep reflection on first-order desires, questioning what has caused them and whether to try and change them. She does not deny that endeavoring to achieve such a “heroic” type of autonomy is worthy.⁸⁵ However, under her conception, a minimal level of autonomy is present even among first-order desires, and beings possessing even a minimal degree of autonomy are entitled to respect for that autonomy. She argues that the type of autonomy we humans value for ourselves is the freedom and ability to make our own choices for our own reasons, and this leads us to “respect autonomy where and when we find it.”⁸⁶ If we accept that human autonomy is worthy of respect, there is no good reason, in her view, not to respect the autonomy of animals as well.

In Thomas’s account, respect for autonomy is not just one additional ethical consideration to add to an account of animal welfare; on the contrary, she believes characteristics of self-awareness and agency, and the autonomy that they make possible, are what makes animals “morally valuable” in the first place.⁸⁷ Thomas proposes expanding more traditional accounts of animal welfare to recognize this. Doing so, she proposes, would shift the focus – what “matters” ethically – from the animal’s interests to the individual “who experiences the thwarting or fulfilment of those interests.”⁸⁸ One consequence is that not all animals of the same species would warrant the same treatment, as desires, preferences, and choices vary from one individual to another. Rather, we would be obliged to expend the time and effort

⁸³ *Ibid.*, (p. 3).

⁸⁴ *Ibid.*, (p. 75)

⁸⁵ *Ibid.*, (p. p 70

⁸⁶ *Ibid.*, (p. 91).

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*, (p. 69).

necessary to understand what an individual may want for herself.⁸⁹ In addition, at least in the case of domestic animals, respecting autonomy also requires finding ways to allow animals to fulfill their desires while protecting them from likely and severe harm. Thomas provides the example of taking her dogs to a park where they can safely run free rather than attempting to respect their autonomous desire to run outside by opening the door to let them dash out onto the highway.⁹⁰

The second account derives from a newer formulation of feminist animal care theory. Originating in the 1980s, care ethics holds that ethical frameworks centered on principles, rights, and justice are inadequate for fully appreciating the ethical dimensions of many situations. Such frameworks, care ethicists argue, result from the historical exclusion of women, society's principle caregivers, from philosophical discussions. Care ethicists emphasize the importance of caring, empathy, relationships, and context in ethical decision-making. They maintain that to fully understand a situation's ethical dimensions, we must pay attention to parties' relationships and responsibilities to one another.⁹¹ Feminist animal care theory extends these conclusions to animal ethics, arguing that compassion and emotional responses to animals and the particularities of a given situation are important in determining what is morally acceptable.⁹²

Josephine Donovan emphasizes that feminist animal care theory must involve a "dialogical method." That is, ethical reasoning must proceed as a dialogue *with* animals, rather than a monologic process in which we merely think "about" them.⁹³ By "dialogical method," what she calls for is paying attention to animals' communications and responding to them in an evolving conversation of sorts, rather than "imposing on them a rationalistic, calculative grid of

⁸⁹ *Ibid.*, (p. 5).

⁹⁰ *Ibid.*, (p. 93)

⁹¹ Donchin, A. & Scully, J. (2015). Feminist Bioethics. In E.N. Zalta *The Stanford Encyclopedia of Philosophy*. Retrieved from <https://plato.stanford.edu/archives/win2015/entries/feminist-bioethics/>

⁹² Donovan, J. (2006). Feminism and the Treatment of Animals: From Care to Dialogue. *Journal of Women in Culture and Society*, 31 (2), 306. Retrieved from:

http://fewd.univie.ac.at/fileadmin/user_upload/inst_ethik_wiss_dialog/Donovan_Josephine_2006_Animals_From_Care_to_dialogue_9511932.pdf

⁹³ *Ibid.*

humans' own monological construction."⁹⁴ Including animals' communications in our deliberations, she writes:

"is not so much ... a matter of caring for animals as mothers (human and nonhuman) care for their infants as it is one of listening to animals, paying emotional attention, taking seriously – *caring about* – what they are telling us."⁹⁵

While Donovan does not articulate her view in terms of autonomy *per se*, her emphasis on determining and valuing an animal's own preferences and feelings are quite close to what I (and other authors like Thomas) have in mind as far as "respecting animals' autonomy." Her point is that our ethical assessment of the situations often cannot be wholly determined from "the outside," by an assessment of, for example, a list of objective welfare standards. We must also include the individual animal's perspective about how she wants her own life to go.

Donovan points out that caring about animals motivates us to understand their desires and feelings, as they are communicated by behavior, vocalizations, and "all communicative signs detectable by the human brain."⁹⁶ Even if we cannot know *exactly* what the animal's desires are, we can often understand enough about her experience to formulate an adequate ethical response.⁹⁷ For example, she presents the fleeing of a deer from a hunter as a communication that he or she does not want to be injured or killed.⁹⁸ Interacting over time with a particular individual can increase one's understanding of what that individual's postures, behaviors, and other expressions signify, especially in the case of idiosyncratic exchanges specific to the relationship.⁹⁹

A final recent approach to animal ethics is that of Sue Donaldson and Will Kymlicka. They propose an ethical theory based on extending citizenship theory to nonhuman animals, thereby recognizing them as significant members of human-animal society who ought to have a role in shaping

⁹⁴ *Ibid.*, (p. 306).

⁹⁵ *Ibid.* (p. 305).

⁹⁶ *Ibid.*, (pp. 309, 313).

⁹⁷ *Ibid.*, (p. 321).

⁹⁸ *Ibid.*, (p. 316)

⁹⁹ *Ibid.*, (p. 322)

the norms of that society.¹⁰⁰ They criticize several other approaches to animal ethics as denying that animals have vital interests in autonomy and self-determination.¹⁰¹ Domesticated animals, they write, are similar to other disadvantaged groups in society in that they are acutely vulnerable to “unjustified paternalism,” or having their own decisions and preferences overridden ostensibly for their own good.¹⁰² Unlike some animal ethicists who see no way around this issue as long as animals remain dependent members of human-animal society, Donaldson and Kymlicka (henceforth D & K) believe humans can enable animals to have a role in authoring the rights and responsibilities of citizenship that their model calls for.

D & K tend to use the term *agency*, rather than *autonomy*, but their meaning is quite similar to mine. Agency, for them, is “self-willed, or initiated action which carries an expectation of efficacy.”¹⁰³ It involves self-determination, in the sense of making or causing things to happen, whether the “things” happen directly through one’s own behavior or indirectly through the behavior of another. They offer the example of a cat meowing for her supper; if it is produced upon her request, “she has exercised agency. If I ignore or misunderstand her requests... then her agency has been thwarted.”¹⁰⁴ What D & K mean by “enabling someone’s agency” is essentially what I have in mind when I refer to promoting or respecting that individual’s autonomy.

While “enabling” has a different meaning than “respecting,” the congruence of these concepts makes when we invoke a *relational* account of autonomy, that is, one which recognizes the extent to which one’s autonomy is a product of one’s various social relations, the focus of Chapter Three of this thesis. Catriona Mackenzie and other feminist authors argue against equating autonomy with self-

¹⁰⁰ Donaldson, S. & Kymlicka, W. (2012). Citizen Canine: Agency for Domesticated Animals. Presented at "Domesticity and Beyond: Living and Working with Animals" conference, Queen’s University. 1. Retrieved from: https://www.academia.edu/2394661/Sue_Donaldson_and_Will_Kymlicka_Citizen_Canine_Agency_for_Domesticated_Animals_2012

¹⁰¹ *Ibid.*, 2.

¹⁰² *Ibid.*, 3.

¹⁰³ *Ibid.*, 6.

¹⁰⁴ *Ibid.*

sufficient independence, as this implies that dependence on others entails a lack of autonomy.¹⁰⁵ They point out that one's capacity for self-determination *always* depends to some degree on "interpersonal, social, and institutional scaffolding";¹⁰⁶ one's social milieu determines one's available options, whether one is in a position to make choices, and whether one's status as a decision-maker is recognized. D & K extend these conclusions to animals. They argue that the dependence of domesticated animals on humans does not obviate the possibility of them acting as agents. Their subjective good can be articulated by their human caregivers and can be incorporated into decisions that affect them individually or as a group.

Facilitating animals' agency may involve ensuring they "have a say" in the construction of infrastructure, laws and policies, and social norms that affect them. One example is design and engineering of social spaces. Recall Thomas's solution to the potential conflict between respecting her dogs' preference to run freely while protecting their safety: she takes them safely to the park but keeps them off the highway. D & K describe how Denmark dealt with a similar conflict between restricting (human) children's mobility and freedom for the sake of their safety by creating more "car-free spaces," thereby restricting cars rather than children. A similar approach might be taken to promote animal agency on the societal rather than individual level.

D & K draw an important distinction between *macro agency* and *micro agency*, a topic we will return to in Chapter Four. Micro agency encompasses choices animals make within relationships whose purposes have already been defined by humans. Their example is training animals for sports or other specialized activities which are chosen and directed by humans, but allow the animal to engage in an increased amount of choice-making. Providing captive animals with environmental enrichment that they

¹⁰⁵ Mackenzie, C. (2014). The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability." In C. Mackenzie, W. Rogers, & S. Dodds (Eds.) *Vulnerability: New Essays in Ethics and Feminist Philosophy* (33-59). New York, NY: Oxford UP.

¹⁰⁶ *Ibid.*, 42.

can choose how and when to manipulate, as discussed in the Introduction, could also be considered an instance of enabling animals' micro agency.

Macro agency, on the other hand, involves being able to "jointly author" the conditions of one's relationship and being able to make the choice to remain in or leave the relationship. D & K point out that we often assume that domesticated animals are incapable of macro agency, that is, that by virtue of their very domestication, they lack the capacity to determine the fundamental shape of their lives. Most people seem to assume that domesticated animals' "macro frame is...fixed by their evolutionary history and/or species nature, pre-determining a life of rigid dependence on humans and human society."¹⁰⁷ However, D & K argue that the human(s) on whom domesticated animals are dependent can enable them to exercise some aspects of macro agency by ensuring that they have "a meaningful right of exit... rather than forced participation" in human-animal society and by providing options for them to choose from among a spectrum of choices for the shape of their lives.¹⁰⁸

Another component of D & K's discussion that is especially pertinent to this thesis is the epistemic issue of knowing what an animal's subjective good is or would be: how can we know what she prefers or which option she would choose, without being able to discuss this in a human language?¹⁰⁹ Though they acknowledge the "difficulties involved in preventing errors and the cooption of the discourse," D & K go on to offer a variety of means we have available.¹¹⁰ They argue that communication around this is not a theoretical and practical impossibility, as often assumed. Rather, as children, humans are often naturally good at understanding animal communications; it is socialization into "human supremacy," they argue, that causes us to "forget," as we are taught that what the animal is communicating about her wants is not important. They also note that the discipline of animal behavior,

¹⁰⁷ Donaldson, S. & Kymlicka, W. (2012). *Citizen Canine: Agency for Domesticated Animals*. (p. 6).

¹⁰⁸ *Ibid.*, 3.

¹⁰⁹ *Ibid.*, 5.

¹¹⁰ *Ibid.*

a field that is currently recognized as a specialty in veterinary medicine, offers an additional tool for the successful interpretation of animal communication.

Each of these accounts has a different emphasis stemming in part from the traditions from which they spring. Regardless of its specifics, adopting an account of animal ethics that values autonomy or agency, rather than solely welfare, promises to be useful in practice on a number of levels. For animal caregivers, adopting such a perspective may, as philosopher Katie McShane points out, better counteract the biases and “wishful thinking” that people are prone to: “It might be easier to convince yourself that an animal in a lab cage is well-cared-for than to convince yourself that the animal would choose to be so-caged.”¹¹¹ The fact that it is psychologically easier to deceive oneself about what is “good” for someone than about what they will (or would) consent to may be one of the reasons that social movements against oppression of certain groups of humans have relied on appeals to autonomy. Similarly, advocacy efforts aimed at improving society’s treatment of animals may benefit from incorporating autonomy considerations into their arguments.

From Respect for Animal Autonomy to Respect for Veterinary Patient Autonomy

One need not accept Thomas, Donovan, or D & K’s specific defenses of the ethical value of animal autonomy or agency to entertain the topic of this thesis. One also need not adopt the term *autonomy* to critically assess my arguments— some may prefer to speak of *agency* or *the right to make personal choices*, in the words of animal ethicist Frédéric Côté-Boudreau.¹¹² If one accepts even the

¹¹¹ Katie McShane personal communication.

¹¹² Frédéric Côté-Boudreau is an up-and-coming philosopher whose focus is on the right to make personal choices and shape one’s own life, and the applicability of this right across species boundaries. He argues that the criteria for holding this right are the abilities to take care of oneself and to follow one’s subjective good. These abilities, he argues, are learnable and consistent with the reality that individuals’ personal choices may merit respect in some situations or aspects of their lives, but not others. He sees effective choice-making as one interest among many that both animals and humans have, and as rooted in a more general interest in not being dominated. It was his dissertation proposal which initially directed me to the works by Donovan and D & K cited above. Frédéric Côté-Boudreau. “Animals, Autonomy, and the Right to Make Personal Choices.” (Dissertation Proposal for Queen’s University Department of Philosophy.) Accessible at:

relatively unambitious premise that the choices and desires of animals ought to matter ethically in some way, then – given the centrality of respect for patient autonomy in (human) medical ethics – this ought to justify exploring of the prospects for incorporating a similar value in veterinary medical ethics.

Such an exploration is all the more justified when we consider that many of those who advocate for incorporation of respect for animal autonomy in animal ethics nonetheless seem to assume that overriding animal autonomy is unproblematic if done in the name of veterinary care. Providing veterinary care is a moral obligation we have to animals in our care, and the assumption seems to be that sacrificing autonomy is inevitable in the course of administering veterinary care. For example, Donovan writes:

“A dialogic ethics does not assert that the animal’s position should be the only matter taken into consideration or that the human should automatically comply with the animal’s wishes. Ethical decision making is in fact made dialogical by the introduction into the conversation of factors the human knows beyond the animal’s ken, which may be relevant to the ethical choice. In the case of domestic animals for whom one has assumed responsibility, such factors might include, for example, a decision to give one’s companion animal a vaccination, even though one knows the animal doesn’t enjoy going to the vet or receiving a shot. One nevertheless decides in this case to override the animal’s immediate wishes because one sees that the animal’s suffering is likely to be minimal and temporary and that the long-term result is likely to be beneficial to the animal, saving her from worse pain and suffering.”¹¹³

Though Donovan clearly values the animal’s desires and preferences, in the case of veterinary interventions with a high likelihood of benefit and low risk of harm, she seems prepared to accept as unproblematic a paternalistic solution: overriding the animal’s wishes for the animal’s own benefit.

Similarly, Thomas seems to consider it unproblematic to override animal autonomy in the veterinary context:

“Cases where we might override someone’s autonomy would include harm to themselves or potential harm to others, and this would only occur under very serious

http://www.academia.edu/13598429/Animals_Autonomy_and_the_Right_to_Make_Personal_Choices_Dissertation_Proposal_2015_

¹¹³ Donovan 317.

and exceptional circumstances. Examples of this could include treating an animal medically, even if it means reducing their autonomy for a period of time....”¹¹⁴

Both of these authors seem to assume that, given the welfare stakes involved and animals’ limited ability to understand the benefit of medical interventions, decisions about veterinary interventions involve a choice between only two alternatives: *either* respect the animal’s autonomy *or* provide them with the medical care which is likely to improve their welfare. As I will discuss later, this is a construal I have also found in sanctuaries that value promoting animal autonomy.

Summary and Looking Ahead

My purpose in this chapter has been to uncover the origin of the assumptions that animals do not qualify as autonomous beings or that they are incapable of exercising autonomy, challenge this assessment, and to present various contemporary arguments that respect for animal autonomy (or something like it) can and should have a role in animal ethics. From the approaches described, I hope that a sense has emerged of what I mean by *autonomy* in this thesis. It refers to making decisions and initiating actions that shape one’s life in small and large ways, for one’s own reasons. An animal ethics that incorporates respect autonomy does not limit its concern to strictly welfare considerations, such as minimizing suffering or providing for the expression of species-typical behaviors. Rather, it seeks understand what matters to individual animals and recognizes an obligation to enable animals to make large and small choices about their lives.

As we will see in the next chapter, conventional veterinary medicine and mainstream medical ethics have thus far failed to acknowledge autonomy as a consideration when it comes to veterinary patients. Veterinary medical ethics currently says little to nothing about patient autonomy. Despite biomedical ethics setting a lower bar for autonomy than some of the accounts reviewed in this chapter, the mainstream account of autonomy provided by this field, when exported to the veterinary realm,

¹¹⁴ Thomas (p. 106).

results in the conclusion that captive animals fail to qualify as competent, or sufficiently capable of autonomous medical decision-making. As conceived by Tom Beauchamp and James Childress, the major proponents of the mainstream account,¹¹⁵ veterinary patients' status as "never-competent" relieves practitioners of the duty to respect their autonomy, replacing it instead with the responsibility of consulting a surrogate who will use welfare standards alone to make decisions for the animal.

¹¹⁵ Ells, C. (2001). Shifting the Autonomy Debate to Theory as Ideology. *Journal of Medicine and Philosophy*, 26 (4), 417.

CHAPTER TWO

Introduction

As we saw in Chapter One, although philosophers have traditionally denied that animals have the capacity for autonomy, the grounds of this assumption have recently begun to be questioned. Several animal ethicists now consider animal autonomy or agency a relevant moral consideration, either adding to or underlying more traditional, welfare-based concerns. However, even those persuaded that an animal's exercise of autonomy is morally valuable often assume that protecting or improving health through veterinary care requires and justifies overriding autonomy through paternalistic intervention.

In this chapter, I turn to the dominant ethical frameworks in (human) medicine and veterinary medicine. First, I will survey veterinary ethics, paying particular attention to the role of respect of autonomy.¹¹⁶ Then I will describe what I take to be the "mainstream account" of respect for autonomy in human medical ethics and then extrapolate it to the veterinary realm to see what the prospects are for incorporating a similar value in veterinary ethics. Because of some key similarities between pediatrics and veterinary practice, I will occasionally consult the pediatric medical ethics perspective.

Frameworks in Veterinary Medical Ethics

As a discipline, veterinary ethics is substantially less developed than human medical ethics, especially with regard to the practitioner's obligations to her patients. To get a sense of the dominant views regarding this issue, I will examine the American Veterinary Medical Association's Principles of Veterinary Medical Ethics and the perspectives of the two preeminent philosophers in the field, Bernard Rollin and Jerrold Tannenbaum. As we will see, despite the central role that respect for patient

¹¹⁶ In this thesis, the term "client" will refer to the human client of a veterinarian (often referred to as "owner" or "pet parent" in companion animal practice). The veterinary patient is the animal being evaluated or treated by the veterinarian. Caregivers may be clients or other humans who tend to a domesticated or captive animal's needs.

autonomy currently plays in human biomedical ethics, the concept receives scant mention in veterinary medical ethics – though respect for *client* autonomy is sometimes discussed. These accounts differ in what they see as the proper relationship between the veterinarian and client and between the veterinarian and the patient. Ezekial Emanuel and Linda Emanuel have pointed out that, in human medical ethics, different models of the physician-patient relationship also exist, with autonomy being conceived differently by each model.¹¹⁷ I will draw on their analysis to help discern when the standard veterinary accounts may be appealing implicitly to certain conceptions of autonomy or respect for autonomy to undergird their recommendations.

The American Veterinary Medical Association (AVMA) describes nine Principles of Veterinary Medical Ethics.¹¹⁸ Most principles do not directly discuss the specific obligations of the veterinarian to the patient, but those that do refer to the “welfare” or health of the animal, and the importance of compassion. While the concept of welfare is never defined, the surrounding discussions suggest that the AVMA conceives of welfare primarily in the negative; that is, welfare is that which is impinged upon by disease, suffering, disability, fear, and pain. It can be promoted by the minimization of these factors.

Autonomy is not mentioned outright in any of the Principles, but respect for the client’s autonomy is presumably the value underlying the ethical obligation of the veterinarian to “inform the client of the expected results and costs, and the related risks of each treatment regimen.”¹¹⁹ As we shall see, providing adequate information for decision-making is often cited as a crucial aspect of respecting patient autonomy in human medicine. However, the injunction as described in the AVMA Principle falls short of stringent requirements for obtaining the informed consent of human patients. Despite the requirement to provide some essential information to the client, the Principles seem to leave medical

¹¹⁷ Emanuel, E.J. & Emanuel, L.L. (1992). Four models of the physician-patient relationship. *Journal of the American Medical Association*, 267 (16), p 1-13.

¹¹⁸Principles of Veterinary Medical Ethics of the AVMA. Retrieved from:

<https://www.avma.org/kb/policies/pages/principles-of-veterinary-medical-ethics-of-the-avma.aspx>

¹¹⁹ *Ibid.*

decision-making solely up to the veterinarian, stating, “Attending veterinarians are responsible for choosing the treatment regimen for their patients.”

Given the lack of an explicit role for client or patient values, the veterinary-client and veterinary-patient relationships the Principles seem to endorse are equivalent to what Emanuel and Emanuel refer to as the *paternalistic model* of physician-patient relationship in human medicine.¹²⁰ Under this model, the correct or best medical decision is assumed to be determinable solely by reference to “shared objective criteria,” without any need for consideration of the patient’s (or, in veterinary medicine, the client’s or patient’s) subjective values. To the extent that respect for autonomy plays any role under the paternalistic model,¹²¹ patient autonomy is construed as the patient’s (or client’s) assent, now or at a later date, to the physician’s recommendations and the “objective values” on which they are based. In human medicine today, such a paternalistic physician-patient relationship is considered appropriate only in limited situations, like emergencies, where the need to provide immediate care precludes any significant discussion of the patient’s values.¹²²

Bernard Rollin, a well-known scholar in the field of animal and veterinary medical ethics, has delved far deeper into the philosophical aspects of veterinary medical ethics. He describes several classes of veterinarians’ ethical obligations: those owed to clients, to peers in the profession, to society in general, to veterinarians themselves, and to patients. He notes that obligations to patients are the most obscure class, largely because our society has an inchoate and shifting “social ethic” when it comes to animals.¹²³ As a whole, society as a whole – at least as judged by its current laws – requires little in the way of ethical treatment of animals beyond barring deliberate and unnecessary cruelty to animals.

¹²⁰ Emanuel and Emanuel 3.

¹²¹ A detailed discussion about a closely related topic, paternalism, will be undertaken in Chapter Four.

¹²² Emanuel and Emanuel 5.

¹²³ Rollin, B.E. (2006). *An Introduction to Veterinary Medical Ethics: Theory and Cases* (2nd ed.). Ames, IA: Blackwell Publishing. (pp. 14-15).

Because the social ethic gives little guidance to veterinary professionals in this arena, Rollin argues, the veterinarian's personal ethic plays an important role in shaping what she sees as her obligation(s) to her patients. Unfortunately, at least in my own experience of veterinary school (2004-2008), encouraging students to develop their personal ethic was not always prioritized and, at times, even seemed to be frowned upon.¹²⁴ Like most other scientific fields, veterinary medicine was historically influenced by logical positivism, particularly its conceptually confused notion that science must be "value free";¹²⁵ this may explain why ethical reflection was not encouraged in veterinary programs for much of the twentieth century. With the fall of logical positivism, many have realized that values cannot be separated from the enterprise of science, as there are invariably *some* values that are accepted, and denying this fact only obscures evaluation of the values in play. Rollin points out that as society as a whole has begun to express concern for assuring that the animals we use "live decent and happy lives",¹²⁶ it is becoming more acceptable, and even expected, for veterinarians to explicitly address ethical dimensions of practice. To this end, AVMA has recently convened an Animal Welfare Committee, and animal ethics is a central concern of professional organizations such as the Humane Society Veterinary Medical Association and the Society for Veterinary Medical Ethics.

Rollin argues that the fundamental moral question for every practitioner is "To whom does the veterinarian owe primary obligation: animal or owner? Ought the model for the veterinarian be the pediatrician or the car mechanic?"¹²⁷ That is, whose interests come first or, perhaps, count at all? Rollin recommends the pediatrician model, seeing the veterinarian's role as a patient advocate first and

¹²⁴ For example, when I requested permission to obtain an ethically-sourced cadaver for dissection in Equine Anatomy, rather than use the cadaver of one of the healthy ponies routinely sacrificed for use in the course, I was required to agree to permanently withdraw from veterinary school if a suitable cadaver could not be obtained in time. Fortunately, I was able to locate and arrange for donation of two such cadavers in the months leading up to the class. When I expressed, in a survey distributed by the administration to students, my opinion that such a threatening response discouraged ethical growth and integrity, I was sharply reprimanded for my comments.

¹²⁵ Rollin, B.E. (2006). *An Introduction to Veterinary Medical Ethics: Theory and Cases* (2nd ed). 27.

¹²⁶ *Ibid.*, (p. 38).

¹²⁷ *Ibid.*, (p. 17).

foremost. He points out that, while the vast majority of today's veterinarians would likely ascribe to the pediatrician model, the social ethic toward animals has historically promoted the mechanic model.^{128, 129}

While Rollin maintains that determining what is in the "best interest" of an animal, in a global sense, may be difficult or impossible in many cases,¹³⁰ he believes animal welfare can be effectively protected if we focus on respecting the animal's *telos*, or fundamental nature.¹³¹ *Telos* encompasses an animal's evolutionarily- and genetically-determined functions and activities.¹³² Rather than construing animal welfare merely as the absence of pain and suffering, as the AVMA does, Rollin sees animal welfare as ensuring animals can engage in species-typical behavior and live a life that is in line with common sense understandings of what is essential about that type of creature – e.g., respecting the "dogness" of a dog, the "pigness" of a pig. That society is increasingly concerned with respecting animals' *telos* in our interactions with them can be seen, he notes, in trends in legislation. He points to, for example, the legal mandate to ensure primate psychological well-being in research facilities and the movement in zoos to create environments that address the needs of the animals rather than merely being pleasing to the human eye.¹³³

While *telos* is a common sense notion, Rollin argues that their expertise enables veterinarians to recognize more readily when *telos* is being violated. In addition, their status as "experts" combined with the ethical commitments to animal welfare engendered by their professional role serve to give veterinarians greater power to speak up for and intervene on behalf of animals. Although the moral and legal status of animals in society means that their treatment is often left to the personal ethic of their "owners" (the veterinarian's clients), Rollin argues that veterinarians can and should use the

¹²⁸ *Ibid.*, (p. 27).

¹²⁹ In my own experience, at least some practitioners of "production" or "food animal" medicine continue to ascribe to the mechanic model.

¹³⁰ *Ibid.*, (p. 63).

¹³¹ *Ibid.*, (p. 35).

¹³² Rollin, B.E. (2006). *Animal Rights and Human Morality* (3rd ed.). New York, NY: Prometheus Books. (p. 100).

¹³³ Rollin, B.E. (2005). Ethics of critical care. *Journal of Veterinary Emergency and Critical Care*, 15 (4), 235.

Aesculapian authority¹³⁴ with which they are endowed as healers to discourage clients from pursuing interventions or maintaining animals under conditions contrary to their welfare.¹³⁵ Not only do veterinarians owe this duty to their patients directly, he says, they are expected by society to “champion animal welfare and lead in welfare reform... with regard to all animals.”¹³⁶

Defining animal welfare in terms of *telos* and asserting a strong role for the veterinarian in terms of serving as patient advocate leaves open the possibility of a veterinary obligation to respect patient autonomy. After all, if an animal of a given species and level of development typically exercises (at least some) autonomy or agency, promoting this would presumably be an important part of respecting his or her *telos*. However, as presented, Rollin’s account does not explicitly require incorporation of respect for patient autonomy as a value. *Telos* appears to be determinable by reference to species, rather than individual characteristics – and there may be disagreement regarding what constitutes the *telos* of a given species.¹³⁷ In Rollin’s examples, ascertaining the individual patient’s desires or values is not mentioned as part of the process of the veterinarian determining what recommendations to make. Rather, ethical decision-making about veterinary care can proceed by “external” evaluation of health related factors and apparent fulfillment or frustration of *telos*. Finally, Rollin does not discuss ethical issues regarding the *delivery* of veterinary care, which – as we shall see – is often the context in which veterinary patient autonomy is most dramatically overridden.

Rollin’s discussion does seem to acknowledge, if obliquely, an obligation to respect client autonomy. I suspect this is a reflection of the fact of that, in our society, clients are typically the ultimate deciders when it comes to which veterinary interventions to pursue, rather than an endorsement of the idea that clients are always the best decision makers for veterinary patients. Rollin maintains that, once

¹³⁴ “Aesculapian authority” refers to the respect, power, and privilege that are accorded veterinarians and other health professionals by virtue of their training and expertise in medical matters.

¹³⁵ Rollin, B.E. (2006). *An Introduction to Veterinary Medical Ethics: Theory and Cases* (2nd ed.). Ames, IA: Blackwell Publishing. (pp. 87-88).

¹³⁶ Rollin, B.E. (2005). Ethics of critical care. *Journal of Veterinary Emergency and Critical Care*, 15 (4), 237.

¹³⁷ Thomas (p. 119).

the veterinarian has determined which intervention(s) would most benefit the patient, she ought to work to persuade the client to take this route, ideally by invoking the client's own values. This type of veterinarian-client relationship is similar to the "deliberative model" of physician-patient relationship discussed by Emanuel and Emanuel. Under this model, the patient (or, in this case, the client) acts autonomously when they (1) consider their own values as well as other, health-related values, (2) understand the relation of these values to potential medical interventions, and (3) engage in moral deliberation with these factors in mind. Under this model, veterinary practitioners respect their client's autonomy when they get to know the person, introduce health-related values she may not have considered, and facilitate her moral deliberation.¹³⁸ Of note, the deliberative model is the one recommended by Emanuel and Emanuel for most physicians and patients in human medicine.¹³⁹

The final major text on veterinary ethics is Jerrold Tannenbaum's *Veterinary Ethics*. Tannenbaum maintains that when confronting ethical problems in veterinary medicine, all parties actually or potentially affected by a given issue should be considered, including the veterinary patient, other animals, the client, other clients or members of the public, the veterinarian(s) involved, other veterinarians, and other individuals involved in providing veterinary care, such as veterinary technicians.¹⁴⁰ Unlike Rollin, Tannenbaum does not rank a veterinarian's obligations to her patient as higher than obligations to other parties. In fact, he explicitly defends the claim that (all) humans are "superior in moral value and status" to (all) nonhuman animals, thereby justifying the attachment of greater moral weight to human interests.

Among the factors that are relevant to our ethical reasoning about veterinary patients, Tannenbaum presents an account of several interests that animals may have. One is an interest in "not suffering pain, or a certain kind of negative psychological state," especially if the state is intense and

¹³⁸ Emanuel & Emanuel 2-3.

¹³⁹ Emanuel & Emanuel 6-8.

¹⁴⁰ Tannenbaum, J. (1989). *Veterinary Ethics*. Baltimore, MD: Williams & Wilkins. (pp. 88-89).

long-lasting. He seems to acknowledge that animals have both physical and emotional subjective experiences, which can interact; for example, anxiety and fear can make the experience of pain worse and can persist after the pain has disappeared, potentially being more unpleasant than the initiating physically painful experience.¹⁴¹ Tannenbaum also acknowledges that animals may have an interest in experiencing pleasure, under which he includes the exercise of curiosity and the fulfillment of basic biological drives.¹⁴² In line with his commitment to attaching greater moral weight to human interests, he makes a point of noting that “animal pleasures might not weigh heavily against human needs.”¹⁴³

Tannenbaum’s account seems to deny that animals have any interest in determining the shape of their lives or that we have a duty to promote or respect their autonomy. He explicitly asserts that autonomy, which he defines as “the capacity to decide on one’s own that one will make decisions and long-term plans and to work to put these decisions into effect,”¹⁴⁴ is a *human* capacity shared by few, if any, animals.¹⁴⁵ As such, he holds it to be the source of many “human rights” that animals lack.¹⁴⁶ The capacity for autonomy, he asserts, contributes human moral superiority, or greater moral standing. Tannenbaum does not elaborate on this putative connection, other than to say it is related to self-awareness, or *being aware that one is an experiencing being, distinct from others*.¹⁴⁷

Tannenbaum’s views on self-awareness are worth scrutinizing, because parties on both sides of the animal autonomy debate consider the capacity of self-awareness to be central.¹⁴⁸ One of Tannenbaum’s claims is that the moral importance of self-awareness stems from the fact that, while any sentient being can experience pleasure and pain, only self-aware beings can anticipate future

¹⁴¹ Tannenbaum, J. (1995). *Veterinary ethics: animal welfare, client relations, competition and collegiality* (second ed.). St. Louis, MO: Mosby-Year Book, Inc. (p. 123).

¹⁴² *Ibid.*, (pp. 166-167).

¹⁴³ *Ibid.*, (p. 124).

¹⁴⁴ Tannenbaum, J. (1989). *Veterinary Ethics*. (p. 97).

¹⁴⁵ *Ibid.*, (pp. 99-100).

¹⁴⁶ Tannenbaum, J. (1995). *Veterinary ethics: animal welfare, client relations, competition and collegiality* (second ed.). (p. 136).

¹⁴⁷ *Ibid.*, (p. 125).

¹⁴⁸ Tannenbaum, J. (1989). *Veterinary Ethics*. (pp. 97-98). Thomas (pp. 37-67).

experiences of pleasure and pain and have emotional responses about these forecasted experiences.¹⁴⁹

Another claim that Tannenbaum presumably takes as self-evident, for he offers only minimal support for it, is that the vast majority of animals lack self-awareness. He grants that a tiny minority of animal species, such as chimpanzees, may be self-aware (and thus entitled to higher moral status than other animals), based on their ability to deceive one another and their performance on “mirror-recognition” tests.¹⁵⁰ The mirror-recognition test is an experiment devised by Gordon Gallup, Jr. in 1970, which begins with giving an animal access to a mirror for a period of time.¹⁵¹ She is then anesthetized and an odorless, non-palpable colored mark is placed a part of her body that she can only see with the mirror. When the animal awakens, she is provided with the mirror and any attempts to touch or inspect the mark are noted. Like Gallup, Tannenbaum seems to believe that “passing” the mirror test, by showing evidence that one recognizes that it is oneself in the mirror, indicates self-awareness.

These two claims are difficult to reconcile with one another. Even animals with a very rudimentary nervous system show the ability to anticipate future experiences and respond to them, at least behaviorally.¹⁵² For example, a mollusk whose siphon is gently touched will initially only withdraws its siphon slightly. However, if the gentle touch is followed repeatedly by an electric shock, the mollusk will soon learn to vigorously withdraw its siphon and gills in response to the gentle touch, apparently in anticipation of the electric shock. Anyone who lives with a companion animal can likely give examples of her excitement in anticipation of a walk, game, or treat, or her emotional distress in anticipation of something unpleasant – perhaps a bath or being left alone. Yet, Tannenbaum holds that at best a few animal species have “limited” self-awareness – and he probably doesn’t mean mollusks! This suggests that he may assign different meanings to the term “self-awareness” at different points in his discussion.

¹⁴⁹ Tannenbaum, J. (1989). *Veterinary Ethics*. (p. 97).

¹⁵⁰ *Ibid.*

¹⁵¹ Gallup, G.G. (1970) Chimpanzees: Self-Recognition. *Science*, 167 (3914), 86-87.

¹⁵² Hawkins, R. D., & Byrne, J. H. (2015). Associative Learning in Invertebrates. *Cold Spring Harbor Perspectives in Biology*, 7(5). Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4448622/>

Recently, efforts have been made to define more carefully and investigate empirically the question of self-awareness in animals. Marc Bekoff and Paul Sherman propose a continuum of “self-cognizance” along which various species (and individuals) may fall, identifying three distinct levels of self-cognizance that other authors, like Tannenbaum, may have previously run together under the umbrella of “self-awareness.”¹⁵³ They believe that empirical investigation has and will continue to demonstrate that an animal’s position on this continuum is determined partly by her evolutionary history, social structures, and life-history characteristics.

At its most basic, self-cognizance involves determining whether something or someone is the same phenotype as oneself. Such “self-referencing,” as they term it, need not be conscious; Bekoff and Sherman point out that the immune system also carries out this type of discrimination without consciousness.¹⁵⁴ Currently, the claim that birds, animals, and octopuses are conscious is considered rather controversial.¹⁵⁵ The next higher level under their scheme they term “self-awareness,” which they define as a cognitive process that allows a possessor to differentiate her own body from that of others and from the rest of the world and to conceptualize possession, such as “my” food item or “my” territory.¹⁵⁶ Self-awareness, in this sense, is necessary for animals to function in social and ecological settings, for example, moving their bodies through a complex environment, interacting with conspecifics and predators/prey, and understanding the potentially complex social hierarchy of their group. Thomas presents a range of arguments and empirical evidence that many animal species possess a level of self-awareness somewhere in this neighborhood.¹⁵⁷ Thomas likens this level to what she terms *phenomenal*

¹⁵³ Bekoff, M. & Sherman, P. (2004). Reflections on animal selves. *Trends in Ecology and Evolution*, 19 (4), 176.

¹⁵⁴ *Ibid.*, 177.

¹⁵⁵ Low, P. (2012). The Cambridge Declaration on Consciousness. Proclaimed at the “Francis Crick Memorial Conference on Consciousness in Human and non-Human Animals” on July 7, 2012.

¹⁵⁶ Bekoff and Sherman 177.

¹⁵⁷ Thomas (pp. 38-60).

self-awareness, that is, that there be “something it is like” to be that individual, and that she is aware of her own desires, emotions, and preferences.¹⁵⁸

Finally, at the far end of Bekoff and Sherman’s self-cognizance continuum is “self-consciousness,” which requires having a theory of mind, i.e., understanding that others have different beliefs, perspectives, and emotions than oneself, and being able to think about oneself as an individual in relation with others. Studies suggest that human children must develop a theory of mind, rather than it being innate, and that this happens around the same time as the ability to take the self as an object of reflection and evaluation emerges.¹⁵⁹ Bekoff and Sherman theorize that this level of self-cognizance is evolutionarily selected for when individuals have repeated interactions, either competitive or cooperative, with others, and thus benefit from self-reflection and revising their future thoughts, feelings, and behaviors in response to others’ reactions to them.¹⁶⁰

When Tannenbaum presents the mirror-recognition test as assessing self-awareness, he seems to have in mind this level of self-cognizance. Presumably, if a being can look in a mirror and realize that the spot is on her own face, she understands herself as a separate being among others, one that can be an object of her attention. However, despite frequent reference to this test in discussions about self-awareness/self-consciousness, many have pointed its methodological limitations.

Rollin pointed out early on that passing the mirror-recognition may be a sufficient condition for attributing self-awareness, but fails to be a necessary one.¹⁶¹ Rollin notes that it is difficult to believe that chimpanzees and orangutans, because they pass the mirror recognition test, are self-aware, but gorillas – who are more closely related to chimpanzees and humans than are orangutans – are not self-aware because they fail it. Now that we know that some gorillas (e.g., Koko the signing gorilla who lives

¹⁵⁸ Thomas (pp. 40-42, 55-60).

¹⁵⁹ *Ibid.*, (p. 390).

¹⁶⁰ Bekoff & Sherman 177.

¹⁶¹ Rollin, B.E. (1998). *The Unheeded Cry: Animal Consciousness, Animal Pain, and Science* (expanded ed.). Ames, IA: Iowa State UP. (p. 264).

in closely with humans¹⁶²) do pass the test, this discrepancy is explained by gorillas' general aversion to direct eye contact, as this is a threatening communicative gesture.¹⁶³ Other animals may fail the test, not because they cannot recognize themselves but because they are unconcerned about the mark, have a body structure that makes it difficult or impossible to remove it, or simply fail to give a "detectable behavioral response."¹⁶⁴ Like Bekoff and Sherman, Rollin finds it much more plausible to conceive of self-awareness as a continuum, along which we would find awareness of phenomenal states like pain and itching, perception of dangers and threats, and faculties that permit complex social interactions.¹⁶⁵

As science has discovered how highly developed certain sensory modalities are in other species, critics of the Gallup have pointed out that the mirror-recognition test is inherently biased in favor of beings who, like humans, rely on vision for recognizing others.¹⁶⁶ Vision, incidentally, seems to be the only sensory modality that is well developed in humans relative to other species. Those who pass the mirror-recognition test essentially show that they recognize their own *image* and take it as an objection of investigation. Yet, many species rely on smell or other sensory modalities for taking in information about the world, and especially for recognizing others. Recently, an "olfactory-mirror" recognition test has been developed for dogs.¹⁶⁷ It showed that, when presented with the urine of another dog, their own urine, and an adulterated version of the own urine, dogs will spend the most time sniffing the sample of their own urine mixed with a modifying odor.¹⁶⁸ As yet, there is no definitive consensus on

¹⁶² Patterson, F. & Gordon, W. (1993). The Case for the Personhood of Gorillas. In P. Cavalieri & P. Singer *The Great Ape Project: Equality Beyond Humanity*. New York, NY: St. Martin's Press. (pp. 70-72).

¹⁶³ Kind, A. (2015). *Persons and Personal Identity*. Cambridge: Polity Press. (no page number in online version). Retrieved from https://books.google.com/books?id=SiuwCgAAQBAJ&pg=PT3&dq=9781509500246&hl=en&sa=X&ved=0ahUKEwj1vanQzZjXAhUj_4MKHYIWAK4Q6AEIKDAA#v=onepage&q=gorilla&f=false

¹⁶⁴ Bekoff & Sherman 178.

¹⁶⁵ Rollin, B.E. (1998). *The Unheeded Cry: Animal Consciousness, Animal Pain, and Science*. (pp. 264-265).

¹⁶⁶ Bekoff M. & Sherman 178.

¹⁶⁷ Horowitz, A. (2017). Smelling themselves: Dogs investigate their own odours longer when modified in an "olfactory mirror" test. *Behavioural Processes*, 143, 17-24.

¹⁶⁸ To see the test for yourself: Gorman, J. (2017). Dogs Recognize Themselves in Test Based on Smell, Not Sight (article and video). *New York Times*. Sept, 22, 2017. Retrieved from: <https://www.nytimes.com/2017/09/22/science/dogs-smell-recognition.html?mcubz=1&r=1>

what this entails for self-awareness, but it seems to support the idea that dogs can recognize themselves and take their own scent, at least, as an object of investigation. Given all of these concerns, it seems safe to say that the mirror-recognition test is not as diagnostic as Gallup and Tannenbaum assume.

Even if an empirical method can be found for differentiating exactly where along the self-cognizance continuum an individual lies, it is not clear that a highly advanced type of self-awareness is necessary for one to be capable of at least a degree of autonomy or to warrant moral consideration. Tannenbaum's definition of autonomy – "the capacity to decide on one's own that one will make decisions and long-term plans and to work to put these decisions into effect" – relies on a high level of self-awareness in that "deciding to make decisions" implies taking one's decision-making as an object of reflection. However, we can likely point to decisions we simply make, without "deciding to decide," that are nonetheless based on our reasons and that we consider autonomous. In such cases, our reasons may simply amount to our own desires, emotions, and preferences, for which only a moderate level of self-awareness is necessary. Tannenbaum seems to be asserting that straightforward decisions made on the basis of such reasons do not constitute the exercise of autonomy, but he does not defend this claim.

Tannenbaum links autonomy to the making and carrying out of long-term plans, and the capacity for long-term planning tends to be correlated with possession of higher levels of self-awareness, both developmentally within the human species and evolutionarily among animal species. However, his focus on long-term planning is problematic. While (many) humans certainly excel at long-term planning compared to other species, many animals' level of self-awareness is such that they *can* prepare for future conditions and activities. Many animals cache food whose location they recall many months later. Some animals make and transport basic tools, indicating that they are acting in the present with a specific future activity in mind. And, again, as humans we sometimes make decisions that affect only the immediate present, and still value these as autonomous decisions if we make them based on our own reasons.

In contrast to his position on veterinary patient autonomy, Tannenbaum does focus on the veterinarian's duty to respect the client's autonomy, specifically her obligation to seek the client's informed consent. This is conceived as giving the client all the information she needs to make a decision and doing so without applying any pressure or influence, overt or subtle.¹⁶⁹ In contrast to Rollin, Tannenbaum explicitly cautions against veterinarians providing information in ways that are intended to steer the client in a certain direction. The veterinarian-client relationship is premised on the understanding that the patient is the client's property and, Tannenbaum argues, it is this ownership relationship and the client's greater understanding of her own particular situation that militate against the veterinarian presenting information in anything other than an absolutely unbiased manner.¹⁷⁰

Tannenbaum's account recalls the "informative model" of physician-patient relationship discussed by Emanuel and Emanuel. Under this model, the physician presents all relevant information for the patient to decide which medical intervention they want, and then facilitates or executes the intervention the patient selects. The physician's values play no role; she is responsible strictly for the facts, while the patient is responsible for making a decision based on her own values. Applying this model to veterinary medicine, client autonomy equates to the client choosing and controlling medical interventions. The veterinarian respects the client's autonomy by presenting information in an unbiased manner and carrying out her decisions.

In human medicine, this model is recommended for certain situations, such as walk-in medical centers, where the relationship between the physician and patient is likely to be very short-lived.¹⁷¹ This is because, for longer term relationships, patients seem to expect a more caring, less detached physician, one who can make individualized recommendations by assimilating their medical knowledge,

¹⁶⁹ Tannenbaum, J. (1989). *Veterinary Ethics*. (p. 121).

¹⁷⁰ Tannenbaum, J. (1995). *Veterinary ethics: animal welfare, client relations, competition and collegiality* (second ed.). (pp. 181-183).

¹⁷¹ Emanuel and Emanuel 7.

past experience, and the patient's unique standpoint.¹⁷² The informative model is considered non-ideal as a default because it assumes that patients usually have a clear and unchanging understanding of their values and desires when, in fact, they may seek out a physician in part because they expect she will introduce health-related values into their deliberations about the relative importance of their values.¹⁷³ In my experience, information can rarely be communicated with zero bias, as word choice inevitably imparts some slant, even with the presentation of statistical success rates ("this therapy succeeds most of the time" v. "this therapy fails 40% of the time") and mean survival rates ("she could have another 3 good months" v "she will likely be euthanized within 3 months"). This makes the attainability of this ideal questionable.

Before turning to the mainstream account of respect for (human) patient autonomy, I will briefly examine an issue that both Rollin and Tannenbaum consider central to veterinary medical ethics: the "dual masters" served by the veterinarian. Tannenbaum writes:

"[Veterinarians] serve both animals and people. This dual function can put veterinarians in an impossible position when what is good for the patient is not good for the client, or when helping the client means harming the patient."¹⁷⁴

Tannenbaum notes that, because the veterinarian works for the client, it is the client who "retains the right to decide which services will be provided."¹⁷⁵ As we saw above, Rollin also notes the veterinarian's fidelity conflict, but recommends resolving it by modeling the veterinarian on the pediatrician, rather than the mechanic, and being an advocate for the animal patient's best interest.

Rollin's analogy is useful in that we can easily grasp the difference between a mechanic's relationship to a damaged car and a pediatrician's relationship to her sick patient. Pediatrics is also similar to veterinary medicine in involving a three-party therapeutic relationship rather than the two-

¹⁷² *Ibid.*, 5.

¹⁷³ *Ibid.*, 5-6.

¹⁷⁴ Tannenbaum, J. (1995). *Veterinary ethics: animal welfare, client relations, competition and collegiality* (second ed.). (p. ix).

¹⁷⁵ *Ibid.*, (p. 181).

party physician-patient relationship that is standard in medicine. The physician-parent-patient is structurally similar to the veterinarian-client-patient relationship in many ways; for example, there is often a close relationship between the non-clinician members of the relationship, and both pediatric and veterinary patients are typically limited in their understanding of medical issues.

However, Rollin's analogy seems to gloss over the potential conflicts of duty that pediatricians encounter in their course of practice. While familial love often dictates that parents (or guardians) will choose a course based solely on what is best for the child, differences in parental and physician values at times mean that there will be disagreements about how to construe the child's "best interest" and what will in fact promote it. And, just as a veterinarian may feel a client is putting her own minor interests ahead of the animal's most vital interests, pediatricians may sometimes encounter parents whose values seem to prevent them from selecting interventions that are necessary to protect or heal the child – or perhaps even ensure her survival.¹⁷⁶ Scenarios in which parents hold religious convictions regarding blood transfusion come to mind, or parents who eschew the use of vaccinations or antibiotics. In such cases, both physicians and veterinarians may be left questioning which individual they owe a greater obligation of fidelity. How do pediatricians navigate the challenge of "serving two masters," or protect the interests of the child patient while also respecting the wishes of the child's parents or guardians?

While the American Academy of Pediatrics Committee on Bioethics considers the pediatrician's primary duty to be representing the patient's best interests,¹⁷⁷ it generally recommends abiding by parental wishes unless the child is likely to be subjected to serious harm, suffering, or death, at which

¹⁷⁶ Adam M.B. (2011). Session 9. Pediatrician-Parent-Patient Relationship: Obligations of Veracity, Fidelity, and Confidentiality. In M.B. Adam, D.S. Diekema, & M.R. Mercurio (Eds.) *American Academy of Pediatrics Bioethics Resident Curriculum: Case Based Teaching Guide*. (pp. 57-58).

¹⁷⁷ Committee on Bioethics. (1995). Informed Consent, Parental Permission, and Assent in Pediatric Practice. *Pediatrics*, 95 (2), 315.

point a hospital ethics committee or the court may be asked to become involved.¹⁷⁸ While veterinarians also frequently defer to the wishes of the client who will not be persuaded, they lack the option of seeking outside intervention, even in extreme cases. At most, veterinarians concerned about a particular patient may request a “welfare check” by animal control agencies, but animal control officers are rarely empowered to intervene in a meaningful way. When the threat of harm, suffering, or death of their patient is too great for veterinarians to bear, their options are typically limited to offering euthanasia at no charge (for a severely suffering animal or one with a grave prognosis) or persuading the client to surrender the patient to the veterinarian or clinic to assume care and costs associated with treatment.

The “family-centered ethic” is another approach put forth for dealing with such situations in pediatrics.¹⁷⁹ This approach considers the benefits and burdens of a decision on the child as well as other family members, the responsibilities family members have to one another, and the vulnerability of the child. The physician attempts to “harmonize” the values of all family members while also encouraging parents or guardians to focus on what is truly in the best interest of the child. A version of this approach is frequently utilized by veterinarians. For example, one common conflicting “value” is cost reduction: many private practice veterinarians spend a great deal of time modifying diagnostic and treatment plans to keep financial costs at or below the burden the client is willing or able to accept. This often entails providing less than ideal care, but enables the patient’s most pressing needs to be met.

Human Medical Ethics: The Physician’s Duties

Respect for patient autonomy is among the central values in medical ethics. However, it is not the only duty, nor is it necessarily more important than any other. Contemporary accounts of medical

¹⁷⁸ Cumming, C.L. & Mercurio, M.R. (2001). Session 10. Autonomy, Beneficence, and the Rights of Parents and Children: Exploring the Application of Ethical Principles in Pediatrics. In M.B. Adam, D.S. Diekema, & M.R. Mercurio (Eds.) *American Academy of Pediatrics Bioethics Resident Curriculum: Case Based Teaching Guide*. (p. 68).

¹⁷⁹ Harrison, C., Kenny, N.P., Sidarous, M., & Rowell, M. (2012). Bioethics for Clinicians: Involving Children in Medical Decisions. In Ed. E. Gedge & W.J. Waluchow *Readings in Health Care Ethics*. Buffalo, NY: Broadview Press. (pp. 93-94).

ethics identify several other core duties that practitioners have toward their patients. I will briefly review these before focusing on respect for autonomy.

First, the duty of beneficence requires physicians to do good for their patients by protecting their interests and promoting their welfare.¹⁸⁰ Positive acts that protect a patient from an illness, resolve an ailment, or relieve unpleasant symptoms are examples of a physician fulfilling her duty of beneficence. The maxim *primum non nocere*, or “first, do no harm,” is the origin of another duty, that of non-maleficence. Non-maleficence requires that physicians consider the possible harm that a potential treatment might cause and consider whether modifying the medical intervention, or perhaps even providing no treatment at all (e.g., benign neglect), may be a better option. The principle of justice in the medical context requires just access to health care, fair allocation of resources, and the equitable distribution of risks and burdens when it comes to biomedical research using research subjects.¹⁸¹ Finally, fidelity is often considered a principle of medical ethics, requiring that the physician consider her patients’ interests first among all others.¹⁸² This includes prioritizing patient’s interests both when they might conflict with the physician’s self-interest and when they conflict with the interests of other people.¹⁸³ The duty of fidelity also requires that physicians keep their patient’s confidences, carry out their promises to their patients, and follow their patients’ expressed wishes.¹⁸⁴

Conflicts between various duties can and do arise, requiring the physician to either find a path that adequately fulfills both obligations or balance the competing obligations to determine which is more compelling in the specific context. Risky procedures that stand to drastically improve a patient’s health if successful may pit the duty of non-maleficence against that of beneficence. The duties of beneficence and respect for autonomy come into conflict when the patient declines an intervention that

¹⁸⁰ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 151,202).

¹⁸¹ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (pp. 240-287).

¹⁸² Davenport, J. (1997). Ethical Principles in Clinical Practice. *The Permanente Journal*. 1997 (1), 23-24. Retrieved from: <http://www.thepermanentejournal.org/files/Summer1997/principles.pdf>

¹⁸³ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 311).

¹⁸⁴ Davenport, J. 23-24.

the physician believes would greatly improve her welfare or save her life (or, conversely, when a patient seeks out an intervention whose risks far outweigh its potential benefits). As we will see in Chapter Three, this conflict is at the heart of questions about when paternalism, or over-riding a patient's decision for her own good, is justified.

Respect for Autonomy in Mainstream Medical Ethics

Given the parallels between human and veterinary medicine, it is useful to consider what conclusions might be drawn about respect for veterinary patient autonomy if we were to export the approach of mainstream (human) medical ethics. However, we must first get clear on what this approach to autonomy is. In this section, I will present this account, taking Beauchamp and Childress's discussion in *Principles of Biomedical Ethics* (henceforth B & C) to represent the mainstream account of autonomy and respect for autonomy in (human) medical ethics.

Like many authors, B & C begin their account by noting that the term "autonomy" is not used univocally throughout the literature.¹⁸⁵ They equate autonomy with *self-rule*, specifying that autonomous decision-making must be "free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice."¹⁸⁶ B & C are careful not to require too demanding a conception of autonomy, because they believe that the account used in medical ethics must count the "everyday" choices of ordinary people as autonomous and worthy of respect.¹⁸⁷

B & C argue that an action is autonomous if it satisfies three conditions: (1) it must have been chosen intentionally, not accidentally, (2) the individual who has chosen it has done so with sufficient

¹⁸⁵ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 99)
Wardrope, A (2015). Autonomy as Ideology: Towards an Autonomy Worthy or Respect. *The New Bioethics*, 21 (1), 57.

¹⁸⁶ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 99).

¹⁸⁷ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 104).

understanding, and (3) its choosing must not have been the result of “controlling influences.”¹⁸⁸ The first condition is all-or-none, that is, an action is either intentional or accidental/inadvertent. The other two conditions admit of degrees, and must only be fulfilled to a substantial degree, not completely, for an individual to qualify as autonomous.

The requirement of understanding requires both that the physician provide adequate information and, as other writers about decisional capacity stress, that the patient has the capacity to comprehend the facts and to appreciate the significance of her medical condition, the decision to be made, and how the decision stands to affect her future experience.¹⁸⁹ B & C emphasize that it is only *sufficient* understanding that is required, since the level of understanding reached by patients is typically less than that of the physician, and full understanding is an ideal rarely if ever reached.¹⁹⁰ Adequate reasoning capacity is also necessary for understanding how one stands to be affected by an illness, an intervention, or a decision. Decisional capacity scholars consider the sub-capacity of reasoning satisfied if the patient can weigh risks and benefits and consider possible consequences. As a requirement for autonomy, it is often left vague, presumably because – given the empirical evidence for how *irrationally* we often behave – setting the bar too high might result in finding many or most patients are decisionally incapable.¹⁹¹

B & C’s third condition, noncontrol, requires that, for an action to be autonomous, the individual undertaking it must “be free of controls exerted either by external sources or by internal states that rob the person of self-directedness.”¹⁹² Not all forms of external influence undermine autonomy, but coercion and manipulation do, a topic we will consider in more depth in Chapter Four. Examples of

¹⁸⁸ *Ibid.*

¹⁸⁹ Charland, L.C. (2015). Decision-Making Capacity. In E.N. Zalta (Ed.) *The Stanford Encyclopedia of Philosophy*. Retrieved from <https://plato.stanford.edu/archives/fall2015/entries/decision-capacity/>

¹⁹⁰ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 104).

¹⁹¹ Charland, L.C.

¹⁹² Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 104).

“internal influences” given by B & C include mental illness and the immaturity of infants and young children.

B & C see *respecting* a patient’s autonomy as acknowledging her right to make choices based on her values and desires. This respect entails both taking a certain attitude toward the patient and performing certain actions. It entails negative duties, such as refraining from interfering with the autonomous decision-making of a patient, and positive duties, such as providing adequate information to permit decision making. Physicians may sometimes have a duty to help develop or maintain a patient’s capacity for autonomous choice by addressing fears or other conditions “that destroy or disrupt autonomous action.”¹⁹³

The conception of autonomy put forth by B & C acknowledges that autonomy is a matter of degree, with greater understanding and freedom from controlling influence leading to greater autonomy. Similarly, they also note that, as with all abilities, one’s ability to make autonomous decisions falls on a continuum, from completely incapable to highly capable. However, B & C advocate setting a threshold level of autonomous decision-making ability, above which an individual is considered *competent* at the task of making a medical decision and below which she is considered *incompetent*.¹⁹⁴ Competent individuals must be able to understand information given to them, consider their options in light of their values, intentionally pursue a given outcome, and communicate their wishes.¹⁹⁵ Competency, B & C recommend, should *not* be viewed as coming in degrees.¹⁹⁶ Rather, above the above the threshold, all individuals must be treated as *equally* competent to make decisions and below it, they are considered *equally* incompetent.¹⁹⁷

¹⁹³ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 103).

¹⁹⁴ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 117).

¹⁹⁵ *Ibid.*, (p. 116).

¹⁹⁶ *Ibid.*

¹⁹⁷ *Ibid.*, (p. 117).

Competence is also considered by B & C to be a presupposition of obtaining informed consent.¹⁹⁸ *Informed consent* is defined in their account as “an individual’s *autonomous authorization* of a medical intervention or of participation in research.... a person must do more than express agreement or comply with a proposal. He or she must *authorize* something through an act of informed and voluntary consent.”¹⁹⁹ They propose a seven-element definition of informed consent that they divide into threshold, information, and consent elements. The threshold elements are competence and voluntariness. The information elements are disclosure (of material information), recommendation of a plan, and understanding (ensuring the patient understands the information and the recommendation). The consent elements are decision and authorization.

B & C defend the view that judgments about competency should distinguish “persons whose decisions should be solicited or accepted from persons whose decisions need not or should not be solicited, or accepted.”²⁰⁰ They acknowledge that we still owe moral respect to incompetent individuals,²⁰¹ and acknowledge that competency is always relative to a specific decision or range of decisions so that a patient may be competent to make decision about things like food preferences and initiating contact with friends, but may nonetheless be incompetent to make medical decisions.²⁰² However, unless the possibility exists of rendering an “incompetent” patient competent, the physician does not have a duty to respect her autonomy regarding medical decisions. For patients who have never qualified as competent, they hold, we need not consider what decision they would make if they *were* competent, for there is no basis for making “a judgment of their autonomous choice.”²⁰³ Instead, the

¹⁹⁸ *Ibid.*, (p. 124).

¹⁹⁹ *Ibid.*, (p. 122).

²⁰⁰ *Ibid.*, (p. 114).

²⁰¹ *Ibid.*, (p. 108).

²⁰² *Ibid.*, (p. 115).

²⁰³ *Ibid.*, (p. 227).

physician's obligation is to find a surrogate decision maker who then uses the appropriate standard to make medical decisions on behalf of the patient.²⁰⁴

For surrogate decision-making, B & C describe essentially two standards by which surrogates' decisions can be guided. One is autonomy-based while the other is welfare-focused, that is, it asks which action is in the patient's best interests. The autonomy-based standard relies on wishes and judgments the patient communicated before their loss of autonomy; the locus of respect in these cases is those previous autonomous decisions.²⁰⁵ Ideally, these previously-made decisions would be explicit and clearly applicable to the situation the now-incompetent patient is in. However, if an incompetent patient ends up in a scenario that she never foresaw or expressed treatment preferences about, B & C allow that a surrogate who knew the patient and her values well may "substitute" their own judgment in making a decision about treatment that is likely to be what the patient, when still autonomous, would have made.²⁰⁶

For never-competent patients, however, their recommendations are quite different. They note: "We obviously cannot follow a substituted judgment standard for never-competent patients, because no basis exists of a judgment of their autonomous choice."²⁰⁷ Thus, in cases where a patient *never* qualified as sufficiently autonomous, the surrogate must use the "best interest standard." Under this standard, the primary values appealed to are beneficence and nonmaleficence: the surrogate is charged with determining "the highest net benefit among the available options," where net benefit is determined by considering the risks and probable benefits of all options.²⁰⁸ Welfare and quality of life are the sole measures in determining the patient's best interest.

²⁰⁴ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 111).

²⁰⁵ *Ibid.*, (p. 140).

²⁰⁶ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 227).

²⁰⁷ *Ibid.*

²⁰⁸ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 138-139).

Applying B & C's Principles of Respect for Autonomy to Veterinary Medicine

While B & C do not discuss animals in their chapter about respect for patient autonomy briefly, they do touch briefly on the potential for animals to have autonomous capabilities in their opening chapter on moral status.²⁰⁹ Here, B & C note that while many bioethicists claim that nonhuman animals lack autonomy, “this premise is more assumed than demonstrated.”²¹⁰ They go on to cite examples of autonomous capabilities in wild animals, such as the ability of many animals to “forge intentional plans of action for hunting, stocking reserve foods, and construct dwellings.”²¹¹ When discussing moral duties owed to two potential categories of research subjects, deteriorating Alzheimer’s patients and language-trained apes, B & C suggest that cognitive capacities including or underlying autonomy exist on a single continuum along which both humans and nonhuman animals fall.²¹² While humans are usually more toward the “advanced” end of the spectrum, they note, in cases of disability or dementia, their cognitive capacities – potentially including that for autonomy – may be surpassed by animals.

Given that B & C do not discount the possibility that at least some animals having autonomous capacities, it initially seems curious that they fail to consider animals in their discussion of respect for autonomy.²¹³ In this section, I will attempt to elucidate a potential justification for this by extrapolating their account to animals. I show that, however autonomous animals’ decisions might at times be under B & C’s account, virtually no animal would qualify as “competent,” or sufficiently autonomous to make medical decisions, thus making it unnecessary – or perhaps impossible by definition – to respect their choices in this arena.

First, we may look at B & C’s three conditions for autonomous action: (1) intentionality, (2) understanding, and (3) absence of external control. When it comes to decisions, medical or otherwise,

²⁰⁹ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (pp. 65-72; 101-149).

²¹⁰ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 73).

²¹¹ *Ibid.*

²¹² Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (pp. 69 & 70 and pp. 96 - footnote 21).

²¹³ *Ibid.*, 65-72; 101-149.

animals seem to have the potential to meet the requirement of intentionality. That is, their actions are not universally accidental; a chimpanzee will intentionally swallow a flavored medication or spit it out, a dog who holds still for placement of an intravenous catheter has made a decision to do so – she may or may not be coerced into doing so, but it is no accident. Similarly, in theory and sometimes in practice, animals seem to be able to meet the criteria for acting without external controls. They permit or undertake at least some medical actions without being coerced. For example, they may happily hop on a scale, ingest an offered chewable medication, or permit an injection with a needle of so small a gauge as to be nonpainful. The “internal influences” B & C consider as potential controlling factors may generally be a greater concern for animals than adult humans, in that fear may be more likely to trigger “fight or flight” mode in an animal, and B & C would likely consider this state of mind to be a controlling influence.

It is in the requirement of sufficient understanding where animals most obviously – and perhaps universally – fail to meet B & C’s criteria for autonomous actors in health care decisions. We may be able to point to certain situations where an animal does seem to have a level of understanding on par with that of a typical human patient. For example, it is documented that wild apes ingest specific parts of certain plants when they are ill;²¹⁴ even if their level of understanding is as rudimentary as associating this action with expected relief in the near future, this is likely equivalent to many humans’ understanding of remedies we commonly reach for to relieve headaches or indigestion. In addition, veterinary clients often recount stories of pets seeking human assistance with medical problems. For example, animals who have become injured while roaming frequently return home, and sick animals

²¹⁴ McLennan, M.R. & Huffman, M.A. (2012). High frequency of leaf swallowing and its relationship to intestinal parasite expulsion in “village” chimpanzees at Bulindi, Uganda. *Am J Primatol*, 74(7), 642-650.
McLennan, M.R., Hasegawa, H., Bardi M, & Huffman, M.A. (2017). Gastrointestinal parasite infections and self-medication in wild chimpanzees surviving in degraded forest fragments within an agricultural landscape mosaic in Uganda. *PLoS ONE* 12(7). Retrieved from:
<http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0180431&type=printable>

may become “clingy” or otherwise demonstrative. Several of my clients have recounted their pet letting them know of their bladder problems by walking directly in front of them and passing bloody urine on the floor. One interpretation of this behavior is that, perhaps based on past experiences of humans providing comfort or relief, the distressed animal understands that her human companion may have the ability to render aid, even if she cannot imagine the specifics of what that aid might be.

However, for most medical interventions that a veterinarian may recommend for a patient, “sufficient understanding” requires the use of concepts and abstract ideas that are out of reach for an animal. An animal’s understanding of an illness is likely limited to her subjective experience of its symptoms, or perhaps an association with an inciting cause such as a traumatic event or ingestion of a particular substance. Without linguistic ability and the extent of future-oriented thought that humans have, an animal likely cannot understand that a disease is expected to take a certain course. Without linguistic ability, sufficient understanding of what is entailed by an intervention, even something as simple as a vaccine, seems impossible, to say nothing of comparing potential alternatives. In addition, understanding that one has an “improved long-term prognosis” if a certain intervention is chosen involves a greater degree of rationality and projection into the future that exceeds the capabilities of most or all animals.

In addition, when it comes to gauging competency and specifically understanding, B & C require giving rational reasons or reasons rooted in risk/benefit analysis.²¹⁵ There are surely many situations in which animals can and do gauge risk and they undoubtedly have reasons for their behavior, the rationality of which is often confirmed by ethological observation. However, in situations where medical care is being delivered, emotional rather than rational reasons may often prevail – for example, fear of the veterinarian (who is a stranger) or being handled in an unusual way – and the risks and potential benefits that the animal considers are likely to be very local and focused on their immediate experience.

²¹⁵ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 118).

Finally, reflecting on B & C's definition of informed consent described above, we may note that, besides failing to meet the standards of patient competency that are presupposed by their schema, veterinary patients are also unable to satisfy information elements and consent elements of informed consent.²¹⁶

Given the inevitable classification of all veterinary patients as "never competent," extrapolating B & C's account leads to the conclusion that the veterinarian's duty is to rely on a surrogate to make decisions in the patient's best interest, where this is defined as the course most likely to provide a net benefit to the patient's welfare and quality of life. Use of this best interest standard seems to accord well with the guidelines to which many animal caregivers aspire when making medical decisions for those in their care. "What is best for the patient?" is often the first – and sometimes the only – question asked for companion animals (both in private homes and in shelters) and for animals living in (some) zoos or sanctuaries. The goal of veterinary interventions in these contexts is often to relieve pain or discomfort and to restore or maintain the patient to a state where they can engage in activities that bring them enjoyment or pleasure, as would be dictated by B & C's best interests standard.

In other contexts, the veterinary situation does not resemble straightforward extrapolation, *mutatis mutandis*, of B & C's requirements for dealing with "never competent" patients. A family's resources (time, emotional, financial, etc.) may significantly constrain the options available to the patient. In a more stark contrast to the situation in human medicine, the veterinarian may consider the principle of fidelity to apply primarily to the client and promoting the client's goals. In the case of "food animal" or production medicine, it may be the client's financial interests or other humans' gustatory interests, rather than the patient's welfare interests, that take priority. Similarly, in zoos, many medical interventions are aimed at creation of offspring from a pre-selected dam and sire, with the ultimate goal of maintaining a genetically diverse captive population; this goal, rather than the patient's welfare interests, takes priority. At times, welfare interests come into play more in terms of what options they

²¹⁶ *Ibid.*, 132.

rule out – what would cause *too much* pain or suffering to the patient – rather than being used in the manner B & C suggest for surrogates, i.e., for choosing the option that could be said to be in the patient’s *best* interest. Whatever the focus of their practice, however, veterinarians today tend to see their duties to the patient as limited to beneficence and non-maleficence, without any obvious role for respecting autonomy.

Pediatric Patients and Respect for Autonomy

B & C do not give much attention to the area of pediatrics and the physician’s duty to respect the autonomy developing autonomy of child patients. However, just as pediatric medical ethics offers ideas for approaching conflicts unique to a three-party therapeutic relationship, pediatrics may provide some insight in dealing with patients incapable of making sufficiently autonomous medical decisions. Young children, at least, would be classified as “never incompetent” to make autonomous medical decisions by B & C’s account, with the by-now-familiar consequence that a surrogate decision maker, usually a parent or guardian, takes on the role of medical decision-maker for them. However, other mainstream accounts take as central the fact that children are in the process of *developing* autonomous capabilities and decisional capacity. As such, pediatricians are encouraged to incorporate the child’s wishes and concerns to the extent reasonable given the type of decision to be made and child’s age and abilities.²¹⁷ Including children in the decision-making process is also believed to provide them with a sense of control which is beneficial for their welfare.²¹⁸

Depending on the gravity of the medical decision and the child’s capacity, pediatric medical ethics increasingly recognizes various decision-making roles for children.²¹⁹ For example, some decisions are fully left up to the child, such as which arm to have blood drawn from, whereas others may involve

²¹⁷ Unguru, Y.T. (2011). Session 4. Informed Consent and Assent in Pediatric. In M.B. Adam, D.S. Diekema, & M.R. Mercurio (Eds.) *American Academy of Pediatrics Bioethics Resident Curriculum: Case Based Teaching Guide*. (p. 27).

²¹⁸ *Ibid.*, (p. 31).

²¹⁹ *Ibid.*, (p. 30).

either consulting the child for their perspective or giving them the opportunity to “ratify” a decision made by their parents. In the case of children, respecting autonomy is often discussed not in terms of informed consent but rather as obtaining the child’s *assent*, where satisfaction of this criterion varies with contextual factors, such as the age of the child and the type of decision.²²⁰

The concept of assent has not, to my knowledge, been explored by veterinary ethicists to date, but given the similarities between some veterinary patients and young pediatric patients, I suspect it could prove useful were we to accept respect for patient autonomy as a relevant value in veterinary medicine. I will explore some possible applications of this concept in Chapter Four.

Summary and Looking Ahead

As our discussion up to this point has made clear, acknowledging that at least some animals are capable of autonomy and value exercising autonomy does not automatically mean that veterinarians or caregivers must respect an animal’s autonomy when making health care decisions. Veterinary medicine has historically concerned itself with obligations of beneficence and non-maleficence; if respect for autonomy has been considered at all, it has been the client’s autonomy that is referenced. Exporting a mainstream account of respect for patient autonomy, like that put forth by B & C, only serves to justify ignoring respect for patient autonomy is appropriate in veterinary medicine, as veterinary patients lack the level of understanding necessary to qualify as “competent” to make medical decisions. Under B & C’s account, veterinary patients’ status as “never autonomous” in the realm of medical decisions entail that decisions about their care are rightfully made not by them, but by a surrogate who considers strictly what best promotes their welfare.

In the next chapter, I will look at how patient autonomy is overridden in veterinary medicine as well as new trends in the profession that seem to promote patient autonomy despite not being

²²⁰ *Ibid*

articulated or justified in such terms. I will explore certain criticisms of mainstream accounts of autonomy and respect for autonomy such as B & C's. Though originally developed with other contexts in mind, these criticisms seem to be relevant to re-considering the role of respect for autonomy in veterinary medical ethics. Specifically, disability scholars and critics in feminist and communitarian circles have questioned how B & C conceive of autonomy and what it means to respect autonomy. Their interpretations call into question the assumption that one cannot or need not respect the autonomy of those falling below the "competency" cut off. The accounts also consider how autonomy might be respected and promoted at more time-points and junctures than typically considered by the mainstream account. As I will argue in the next chapter, these "relational" accounts of autonomy provide a way of understanding autonomy which make the principle of respect for patient autonomy coherent and applicable in a meaningful way to many veterinary cases.

CHAPTER THREE

Introduction

As we saw in Chapter Two, there are many reasons for thinking that respect for patient autonomy has no place as a value in veterinary medicine. It is not acknowledged by the American Veterinary Medical Association or by leading authors in the field of veterinary ethics. Extrapolating the account of autonomy taken by mainstream human medical ethics results in animals being categorized as “never competent” to make autonomous decisions regarding medical care, so the principle of respect for autonomy does not extend to them.

It will come as no surprise, then, that patient autonomy is routinely overridden in the everyday practice veterinary medicine. I will begin Part I of this chapter by describing some of the ways that this occurs, both at the level of *which* veterinary interventions are selected and *how* veterinary care is delivered. I will then describe some recent trends in veterinary medicine, such as “low-stress patient handling” and positive reinforcement training for veterinary procedures, which – implicitly, at least – seem to assign some importance to patient autonomy. These methods seem congruous with animal ethics approaches that acknowledge a role for respect for autonomy, such as those I described in Chapter One. However, as we will see, the rationale their proponents give for these newer approaches is typically “improving animal welfare” rather than “respecting patient autonomy.”

In the second part of this chapter, I introduce some criticisms of B & C’s approach to respect for patient autonomy, including critiques coming from feminist bioethicists, disability scholars, and animal ethicists. I show that the pitfalls of the mainstream approach can be addressed by adopting a relational conception of autonomy. The type of account I have in mind does not limit application of the principle of respect for autonomy to individuals above a certain autonomy threshold, but rather expands our conception of when and where considerations about patient autonomy enter the clinical picture. The

account also revises the idea of what we might mean by the term “respect” as well as what, exactly, is being respected.

What emerges is a conception of respect for patient autonomy that can be applied coherently and meaningfully to veterinary patients, and to human patients who would be denied respect for autonomy under mainstream medical ethics because of their status as incompetent or never-competent. Such an account, I argue, offers a richer account of the motivations underlying the veterinary movements toward low-stress patient handling and positive reinforcement training.

PART I

Patient Autonomy and Veterinary Practice Today

As practiced today, veterinary medicine often involves overriding or failing to consider the patients’ own desires and decisions and disregarding their refusals of veterinary care – in other words, overriding their autonomy. This can take many forms, both in *how* care is provided and *which* interventions are chosen. Veterinary patients may be forced to swallow medications (“stuffing” pills or “pilling” by hand or with a pill-gun) to cure their illnesses or relieve their symptoms. They may be literally dragged into a veterinary clinic they do not wish to enter out of a desire to maintain or improve their health and welfare. In order to perform examinations, diagnostic procedures, and treatments, animals may be restrained or positioned in ways they are clearly not willing to accept, with physical force being used to overpower them. Often, patients express their refusal of a given intervention very vehemently: they may struggle fiercely and become so agitated that they urinate, defecate, or express their anal glands. Animal bites and scratches, the most frequent injury to humans in veterinary clinics, are usually the result of a patient expressing extreme fear or discomfort at what their medical care involves and/or their unwillingness to comply with a veterinary procedure.

It is common practice to administer sedatives and anesthetics to veterinary patients, both to perform surgeries and to enable the performance of diagnostic procedures or treatments in a patient who resists them. Most patients could not be said to assent to sedation or anesthesia, as their knowledge of what is occurring is, in most cases, limited to their subjective experience of receiving an injection; the concept of a shot inducing a decreased level of consciousness is out of reach for all but those who have undergone the procedure numerous times and learned what to expect.

Practices like spaying and neutering arguably run counter to the individual animal's autonomy, at least narrowly conceived (though social and legal conventions dictate that a sterilized animal may be able to enjoy greater access to certain environments than an intact one). These surgeries may hold welfare benefits in some cases, for example preventing certain infections and cancers. However, they are usually justified by reference to the good of the community overall, by controlling the animal population.

In some instances, it is respect for the client's autonomy which motivates interventions that override animal autonomy. Clients may request euthanasia of a healthy animal or, more commonly, one who could be restored to health with relative ease – patients whose behavior clearly expresses that they prefer to go on living. Conversely, clients may demand heroic life-extending care of a terminally ill, suffering pet based on the client's own wishes and concerns, without considering desires or preferences the patient herself might have. Clients may request cosmetic or convenience surgeries, such as ear cropping or declawing, that offer no direct benefit to the patient and whose consequent pain and, in some cases, disability are not something the patient would choose for herself. When performing procedures that seem to run counter to their patient's welfare and wishes, veterinarians acquiescing to clients' wishes often justify their decision with reference to beneficence and nonmaleficence. They note that the patient relies for her on-going care and survival on the human client soliciting the veterinary procedure, and cite examples where denying a client's request resulted in their abandonment of the

animal or “taking matters into their own hands” and attempting to perform a medical procedure or end the animal’s life through inexpert means.

In any case, far from being done out of malicious intent, the purpose of overriding the desires and preferences of patients is typically to fulfill the veterinarian’s duties of beneficence and nonmaleficence to the patient. These duties often require that certain interventions be undertaken, yet left to their own devices, the patient would decline them. She is unable to appreciate that some interventions are in her own best interest, and the unfamiliar experience of veterinary intervention is likely a source of fear and anxiety for her, leading her to wish to escape it. Under mainstream accounts of autonomy, to respect that animal’s autonomy would mean to avoid interfering with her immediate decision to decline veterinary intervention. Since doing so would require caregivers and veterinary practitioners to neglect their duty to provide the intervention determined to be in the patient’s best interest, overriding the patient’s autonomy seems to be required.

Even in settings where animals’ preferences are deemed very important and where caregivers strive to increase animals’ choices and control – that is, contexts in which enabling animals to exercise autonomy is valued – veterinary care is often presumed to require overriding of the individual’s preferences. For example, anesthesia is frequently relied upon for providing veterinary care to captive apes and, even in chimpanzee sanctuaries, darting is commonly used as method of inducing anesthesia. This involves shooting the patient with a pressurized, medication-filled dart which discharges the drug after a large-bore needle penetrates her skin. After their initial experience with this procedure, most apes express their strong refusal of the procedure in no uncertain terms, frantically leaping and running within their enclosure and developing dart-avoidance strategies, such as remaining in constant motion or positioning themselves in locations that make darting difficult. Such is their distress that they often scream continuously, urinate, and defecate in panic. I have seen one chimpanzee grab the dart-gun through the mesh and destroy it.

In my experience, most sanctuaries either accept darting as an unpleasant but necessary component of preventing and treating medical conditions or they adopt a policy of providing minimal veterinary intervention. In the latter case, veterinary interventions are only permitted in cases of severe illness or trauma, and preventive care is sometimes inadequate to protect group or individual health.

Low-Stress Patient Handling and Positive Reinforcement Training for Veterinary Procedures

In recent decades, the veterinary profession has shown increased interest in animal behavior and in preventing and treating behavioral/psychological disorders and issues. Veterinary behavior, like surgery or dermatology, is now a specialty in which veterinarians can become board-certified. Examining the view of different generations of veterinarians demonstrates a distinct evolution in how behavior issues in domestic animals are conceptualized and addressed. Veterinarians who graduated twenty years before me tend to believe, for example, in the importance of “establishing dominance” over dogs. They often espouse confrontational methods, like “alpha-rolling,” to manage unwanted behaviors like aggression or unruliness. In contrast, the modern curriculum taught by veterinary behavior specialists requires first examining the reasons underlying a given behavior, such as unmet needs or fears, and addressing these causes. Coercive means, like force or fear, are spurned. Veterinary behavior specialists universally despise Cesar Milan, the famous dog trainer whose television program promotes “showing your dog who’s alpha,” warning their students that he has effectively “turn the clock back forty years” for their discipline.

In this evolution, I detect an unspoken but nonetheless discernible trend toward valuing something in the neighborhood of animal autonomy. The movement toward the newer methods of modifying behavior is justified as being based in science – and it is: they are more effective, last longer, and improve caregivers’ ability to understand the communications of their animals, so they are better equipped to handle future issues. And they are better for animal welfare, eliminating any excuse for

physical punishment , electroshock, and intentionally causing fear. But I have the sense that there is an unarticulated and thus undertheorized valuing of animal autonomy. Perhaps it would be better described as an inclination to limit human domination, which – though out of the scope of this thesis – I suspect could be equated with my understanding of respecting animal autonomy.²²¹

This trend has been accompanied by the development of methods of delivering care that allow animals to cooperate with veterinary procedures or, at least, that do not involve forcing patients to do things they don't want to do. Courses in veterinary schools and in veterinary conferences are increasingly advocating methods of working with animals that permit them to voluntarily choose to undertake behaviors needed to receive veterinary care. From these newer perspectives, a patient refusing to participate in a given procedures is not “bad” or misbehaving; rather, her refusal is a sign that we must rethink our own approach to the patient.

One example of this is veterinarian Sophia Yin's “low-stress patient handling” approach. Yin notes that veterinary encounters often involve the patient becoming fearful, struggling with handlers, and even becoming aggressive. Yin advocates working with patients in ways that minimize fear and anxiety. For example, she suggests accustoming companion animals early in life (during the plastic phase of their development) to basic handling and ensuring that puppy and kitten visits “teach” the patient that the veterinary clinic is a place where she can expect treats, petting, and play. She advocates using deliberate movements to communicate clearly what positions or motions are being asked of the patient

²²¹ In Philip Pettit's chapter “Liberty as Non-Domination” (in *Republicanism – A Theory of Freedom and Government*, New York, NY: Oxford UP) conceptualizes domination in the following way: Someone has dominating power over others to the extent that she can, on an arbitrary basis, interfere with them in a way that makes things worse for them and/or coerce or manipulate them. Freedom, conceived as non-domination, protects individuals by being so dominated through strategies such as reciprocal power. Non-domination means an agent enjoys a level of control with regard to their own destiny – not just everyday decisions. It means they are immune or secure against interference on an arbitrary basis. While this account does focus on interference, the way it define arbitrary is “subject just ... to the decision or judgement of the agent” ... if the interference tracks the relevant interests and ideas of the person who is being interfered with, it is not arbitrary interference.

and to demonstrate that the handler is predictable and trustworthy.”²²² These methods, she explains, enable patients to “willingly comply with procedures.”²²³

Yin seems to justify her approach by appealing primarily to beneficence and nonmaleficence. For example, she writes, “By handling animals [poorly or roughly], veterinarians could be breaking the promise to ‘do no harm’ on a daily basis. Restraining pets in a forceful or crude manner can make pets behaviorally worse to the point where they can no longer receive thorough veterinary care.”²²⁴

Veterinarians who work with the same animals repeatedly have the opportunity to build relationships with them which enable care to be provided efficiently and as enjoyably as possible in the long term. Other accounts in the literature also justify use of low-stress handling techniques in terms of animal welfare, staff safety, and efficiency, without mention of patient autonomy.²²⁵

At times, respect for the patient’s autonomy does seem to be an implicit value underlying Yin’s approach. For example, she recommends that veterinary professionals ask themselves “How can we make the animal feel comfortable and safe so that she cooperates, rather than making her feel threatened so that she thinks she has to protect herself?”²²⁶ This could be read as placing value on the patient’s ability to act autonomously, given the emphasis throughout her writing on patients *choosing* not to struggle and *choosing* to cooperate. However, it might also appeal simply to creating enjoyable states (feeling “comfortable and safe”) as opposed to aversive ones (feeling “threatened”), and the ease with which a cooperative, non-fearful patient allows the veterinarian to do her work. In her work, Yin never explicitly appeals to patient autonomy as a motivation for using her methods.

²²² Yin, S. (2009). *Low Stress Handling, Restraint and Behavior Modification of Dogs and Cats: Techniques for Developing Patients Who Love Their Visits*. Davis, CA: CattleDog Publishing. (p. 56).

²²³ *Ibid.*, (p. 25).

²²⁴ *Ibid.*, (p. 22).

²²⁵ Herron, M.E. & Shreyer, T. (2014). The Pet-friendly Veterinary Practice: A Guide for Practitioners. *Veterinary Clinics of North America Small Animal Practice*, 44(3), 451-81.

²²⁶ Yin, S. (p. 301).

Yin also adapts for companion animal veterinarians the practice of positive reinforcement training (PRT) for veterinary procedures, a method that has been used for some time in contexts such as animal research laboratories, zoos, and sanctuaries. PRT is a training method that typically involves incrementally shaping specific behaviors by providing desired rewards when the individual being trained performs a behavior desired by the trainer. It may also involve creating associations in the animal's mind with between a certain stimulus and something she enjoys.

For example, zoo keepers at Zoo Atlanta have trained numerous gorillas residing there to position their chests for echocardiograms, i.e., heart ultrasounds that detect cardiac diseases and monitor response to treatment. The first step is teaching the animal the meanings of verbal requests such as "hold" (holding still in a given position) and "chest" (pushing her chest up the cage mesh). Once these cues are understood, a prop that is similar in shape and size to an ultrasound probe is used to train the individual to hold their chest up to the mesh in a certain position while light pressure with the sham-probe is applied. A gorilla trained for echocardiograms can have a relatively thorough heart evaluation done in approximately three minutes without the use of sedative or anesthetics. She may, as a result, remain healthier and enjoy a longer life since her heart health can be better managed. My observations of the gorillas suggested that they looked forward to training sessions, sometimes enthusiastically performing behaviors they had learned even when they were not being requested.

As with low-stress patient handling, the rationale given for PRT of veterinary behavior is typically improved animal welfare. With animals trained to participate in their own veterinary care, physical health can be more easily and comprehensively addressed while relying less on anesthesia with its attendant risks. There is less risk of physical harm from darting or manual restraint. Patients do not experience the distress that comes with having a procedure performed on them against their will. PRT is

also touted as “providing a stimulating, enriching, and trusting environment for the animals.”²²⁷ For animals used in laboratory research, PRT is used for both veterinary procedures and invasive procedures done as part of experiments, such as blood collection. In this context, proponents of PRT cite improved animal welfare as well “enhanced flexibility and reliability in data collection” as potential benefits.

To my knowledge, increasing animals’ ability to exercise autonomy is explicitly cited as a reason for undertaking PRT only in the context of training non-veterinary behaviors. Terry Maple describes training mandrills to play tic-tac-toe with zoo visitors as an example of training increasing autonomy, because the animals engaged in training only when they chose to, and learning the new behavior gave them more control of their everyday interactions and opportunities to satisfy their preferences.²²⁸ Aside from this, the closest proponents come to associating PRT with increased patient autonomy in the context of veterinary care is by citing “greater choice and control over daily events” as enhancing psychological well-being.²²⁹ Here, choice and control are considered components of *welfare*, and autonomy is not counted as a distinct good.

Again, this lack of analysis in terms of patient autonomy is predictable, given that respect for patient autonomy is not considered a relevant value in veterinary medical ethics, and mainstream accounts from human medical ethics deny that the principle applies to individuals (such as veterinary patients) who fall below the autonomy threshold. More surprising, perhaps, is that sanctuaries which take promoting animal autonomy and animal welfare as some of their stated goals often fail to use PRT in the veterinary context.

²²⁷ Savastano, G., Hanson, A., & McCann, C. (2003). The Development of an Operant Conditioning Training Program for New World Primates at the Bronx Zoo. *Journal of Applied Animal Welfare Science*, 6(3), 248.

²²⁸ Maple, T. (2007). Toward a Science of Welfare for Animals in the Zoo. *Journal of Applied Animal Welfare Science*, 10(1), 67.

²²⁹ Laule, G.E., Bloomsmith, M.A., & Schapiro, S.J. (2003). “The Use of Positive Reinforcement Training Techniques to Enhance the Care, Management, and Welfare of Primates in the Laboratory” *Journal of Applied Animal Welfare Science*, 6(3), 166.

My impression is that one reason that sanctuaries often fail to incorporate PRT for veterinary procedures is a general mistrust of animal training among those who run sanctuaries. Historically, fear and physical punishment were the typical means of training – and the end toward which animals were trained was performance of an act that would entertain humans or otherwise serve human ends. So both the means and the ends of training are suspect, in the eyes of those working on behalf of animals. This stain on animal training is not easily erased by pointing out that modern means involve reward-based methods, and that the ends are the animals' own best interests.

But there is another reason, one more relevant to this thesis: like most of the rest of us, sanctuary workers and directors have been steeped in a conception of autonomy similar to B & C's, in which respect for autonomy amounts to noninterference in another individual's choices. In this light, training itself, and perhaps even subjecting animals to veterinary interventions at all, already exhibits a lack of respect for autonomy.

What I will argue in the remainder of this chapter is that mainstream conceptions of autonomy, such as B & C's, have major flaws. Adopting an alternative account of autonomy and what it means to respect autonomy, provides us with a richer, more coherent framework for incorporating respect for autonomy as a value in veterinary medicine. Specifically, it enables us to understand the methods just described in terms of promoting and protecting patient autonomy. And, as we shall see in Chapter Four, it helps us parse when practices like training might undermine animal autonomy and when they enhance it.

PART II

Continuums and Thresholds of Cognitive Capacities and their Moral Significance

As discussed in Chapter One, B & C acknowledge that autonomy and the ability to make sufficiently autonomous decisions are matters of degree, varying with factors like the individual's level

of understanding and whether they are controlled by internal or external influences, such as mental illness or coercion.²³⁰ Despite the existence of this continuum, B & C seem to take the principle of respect for autonomy to extend only to individuals above a certain threshold, or level of ability to make sufficiently autonomous decisions. This threshold, they write, identifies those who must be consulted regarding medical decisions and whose decisions warrant respect, so must not be interfered with.²³¹ For patients below the threshold, i.e. “incompetent patients,” the physician’s obligation becomes not to promote patient autonomy but to find a surrogate decision-maker and ensure she uses the appropriate standard to make medical decisions on the patient’s behalf. For patients who have *never* been above the threshold (the “never-competent”), B & C argue that the appropriate standard is one that refers only to welfare and quality of life (the best interests standard). Their argument for disregarding patient autonomy in such cases rests on the claim “no basis exists for a judgment of [never-competent patients’] autonomous choice.”²³²

B & C consider it paternalistic to intentionally override an incompetent patient’s preferences in order to benefit her or mitigate harm to her, even though they would judge her decisions not be not substantially autonomous.²³³ They hold that paternalism is justified in instances where the physician’s duty of beneficence carries greater weight:

“As a person’s interests in autonomy increase and the benefits [of paternalistic action] for that person decrease, the justification of paternalistic action becomes less plausible; conversely, as the benefits for a person increase and that person’s autonomy interests decrease, the justification of paternalistic action becomes more plausible.”²³⁴

By “autonomy interest,” they seem to have in mind the degree to which autonomy is overridden. That is, if autonomy is disrespected in a deep way, the individual’s autonomy interest is greater, whereas, if

²³⁰ Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (p. 113).

²³¹ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 114).

²³² *Ibid.*, (p. 227).

²³³ *Ibid.*, (p. 215).

²³⁴ *Ibid.*, (p. 221).

autonomy is overridden trivially, she has a lesser autonomy interest.²³⁵ Presumably, B & C believe that an incompetent patient stands to gain substantially from paternalistic intervention in medical decisions, either because they cannot make choices or because the choices they do make lack sufficient understanding or are not fully voluntary. In addition, the incompetent patient, because of her lower autonomous decision-making ability, would not be having her autonomy violated in a deep way.

Many authors, such as feminist medical ethicists have criticized the transformation of a multi-faceted spectrum of decision-making ability into a binary choice of respecting the patient's own wishes or desires (autonomy) or ignoring them in the name of benefitting the patient (paternalism).^{236,237} Susan Sherwin points out that this model seems adequate only for "articulate, intelligent patients who are accustomed to making decisions about the course of their lives and who possess the resources necessary to allow them a range of options to choose among."²³⁸ Given all the ways in which one might fall short of such an ideal, such opponents argue, a dichotomy of noninterference in decisions by competent patients or blanket disregard for the autonomy of incompetent patients is inadequate.

The reason that B & C – and mainstream medical ethics in general – take this approach to autonomy may be that, in a range of contexts, the capacity for higher levels of autonomy or rationality is accepted as a threshold which differentiates those who should have a full "say" from those who can be unproblematically spoken for by others. Donaldson and Kymlicka (henceforth D & K) discuss the role of a threshold like this in the case of citizenship:

"In traditional political theory, the citizen has been conceived as a person with capacities for public reason or *logos* or Kantian autonomy or rational reflection and deliberation – complex language-mediated capacities we will call ... 'linguistic agency'.... Linguistic agency has operated not just as an ideal, but as a threshold capacity. Those seen as lacking this capacity have been relegated to the margins of political community,

²³⁵ *Ibid.*, (p. 221).

²³⁶ Sherwin, S. (1992). *No Longer Patient: Feminist Ethics & Health Care*. Philadelphia, PA: Temple U.P. (p. 140).

²³⁷ Wardrope, A. (2015). Liberal Individualism, Relational Autonomy, and the Social Dimension of Respect. 44.

²³⁸ Sherwin, S. A Relational Approach to Autonomy in Health Care. In Ed. E. Gedge & W.J. Waluchow *Readings in Health Care Ethics*. Buffalo, NY: Broadview Press. (p. 17).

situating them as passive wards to whom society owes duties of care rather than as co-citizens with equal rights.”²³⁹

This linguistic agency threshold seems to be part of what B & C require for someone being above the competency threshold, as linguistic agency is necessary for adequate understanding of issues involved in medical decision-making. Similarly, the shift in physician obligations that B & C defend in cases of incompetency parallels the shift in societal obligations that D & K describe as traditionally accepted for individuals below the linguistic agency threshold. Although D & K are concerned with citizenship generally rather than the specific context of medical care, those at the center of their discussion – individuals who lack full linguistic agency, like humans with cognitive disability (CD), children, and animals – are more or less co-extensive with B & C’s class of the “never-competent.”

More parallels emerge when we examine the rationale that D & K articulate as underlying the conventional approach society takes toward people with CD in the context of political decisions:

“If individuals are unable to rationally judge for themselves the soundness of political propositions, society should not seek to mimic consent through the use of trustees tasked to solicit and interpret an individual’s subjective experience. Rather, we should simply acknowledge that ideas of consent are not relevant, and that while we can justify measures ‘for’ them, we cannot justify ourselves ‘to’ them. In other words, trustees for people with CD should make their best judgment of the objective interests of the person being represented, rather than making their best effort to understand how the person with CD conceives her interests.”²⁴⁰

B & C use a similar line of argument in defending the “best interests” standard as the appropriate one for surrogate decision-makers to use when choosing on behalf of incompetent patients. They reject another possible standard, the “substituted judgment” standard, which would direct the surrogate decision-maker to decide as the incompetent person – were they competent – would choose, based on that individual’s values and preferences. B & C reject use of the substituted judgment standard for never-competent patients because, they claim, a surrogate would have no basis for assessing what the

²³⁹ Donaldson, S. & Kymlicka, W. (2016) "Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals." In B. Arneil & N. Hirschmann (Eds.) *Disability and Political Theory* (pp 168-197). Cambridge: Cambridge UP. (p. 169).

²⁴⁰ *Ibid.*, (p. 177).

incompetent individual's autonomous choice would be.²⁴¹ If we substitute the words "medical intervention" for "political proposition" and "who were never competent" for "with CD" in the paragraph quoted above, we end up with a close approximation B & C's account.

As we saw in Chapter One, D & K reject traditional political approaches that exclude those lacking linguistic agency from the political arena. Given the parallels just described, it is unsurprising that their criticism of conventional political theory closely echoes Sherwin's criticism of conventional medical ethics' threshold-based dichotomy. D & K write:

"[We] seem caught between two unsatisfactory models: an anti-paternalistic model which relies entirely on an individual's self-representation of her subjective experience; and a paternalistic model that relies on third-party judgments of objective well-being. Neither model provides a plausible picture for enabling participation by those members of society without linguistic agency."²⁴²

D & K are concerned primarily with showing that the basis and purpose of citizenship is such that linguistic agency should not be used to restrict who should have the rights of full citizenship. They extend the arguments used by disability scholars for the full inclusion of people with CD in the political arena to argue for meaningful citizenship rights for animals. In what follows below, I will review their arguments against using the threshold of linguistic agency to limit political participation and attempt to extrapolate this line of argumentation to the question of respecting patient autonomy in the medical arena, in particular, in veterinary medicine.

The foundation of D & K's argument is that moral status and moral claims are fundamentally connected to having a subjective experience of one's own life and the world; that is, having moral rights is a product of being a *self*, rather than a *thing*.²⁴³ If "someone is home," that is, if there exists a subject who experiences her life "from the inside," then this in and of itself generates the types of

²⁴¹ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 227).

²⁴² Donaldson, S. & Kymlicka, W. (2016) "Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals." (p. 178).

²⁴³ Donaldson, S. & Kymlicka, W. (2011). *Universal Basic Rights for Animals*. In *Zoopolis: A Political Theory of Animal Rights* (pp. 19-49). New York, NY: Oxford UP. (pp. 24-25).

vulnerabilities that moral rights are intended to protect. If individuals have a subjective experience that matters to them, then we ought to recognize them as “having [their] own lives to lead” and as mattering morally.²⁴⁴

D & K argue against animal rights critics who claim that a higher bar than selfhood or subjectivity should be set for mattering morally or for full moral status, and that this bar should be a “further capacity found only amongst humans.”²⁴⁵ An approach that centers on trying to identify such a capacity is flawed for a number of reasons. Cognitive capacities are inevitably on a continuum, with no natural demarcation to be found on which to base a moral distinction. It is difficult to see how one could rationally accept a threshold requirement in order to be afforded full moral status without also accepting that moral status ought to vary with cognitive capacity all across the continuum – a conclusion few if any would be willing to accept. Furthermore, any threshold that one sets will inevitably cut across species lines, for there is no cognitive capacity that all humans have but all other animals do not. In fact, it is unlikely that we could point to any cognitive capacity that any human has during her *entire* lifespan that no animal has.²⁴⁶ Given the fact that humans vary in their cognitive capacity throughout their lives, requiring that one meet a certain threshold of cognitive capacity in order to achieve full moral status turns out to be a much less secure moral basis for protecting even humans of “normal” cognitive function than using D & K’s recommended standard of subjectivity or self-hood.

D & K take care to distinguish their argument from another superficially similar argument for granting moral protections to animals, the “argument from marginal cases,” or AMC. The AMC position is that animals should not be denied moral status on the grounds that they lack certain cognitive characteristics because some humans – among them, some people with CD – also lack them, yet their moral status is preserved; thus, logical consistency requires giving animals the same moral status as

²⁴⁴ *Ibid.*, (p. 28).

²⁴⁵ *Ibid.*, (p. 26).

²⁴⁶ *Ibid.*, (p. 27).

these “marginal” cases of humans.²⁴⁷ D & K argue that the AMC not only exploitatively instrumentalizes the case of humans with cognitive disabilities, it also assumes the very hierarchy they call out as unjustified, namely, one with neurotypical human cognitive capacities at its apex . If moral consideration is rooted in the capacity to subjectively experience one’s life, then there are no “marginal cases” for the AMC to draw upon, because differences in cognitive capacities are conceived nonhierarchically.²⁴⁸ D & K argue that animals should be accorded moral protections because they are selves who subjectively experience their lives, not because their cognitive capacities meet or exceed those of some humans.

On the issue of citizenship rights, D & K join disability scholars who challenge the “neurotypicalist bias” they see as underlying many aspects of society and morality. This is the idea that neurotypical adults and cognitive capacity are the norms against which all others are measured and potentially judged to be deficient.²⁴⁹ As we saw above, humans with lower levels of cognitive function have historically been excluded from full inclusion as citizens on the grounds that they could not understand and reason about political decisions at the level of their neurotypical peers. However, if we take subjectivity and selfhood, rather than neurotypicality, as the core of moral status, then an explicit justification must be given for excluding people with CD from privileges and protections, such as citizenship rights, that they would otherwise be accorded.

If those lacking neurotypical human cognition truly did not have preferences about the norms and structure of their world or the course of their lives, then perhaps what is claimed to be “neurotypical bias” is really a justified distinction. Yet, we can find out simply by inquiring of such individuals that this is not the case. Similarly, proximity to neurotypical adult human cognition might be a justified standard if exerting political agency were truly an option only for neurotypical adult humans. However, individuals with CD can exert political agency in various ways, albeit a type of agency that is

²⁴⁷ Donaldson, S. & Kymlicka, W. (2016) "Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals." (pp. 173-174).

²⁴⁸ *Ibid.*, (p. 174).

²⁴⁹ *Ibid.*, (p. 173).

dependent on others for its actualization. Their capacity to exert political agency is a product not only of their own rational or discursive abilities, but is determined in large part by the social relationships of which they are a part.²⁵⁰ As I will be discussing shortly, we are *all* dependent, to various extents, on others in order to exercise our agency. Thus, denying full citizenship to those with CD is unjustified.

While citizenship is conventionally conceived with the neurotypical adult citizens in mind, advocates for those with CD have increasingly argued for a more inclusive understanding of citizenship:

“Citizenship isn’t a select club for linguistic agents; it’s a commitment to include and empower all members of society, across the whole spectrum of diversity, on their own terms.”²⁵¹

Citizenship means one “counts” as a member of the group. It means participating in the shaping of the social norms of society, just as one is expected to abide by its norms. Governments have an obligation to support their citizens’ legal and political agency.²⁵² Importantly, overcoming neurotypicalist bias in the political realm requires expanding the *locations* and *practices* that define citizenship.²⁵³ The goal is to develop

“new ways of engaging the subjectivity of these co-citizens, focusing less on the ability to articulate or understand propositions, and more on attending to their ‘varied modes of doing, saying and being’...bringing citizenship to the places and spaces where membership and participation are meaningful to the individuals involved.... [We] need to start from those places and spaces and work from the ground up, rather than uncritically assuming that the citizenship functions created by and for neurotypical adults are the only valid ones.”²⁵⁴

Thus, D & K challenge those who argue that, for example, people with CD can only be empowered if they are permitted to vote and serve on juries, on the grounds that these are the “essential functions of citizenship.”²⁵⁵ Rather, what needs revision is our very concept of what constitutes an essential function of citizenship, as these have been defined by neurotypical people, for neurotypical people.

²⁵⁰ *Ibid.*, (p. 170).

²⁵¹ *Ibid.*, (p. 169).

²⁵² *Ibid.*, (p. 170).

²⁵³ *Ibid.*, (p. 171.)

²⁵⁴ *Ibid.*, (pp. 171-172).

²⁵⁵ *Ibid.* (p. 171).

“Instead of fetishizing certain practices such as jury duty or voting as the hallmark of ‘real’ citizenship, we need to consider the new places and spaces of citizenship which are meaningful to people with CD, and which enable them to shape our shared social life.”²⁵⁶

Looking at citizenship in this way, D & K contend the concept of citizenship can and should extend to domestic animals. They have long been members of human-animal society and, as discussed in Chapter One, their perspectives can be incorporated when it comes to establishing social norms and policies.

Turning from the political arena to the medical realm, we might also suspect B & C’s account to contain a neurotypicalist bias. Like the “model citizen” of political theory, the model patient is conceived of as a neurotypical adult, and deviations from this norm lead to assessments of incompetence through which one loses one’s entitlement to autonomy. Just as in the case of citizenship, if we take subjectivity or selfhood as our moral core, we must justify excluding patients who are not neurotypical adults from the rights and protections, such as respect for their autonomy, they would otherwise be accorded. If this exclusion cannot be justified, then it represents neurotypicalist bias rather than a valid distinction.

The purpose of respecting autonomy is to recognize that, as a subject of one’s life, one has an inherent stake in directing that life in a way that aligns with one’s values and concerns. Thus, respecting autonomy may not be relevant if the individual in question does not have (and never did have) her own values or concerns that affect her preferences about what happens to her. But many who would fall below B & C’s threshold retain a desire to direct their lives and do have concerns and preferences that may be different from surrogates’ assessment of their welfare interests. Those without neurotypical adult cognitive capacities may require additional assistance to receive medical care that is in line with their values and concerns. But, again, we are all dependent on others for our ability to develop and exercise autonomous capabilities, so this does not constitute a reason to deny such individuals respect for autonomy.

²⁵⁶ *ibid.*

As a rejoinder, B & C might argue that those below the competency threshold are lacking in the “cognitive skills and independent judgment” needed to comprehend, process, and reason about the issue involved in medical decision-making,²⁵⁷ thus their decisions will lack the adequate understanding and self-directedness necessary for substantial autonomy. Thus, B & C would argue, their schema does not reflect a neurotypicalist bias, but rather a legitimate distinction among patient populations.

However, this approach emphasizes one particular set of “locations and practices” that define exercise of autonomy. The “practice” in this scenario could be considered giving informed consent and the “location” would be the point at which a major decision about medical care needs to be made. However, as we will see in the next section, autonomy, like citizenship, can be reconceived in ways that make it more comprehensive and applicable to individuals who are not neurotypical adults. Rather than restricting what counts as valid exercise of autonomy to conventional practices and locations, which were devised for the neurotypical and necessarily exclude those with “lower levels” of understanding and self-control, we can consider what other practices might constitute meaningful exercise of agency. It is in answering the question of *how* one’s autonomy can be respected, rather than *whether* it should be, that one’s cognitive capacities matter.

As D & K point out with respect to the political realm, it is an open question how we should expand the practices and locations that constitute citizenship so that those lacking linguistic agency are included in shaping social norms. Similarly, I suggest in this thesis that we can examine veterinary practice with an eye toward identifying when, where, and how veterinarians and other caregivers can attend to patient autonomy. We might ask in what ways patient preferences and values might guide medical decisions and the delivery of care. What practices can be incorporated to permit the provision of care without routinely overriding of patients’ decisions and refusals? How can veterinary practice evolve to promote our patients’ agency? Just as D & K’s approach serves to empower those who lack

²⁵⁷ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 117).

linguistic agency to nonetheless shape norms and shared social life,²⁵⁸ such inquires may enable the patients we serve to shape the institution of veterinary medicine.

Towards a Relational Conception of Patient Autonomy

So far we have briefly touched on matters of “dependent agency,” in which individuals rely on others to exert their agency, and have alluded to ways of revising our conception of autonomy to broaden the ways in which it might be meaningfully respected. In this section, I will sketch out various accounts of “relational autonomy” in the feminist and communitarian literature in order to situate the approach I propose for veterinary medicine. Though most accounts of relational autonomy have focused exclusively on human-centered bioethics, once we acknowledge that animals have a subjective experience, their own values and preferences, and the capacity to exert agency, much of the work that has been done appears to be readily extrapolatable to veterinary medicine.

“Relational autonomy” is an umbrella term that may be used to describe a range of accounts, including ones with potentially conflicting aspects. Beginning in the 1970s, feminists and others began to criticize mainstream conceptions of autonomy as overemphasizing independence and self-sufficiency. These were characteristics that the wealthy, white, male philosophers who initially wrote about autonomy believed themselves to possess, but which were usually out of reach for women during times when gender roles were very divergent and unequal.²⁵⁹ The conventional accounts of autonomy put forth by these philosophers, feminists charge, failed to acknowledge the extent to which autonomy requires social relationships in order to be developed and exercised.²⁶⁰ Autonomy is necessarily relational because many different social relationships are required to bring about the conditions in

²⁵⁸ Donaldson, Sue and Kymlicka, Will. “Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals.”

²⁵⁹ Friedman, M. (2003). *Autonomy, Gender, Politics*. (p. vii).

²⁶⁰ *Ibid.*, 81, 96.

virtue of which decisions and behavior exhibit autonomy, especially higher degrees of autonomy.²⁶¹

Thus, one definition of relational autonomy is “the competent exercising of skills, derived and constrained by social circumstances, that facilitate self-direction.”²⁶²

Autonomous capacities require social relationships in order to develop at all. We are all born completely dependent and unable to fulfill any of our basic needs, much less reflect on our desires and initiate actions to execute them. For an infant to grow into an autonomous adult, she must be nurtured, taught, and socialized in ways that allow her to survive, to understand her world, particular situation, and options, and to see herself as someone whose values are “worthy reason for action.”²⁶³ Feminists have argued that the devaluing of what was traditionally considered “women’s work,” such as raising children, led to a failure to recognize this, and to instead conceive of autonomy as an inherent capacity.

Even in adulthood, feminists and communitarians have pointed out, we all require “ongoing interpersonal, social, and institutional scaffolding” to continually develop and exercise our capacity for autonomy.²⁶⁴ The options available to us as agents of our lives – sometimes even our recognition that there is a decision to be made– are constrained both by our material, educational, and social conditions, as well as by the extent to which our society and/or our inner social circle respect our autonomy. Our very ability to set a course for ourselves and then pursue that plan – central to most conceptions of autonomy – depends in part on physical objects (made by others) and cultural and economic factors (products of broad social relationships).²⁶⁵ Interpersonal relationships not only can expand or diminish our willingness to exercise autonomy;²⁶⁶ in many cases, our success or failure at exercising autonomy

²⁶¹ *Ibid.*, 4.

²⁶² Ells, C. 423.

²⁶³ Wardrope, A. (2015). Liberal Individualism, Relational Autonomy, and the Social Dimension of Respect. 41.

²⁶⁴ MacKenzie, C. (2014). The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability.” (p. 42).

²⁶⁵ Wardrope, A. (2015). Liberal Individualism, Relational Autonomy, and the Social Dimension of Respect. 40.

²⁶⁶ Friedman, M. (2003). *Autonomy, Gender, Politics*.(pp. 94-95).

depends on others' responses to our attempts at doing so.²⁶⁷ Our social environment determines, in large part, whether or not our selected ends are *authentic*, that is, whether they are truly "our own," as opposed to being the product of oppressive socialization or originating as a result of unmet needs or undeveloped capacities.²⁶⁸

Decoupling the notion of autonomy from the concepts of self-sufficiency and independence is considered especially important in the context of health care because people who are sick are often critically dependent on others.²⁶⁹ They do not encounter medical professionals from the position of equal power, as contractarian models of the autonomous subject that often suggest.²⁷⁰ Patients' continued exercise of autonomy is contingent on their connections with others who care for them.

In all these ways, autonomy is *causally* relational; that is, the conditions necessary for an individual to act autonomously are crucially dependent on social relationships. In addition, some claim that human autonomy is also *constitutively* relational, or inherently social. As social beings, they argue, we are dependent on others for our very identities, which are shaped in part by our dialogue and other interactions with others.²⁷¹ If autonomy is defined as self-rule, and the self is inherently relational, then autonomy itself must be conceptualized relationally. In addition, the choices we make take place against a background of contrasting options that are chosen by others; what makes an individual autonomous is that they are "ruling themselves," rather than taking a path chosen or dictated by others. Without the contrast with heteronomy, the argument goes, autonomy would lose its meaning.

For the approach I take in this thesis, autonomy is conceived as causally relational, but I do not take a position on whether it is constitutively relational. Animal autonomy is at the center of my inquiry,

²⁶⁷ Sherwin, S. A Relational Approach to Autonomy in Health Care. (p. 24).

²⁶⁸ Wardrope, A (2015). Autonomy as Ideology: Towards an Autonomy Worthy or Respect. 59-61.

²⁶⁹ Cook, R.J. (1994) Feminism and the Four Principles. In R. Gillon *Principles of Health Care Ethics*. Hoboken, NJ: Wiley. (p. 197).

²⁷⁰ Donchin, A. (2001). Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethical Principles. *Journal of Medicine and Philosophy*, 26 (4), 374.

²⁷¹ Friedman, M. (2003). *Autonomy, Gender, Politics*. (p. 95).

Wardrope, A (2015). Autonomy as Ideology: Towards an Autonomy Worthy or Respect. 60.

and the philosophical exploration of animal selfhood is still in its infancy, making such assessments premature. More important, both conceptually and practically, is acknowledging that autonomy and agency are not capacities an individual possesses merely by virtue of cognitive ability, but are always dependent on social relationships. This opens the door to recognizing ways in we might help dependent others – including animals – to exert agency and exercise autonomy in a variety of realms.

It's worth noting that, though mainstream accounts like B & C's are often the target of critics advocating a relational approach to autonomy, B & C acknowledge that when a patient makes a substantially autonomous decision, it is a relational accomplishment: the relationship with the physician influences whether the patient's level of understanding is sufficient. In latter editions of *Principles*, B & C briefly note that "properly structured" accounts of respect for autonomy must not be excessively individualistic and relational accounts of autonomy may be potentially "illuminating and defensible."²⁷²

However, some of B & C's critics charge that their theory must be also be evaluated on the basis of how it has been affected by historical biases and how it affects ongoing discourse.²⁷³ They argue that, while B & C's account of autonomy may be logically consistent with the incorporation of relational concerns, the way B & C "practice the discourse" perpetuates a flawed moral ideology. That is, what B & C in fact count as a moral problem, what they remain silent about, and the assumptions they make about the "typical" patient reflect and reinforce an underlying, seldom scrutinized moral ideology. The moral ideology makes assumption that, such critics charge, fail to accurately reflect the "lived moral experience," the fundamental interdependence of people, and the role of factors aside from rationality in decision-making.²⁷⁴ In concentrating on the competence of individual patients, for example, B & C make problems associated with interdependency seem peripheral and minor, or perhaps not even true

²⁷² Beauchamp, T.L., & Childress, J.F. (2009). *Principles of Biomedical Ethics* (6th ed.). (pp. 99, 102-103).

²⁷³ Ells, C. 424.

²⁷⁴ *Ibid.*, 419, 425.

moral problems, and blind us from approaches to solving them that are social in nature.²⁷⁵ B & C also seem to implicitly assume a “model patient” who is the physician’s intellectual and moral equal, whereas an imbalance of power relationships often exists within health care institutions, and social and political context adds a significant moral dimensions of the physician-patient relationship.²⁷⁶ Some of these critics deny that B & C can ever adequately answer the challenges posed by relational autonomy theorists because, in the words of Carolyn Ells, “to attempt to widen the focus to amend the theory’s short comings is to destroy the theory.”²⁷⁷

Regardless of whether or not the prognosis for B & C’s theory is truly this grave, I maintain that the extent to which physicians and other caregivers can promote patient autonomy is underestimated when the competency threshold is used to limit whose autonomy merits concern. Autonomy, understood by relational theorists as the ability to form, “evaluate, and live in accordance with a conception of the good,”²⁷⁸ is valuable to patients on either side of the competency threshold. In the remainder of this chapter, I will focus on the approaches of two writers on relational autonomy in medicine, Alistair Wardrope and Marian Verkerk. The patients with whom they are concerned are humans who B & C would likely consider below the competency threshold or, in some cases, patients B & C would consider competent but whose ability to exercise autonomy nonetheless seems compromised. I will use their insights to begin to ask how taking a relational approach can help expand the locations and practices of autonomy in the case of veterinary patients.

Synchronic V. Diachronic Dimensions of Respect for Autonomy

In presenting his version of relational autonomy, Alistair Wardrope describes a potential underlying cause of B & C’s advocacy of a threshold to divide patients into competent and incompetent

²⁷⁵ *Ibid.*, 424.

²⁷⁶ Donchin, A. 368, 376.

²⁷⁷ Ells, C. 419.

²⁷⁸ Wardrope, A (2015). *Autonomy as Ideology: Towards an Autonomy Worthy or Respect*. 66.

populations: the overwhelming focus on “crisis” issues in medical ethics. Crisis issues are usually “punctate decisions,” that is, decisions that must be made at a discrete point in time and typically involve a limited range of options.²⁷⁹ Crisis issues involve pressing questions that must be resolved rapidly, and often involve resolving a conflict about “who has ultimate authority to decide on a given course of action.”²⁸⁰ One example is whether to respect a patient’s decision to refuse life-saving care, an issue typically framed as a punctate decision in which the physician’s duty to respect the patient’s autonomy may be at odds with her duty of beneficence. An article on this subject echoes B & C’s directive: “For incompetent patients the question of honoring refusals of treatment does not arise; it is replaced by the issue of who should make decisions for incompetent patients.”²⁸¹

It is not difficult to see why this approach would be appealing. In crisis situations, we need to be able to make decisions quickly and in a way that will lead us to be satisfied with the results in a majority of cases. Algorithms that point clearly to the next step are very helpful in such situations, and by necessity they focus on *synchronic* issues, or relevant considerations at the particular point in time that a decision must be made.²⁸² Looking at respect for autonomy through such a lens, it makes sense to divide patients into two clear-cut groups, competent and incompetent: an emergency physician who finds herself presented with a new patient can rapidly assess the role of respect for autonomy and whether a surrogate must be identified.

However, as Wardrope points out, medical ethics’ focus on crisis issues obscures the equally important domain of “house-keeping issues,” that is, the ways in which the norms that are established in a caregiver-patient relationship through the totality of their interactions work to promote or diminish patient autonomy. These are *diachronic* dimensions of respect for autonomy, in that they extend over time and may evolve over the course of the relationship. In longer-term physician-patient relationships,

²⁷⁹ *Ibid.*, 63.

²⁸⁰ *Ibid.*, 64.

²⁸¹ Miller, B.L. (1981). Autonomy & the Refusal of Lifesaving Treatment. *The Hastings Center Report*, 11 (4), 27.

²⁸² Wardrope, A. (2015). Liberal Individualism, Relational Autonomy, and the Social Dimension of Respect. 42.

the *diachronic* dimensions of respect for autonomy take on greater importance and may even eclipse synchronic dimensions. The norms established between the practitioners and the patient

“come to constrain and enable certain options, such that the major influence of the provider on the patient’s autonomy is already determined by the time the punctate decision arises. For example, [author Rebecca] Kukla points to the ‘practices of self-surveillance, medical monitoring, and hyper-responsibility’ that comprise antenatal care, and suggests that this recurrent emphasis on conscientious self-monitoring may serve to frame the issue of fetal diagnostic testing in such a fashion that undergoing the test ‘may appear to her as the only responsible choice.’”²⁸³

Wardrope argues that the focus on punctate decisions and crisis issues in medical ethics serves as a sort of “dogma,” leading to respect for autonomy being conceived of primarily in synchronic terms.²⁸⁴ A *dogma*, as he understands it, is similar to the “moral ideology” discussed above; it is a proposition that is not argued for but rather a product of how the discourse is practiced and the terms in which moral problems are typically framed.²⁸⁵ Habitually focusing only on the synchronic dimensions of respect for autonomy leads us to ask questions mostly about *what* should be done, rather than *how* care should be provided.²⁸⁶ It artificially narrows the range of what is considered a moral problem.²⁸⁷ Wardrope argues for correcting this unjustified bias by paying more attention to how the norms established in caregiving relationships can promote patient autonomy. Considering autonomy as a “social project” means that respecting autonomy involves anticipating possible choices and what the patient will need in order to make them.²⁸⁸

Norms are established in all kinds of caregiving relationships, and those between animals and human caregivers are no exception. In fact, given that we cannot use symbolic language to explain to

²⁸³ Wardrope, A. (2015). *Autonomy as Ideology: Towards an Autonomy Worthy or Respect*. 63. Quotes Kukla, R. (2005). *Conscientious autonomy: displacing decisions in health care*. *Hastings Center Report*, 35(2), 41.

²⁸⁴ Others, such as Anne Donchin, attribute medical ethics’ focus on crisis issues rather than house-keeping issues as arising from 1) science’s emphasis on generalizable knowledge, 2) medicine’s conception of itself as a science, and 3) house-keeping issues relating to particulars of “everyday medical practice and ongoing relationships” rather than the generalizable principles relied upon to address crisis issues (372-373)

²⁸⁵ Wardrope, A. (2015). *Autonomy as Ideology: Towards an Autonomy Worthy or Respect*, 56.

²⁸⁶ *Ibid.*, 63-64.

²⁸⁷ Eils, C., 417.

²⁸⁸ *Ibid.*, 423.

animals when something unusual might be needed for providing veterinary care, established norms and anticipating future choices may be even more crucial to enabling animals to accept interventions that, while likely to restore them to health, are unlikely to be chosen spontaneously. Many of Yin's recommendations for socializing puppies and kittens could be seen as conscientiously creating such norms. A cat who has positive associations with the vet clinic and has been handled gently and predictably will be more likely to permit placement of an IV catheter when she is ill and in need of treatment, whereas a cat who has had frightening veterinary experiences, or perhaps never been to the vet, is likely to fight against almost any kind of intervention. The latter patient is more likely to be forcibly restrained or sedated when beneficence dictates that a medical intervention is necessary, or the cat may simply not receive any medical care until she is too sick to resist interventions – and perhaps too sick to recover. The foresight involved in providing opportunities for apes to engage in PRT for veterinary behaviors may also be seen as attending to the diachronic dimension of respecting autonomy.

Choosing the Appropriate Locus of Respect

Wardrope makes a related point, which is that a focus on punctate decisions leads to considering the patient's *decision* as the "locus of respect," when we talk of respecting autonomy.²⁸⁹ That is, we demonstrate respect for autonomy by ensuring a given decision is well informed and then facilitating it – or at least not interfering with it. When the patient's decision is our locus of respect, the classification of patients into classes of "competent" and "incompetent" makes sense, because we care about whether a given decision itself is *worthy* of being respected, and one made by an incompetent patient is more likely to be ill-considered or misguided. However, the decision need not be the (sole)

²⁸⁹ Wardrope, A. (2015). *Autonomy as Ideology: Towards an Autonomy Worthy or Respect*, 63 & 68.

locus of respect; we could conceive of the patient herself, the values underlying her decision-making, or her own conception of the good as the locus of our respect instead.²⁹⁰

Incorporating diachronic dimensions of respect helps shift the locus of respect back to the patient as a whole, and leads us to ask how medical caregivers, and perhaps other caregivers, can enable her agency and increase her autonomous capabilities. For example, someone who has had a dominating partner make all of her decisions for her in the past may need support to develop the self-esteem and self-confidence to see herself as a decision-maker. Wardrope also discusses female genital cosmetic surgery (FGCS) and points out that women seeking it frequently have an incorrect belief that the appearance of their external genitalia is not within normal limits and that this negatively affects their worth.²⁹¹ In such cases, conventional medical ethics approaches would likely recommend proceeding with the surgery once the informed consent process has been completed. Wardrope suggests that considering the woman herself as the locus of respect might suggest a different course, for example addressing issues of self-objectification and its effect on autonomous capabilities.²⁹²

With animals, it may also be helpful to consider what the appropriate locus of respect is in a given situation. A dog with a ruptured knee ligament obviously cannot give informed consent or refusal to a surgery to correct the injury. However, her human family may be able to evaluate her values and concerns, and take these as the locus of respect. A decision to pursue surgery may be said to respect the autonomy of young, very active dog who enjoys nothing more than running and has little distress in the veterinary clinic, while an older, more sedentary and fearful dog might have her autonomy better respected by measures such as maintaining her at a lean weight and providing pain medication and joint supplements. In making end-of-life decisions, such as whether to pursue life-extending measures, palliative care, or euthanasia, caregivers can respect the animal patient's autonomy by considering what

²⁹⁰ *Ibid.*

²⁹¹ *Ibid.*, 50.

²⁹² *Ibid.*, 50-51.

matters to her, rather than assuming that extension of life is necessarily good, or basing the decision on their own emotions or convenience.

A Dialogic Approach to Respect

Wardrope proposes an account of respect for autonomy that conceptualizes “respect” in terms other than noninterference. He seeks to reboot the idea of “respect” to model it not on the ideal of respecting a nation’s sovereign boundaries, but on that of respectful conversation:

“The picture that I hope will emerge is one of respect, not as a matter of non-interference in individual decisions, but of taking seriously the other as a rational agent, able to evaluate and give reasons that carry a normative weight for all.”²⁹³

This approach can be used with a patient who has been classified as incompetent because of her insufficient level of understanding or inability to anticipate the likely consequences of a given medical decision. This patient often still has her own reasons for acting or choosing in one way over another, reasons that are important to her. Rather than failing to consult such a patient or disregarding her decision, as B & C seem to require, Wardrope’s conception of respect in the dialogic sense suggests a way for medical practitioners to respect their autonomy: by viewing what patients communicate about their reasons as “an expression of their values” and ensuring that they are incorporated.²⁹⁴

In considering the applicability of this approach to animals, an obvious question is whether animals are legitimately included among Wardrope’s “rational agents,” able to have, give, and evaluate reasons. Animals’ ability to give and evaluate reasons will be considered in subsequent discussions in this thesis, but I will take a moment here to examine address the more fundamental worries. Postulating reasons for actions has such great value in terms of explanation, prediction, and modification of behavior that virtually no one who works or lives with animals can operate without presupposing that animals have such reasons. Yet, it is important to note that, in making this statement and in the

²⁹³ *Ibid.*, 57-58.

²⁹⁴ *Ibid.*, 67.

preceding discussion of animals' reason, I am using the terms "reasons" loosely and colloquially. If autonomy is about choosing and acting based on one's own reasons, it is important to clarify what exactly we mean by "a reason."

In Chapter One, we considered Kant's accounts of rationality and what counts as a reason, but dismissed them as too demanding for modern medical ethics; many if not most human patients would be in danger of having their autonomy overridden because of failure to meet Kant's stringent criteria. Today, "to be rational" is often taken to mean "to be appropriately responsive in one's attitudes and behavior to sufficiently good reasons;" this definition must then be supplemented by a substantive theory of reasons to determine what constitutes a "good reason" and what we mean by appropriately responsive, etc.²⁹⁵

In the context of autonomy, we are concerned with *normative* reasons (also called "justifying reasons") rather than *explanatory* reasons. Explanatory reasons explain why someone acted in a certain way – they need not involve conscious consideration. Normative reasons are considerations that "support, legitimize, or justify an action, whether undertaken or not."²⁹⁶

One potential definition of a normative reason is *a consideration that bears some relation to a motivational fact about an agent.*²⁹⁷ While there is no consensus about whether this is necessarily true of *all* reasons,²⁹⁸ most would accept a consideration fitting this description as at least a candidate for counting as a normative reason for the agent in question. The "motivational fact" in this definition is considered by some philosophers to refer to a psychological state, such as a desire; that is, one has a reason for acting in a given way if doing so would satisfy a desire that one has, even if one is not actually

²⁹⁵ Shafer-Landau, R. (2003). *Moral Realism*. Oxford: Oxford University Press. (p. 168).

²⁹⁶ Shafer-Landau, R. (2003). *Moral Realism*. Oxford: Oxford University Press. (Kindle edition – location 2212)

²⁹⁷ Finlay, S. & Schroeder, M. (2017). Reasons for Action: Internal vs. External. In E.N. Zalta (Ed.) *The Stanford Encyclopedia of Philosophy*. Retrieved from: <https://plato.stanford.edu/archives/fall2017/entries/reasons-internal-external/>

²⁹⁸ Such a claim is associated with the thesis of reasons internalism, while reasons externalism holds that some reasons need not bear any relation to a motivational fact about an agent.

motivated to act in such a way.²⁹⁹ Other philosophers consider the “motivational fact” to be a fact about what the agent is moved to do through her own volition; that is, one has a reason for acting in a given way if one is motivated to do so, whether or not this involves a desire.³⁰⁰ One might, for example, be moved to act in a certain way because of a belief that this is the right way to act or the smart thing to do. In contrast with the tradition, cognitive conceptions held by philosophers like Kant, some feminist theorist have broadened the notion of a reason to encompass “emotions, desires, passions, inclinations, or volitions – in short, any mental state involving any motivation or attitude at all.”³⁰¹ Feminist bioethicists point out that emotions are often major factors in patients’ decision-making; they criticize conventional accounts of medical ethics, which over-emphasize rationality and assume a narrow, highly cognitive construal of “reasons,” for overlooking this fact.³⁰²

Accepting more permissive standards for counting a consideration as a reason ensures that animals easily qualify as having and acting for reasons. However, very permissive accounts may also make it difficult to distinguish between justificatory and explanatory reasons, and perhaps also between good and bad reasons for acting.³⁰³ I do not wish to wade too deeply into the controversy surrounding the proper substantive theory of reasons, but include this discussion merely point out that we are unlikely to find on a plausible theory that both 1) acknowledges and accepts as justificatory reasons the breadth of considerations that “competent” human patients often invoke in making medical decisions, and 2) denies that animals have and act for justificatory reasons.

²⁹⁹ Such a desire may be an actual or a desire that one would have under a particular kind of circumstance, such as possessing full information or being able to deliberate faultlessly. See Finlay S. & Schroeder, M. above.

³⁰⁰ Some would also include counterfactual motivation, that is, if one would be motivated to act in a given way were one to possess full information, then one has a reason to act in that way, even if one is not currently so motivated.

³⁰¹ Friedman, M. (2003). *Autonomy, Gender, Politics*, (p. 10).

³⁰² Eils, C., 418, 425.

³⁰³ McShane, K. (2017) Personal communication.

It is also significant that Wardrope's account does not require that we definitively distinguish justificatory reasons from explanatory reasons. What it requires is taking the time to understand and care about what the *patient* takes as a reason:

“[When] we reason together, our utterances take the form of an invitation – from the speaker, to the listener(s), to accept what is a reason for the speaker as a reason for them too. The conversation attempts to construct a ‘shared space of reasons’; such that it ‘is possible that there is a ‘we’ for which we can [all] speak.’”³⁰⁴

For example, a physician can explore why a patient does not want a recommended intervention and thus identify concerns (real or imagined) that can be then be addressed. In many cases, it may not be the procedure itself that the patient rejects, but an aspect of undergoing it that is frightening or otherwise aversive. While the physician may consider the patient's particular concern unfounded or peripheral, respecting the patient's autonomy, under Wardrope's model, means she must strive to appreciate the patient's standpoint. Often, the patient's concerns may turn out to be easily allayed, such that the conflict between respecting her autonomy and fulfilling the duty of beneficence is resolved.

In this way, Wardrope's dialogic approach to respect is a means of identifying “locations and practices” where respect for autonomy can enter the clinical context in a way that is meaningful to patients. For example, what an elderly dog objects to about a veterinary exam may be something as simple as being forced to stand on a slippery metal table where she cannot get good footing. Perhaps the veterinary clinic's “scent profile,” replete with the smells of potential predators (dogs), is a reason some cats hide as soon as the travel carrier is taken out of the closet. What a chimpanzee finds most objectionable about undergoing an anesthetic procedure may be that, prior to administering medications, her caregivers isolate her in a way that she cannot see or hear her friends. Looking for and accepting animals' reasons as contributing to the “shared space of reasons” naturally suggest ways of respecting veterinary patient autonomy in ways that matter to them.

³⁰⁴ *Ibid.*, 66. Quotes Laden, A. S. (2012). *Reasoning: a social picture*. Oxford: Oxford University Press. (pp. 145-146).

Animals are not only bearers of reasons, they also seem to be able to evaluate reasons and change their minds. For example, many primates who are “retired” to sanctuaries are distressed at the sight of a syringe, which previous experience has taught them is likely to cause them pain or distress. Positive reinforcement training, specifically the use of desensitization and counter-conditioning techniques, is known to often be effective in changing an animal’s emotional response. This type of training can be conceived of as a dialogic process. At the start, the animal has a good reason (fear and past experience) for keeping a far distance from the syringe. The training process might involve presenting the syringe in nonthreatening scenarios, initially at a distance and later in closer proximity, perhaps in the context of enjoyable experiences, such as play or preferred food item. Though often described in terms of “forming associations,” this is equally well explained as a dialogic process during which the trainer introduces new reasons for the animal to modify her prior beliefs.

Another component of Wardrope’s model of dialogic respect is a commitment to trying to understand what the other individual is attempting to communicate, even if we disagree with their assessment or understanding of the situation.³⁰⁵ The hope is to arrive at a shared, coherent perspective with them, and being open to modifying our own position as a consequence of incorporating their reasons. He writes:

“[Respect] crucially involves sensitivity to a patient’s values and self-conception – an attempt to understand them and see the role they play in an agent’s life, but also to work within and against them to move beyond aspects of them that may present barriers to autonomy.”³⁰⁶

What Wardrope has in mind is helping patients to recognize when a value they hold may not truly be their own, that is, when it is “inauthentic.” An inauthentic value or desire is one that the patient holds because of conditions, such as systematic oppression or deprivation, to which she has been subjected. Inauthentic desires and values may lead to someone to form “adaptive preferences” – preferences that

³⁰⁵ Wardrope, A. (2015). *Autonomy as Ideology: Towards an Autonomy Worthy of Respect*, 67.

³⁰⁶ *Ibid.*, 62.

would be different if core needs had been met or crucial capacities developed.³⁰⁷ In cases where this dynamic is suspected, respecting autonomy doesn't mean going along with whatever the patient might assert she wants. Rather, taking the patient herself (or perhaps the concept of autonomy itself³⁰⁸) as the locus of respect may mean helping the patient to develop the requisite capabilities, prompting her to reconsider her preference, or promoting her own "self-trust and self-worth" prior to finalizing a decision.³⁰⁹

In the veterinary realm, we also face challenges in caring for the mental and physical health of veterinary patients who have adaptive preferences. For example, a retired greyhound may have a complete lack of interest in and understanding of play, a former "research" chimpanzee may fear touching the earth and prefer to cling only to wire mesh (the material of laboratory cages), and a sanctuary hen who was reared on a "factory farm" may prefer to remain in a small nest box rather than venture outside. Well-intentioned caregivers may struggle with how best to respect the autonomy of such patients. Taking a dialogic approach allows us to introduce new reasons for the animal to consider and opportunities to build new skills, while also requiring that the caregiver be open to having her own perspective altered as her understanding of the patient's self-conception grows.³¹⁰ Desires the caregiver initially believes to be inauthentic may turn out persist in the face of reflection, despite their origins. Because it is dialogic, the caregiver remains open to exploring other avenues if the patient steadfastly retains her past attitude. Once the concept of respecting autonomy is decoupled from the idea of noninterference, such interventions need not be conceived as paternalistic.

Many examples of positive reinforcement training for veterinary procedures seem to fall naturally under Marian Verkerk's rubric of *compassionate interference*, which Wardrope references in

³⁰⁷ Wardrope, A. (2015). Liberal Individualism, Relational Autonomy, and the Social Dimension of Respect. 41.

³⁰⁸ For an interesting discussion on examining the mutual impact of individuals' decisions on one another's autonomous capabilities, see Wardrope's "Liberal Individualism, Relational Autonomy, and the Social Dimension of Respect"

³⁰⁹ *Ibid.*, 43.

³¹⁰ *Ibid.*, 44.

his own work. Verkerk writes about providing care for homeless drug addicts with a history of psychiatric problems. Because of their proximity to the competency threshold that is so important to standard medical practice, such individuals are at high risk of paternalistic intervention in which their autonomy is overridden, such as forced institutionalization. Verkerk is critical of mainstream approaches to respect for autonomy because they seem to pay little attention to “how the need for coercive interventions can be prevented or, to put it another way, how a situation in which only two strategies remain – leave the patient as he is or use coercion – can be avoided.”³¹¹

Verkerk believes that non-interference is impossible in a caring relationship, because interactions necessarily “make and remake” both parties as persons. Instead, respect for an individual’s autonomy means exercising this power to shape others “wisely and carefully.”³¹² It requires taking the time to understand how patients receiving care see themselves, their concerns, their struggles, and their place in the world.³¹³ Since it is the individual we must respect, not a decision considered in isolation, respecting autonomy may mean engaging with the patient to help her to achieve greater autonomy.³¹⁴ Returning to our previous example of desensitizing and counter-conditioning a chimpanzee to a syringe, the end goal may be to ensure that, when an injection is needed to treat or prevent an illness (a beneficent goal and one likely in line with that patient’s values), she may accept it voluntarily, rather than leaving darting or other autonomy-overriding practices as the sole option.

Summary and Looking Ahead

As we have seen, veterinary medicine traditionally involves the routine and often extreme denial of patient autonomy, at the levels of both medical decision-making and delivery of care. Modern movements in veterinary medicine that acknowledge the importance of securing the veterinary

³¹¹ Verkerk, M. (1999). A Care Perspective on Coercion and Autonomy. *Bioethics*, 13 (3/4): 362.

³¹² *Ibid.*, 366.

³¹³ *Ibid.*

³¹⁴ *Ibid.*, 365.

patient's voluntary participation typically appeal solely to animal welfare, conceived of in terms of physical and psychological health, while remaining silent on the issue of patient autonomy. While this is understandable given the mainstream bioethical approach, I have shown in this chapter that using a relational account of autonomy provides an additional rationale for incorporating techniques like low-stress patient handling and positive reinforcement training for veterinary behaviors. Such an approach helps resolve apparent conflicts between beneficence and respect for patient autonomy by allowing these duties to pull in the same direction. It also suggests options for a more coherent approach to veterinary care in settings where animal autonomy is already valued, such as ape sanctuaries.

As we have seen, B & C's use of a threshold of autonomous decision-making capacity to determine patient competence is similar in structure to traditional political theory's use of linguistic agency to assign full citizenship rights: a spectrum of abilities is transformed into dichotomy which denies one group its right to "have a say." In both cases, the structure of the discourse tends to obscure the fact that one's ability to exert agency and exercise autonomy is relational, that is, it is dependent on social relationships and other socially-rooted factors. When we take subjectivity, or having a subjective experience of one's life, as the core of moral consideration, rather than using neurotypical human cognition as our benchmark, we can begin to broaden our understanding of what it means to respect someone's autonomy.

Although, to my knowledge, relational autonomy as a bioethical concept has not previously been applied to veterinary medicine, some accounts seem readily extrapolatable to animal patients. These include attending to the diachronic dimensions of respect for autonomy and taking the patient (rather than a given decision) as one's locus of respect. In addition, if we draw our concept of *respect* from the model of "respectful dialogue" rather than respecting boundaries, we can respect autonomy by attending to what the patient herself considers a reason and by "compassionately interfering" to promote the patient's autonomy. As I have shown, using this relational lens, veterinary professionals can

identify new “places and spaces” for respecting patient autonomy, locations and practices that matter to the animals themselves. The veterinary patient’s relationships with her caregivers moves to the forefront, as it is through this relationship that we can identify what matters to a patient and can develop strategies for protecting her autonomy during the course of veterinary care.

In the next chapter I will address some final pressing issues with my account and test its ability to withstand criticisms. First will be the issue of interpretation, that is, how can we know what is important to veterinary patients and what their desires, preferences, and values are? Next, I will suggest some concrete ways in which we might respect patient autonomy at both the level of selecting veterinary interventions and in terms of how they are delivered. Finally, I will examine an issue we have seen can be controversial with regard to autonomy, namely, training animals to participate in their care.

CHAPTER FOUR

Introduction

In Chapter Three, I introduced a relational account of autonomy that I argue is applicable to veterinary patients. It enables the medical practitioner's duty to respect autonomy to extend to patients who would fall below B & C's competency threshold, and it helps us to identify "places and spaces" in veterinary practice where patients' exercise of autonomy is meaningful to them. Like other relational accounts, this one acknowledges that an individual's development and exercise of autonomy is inextricably dependent on others in their lives and on social and institutional structures, so the fact that veterinary patients often depend substantially on their caregivers for exerting their agency does not justify devaluing their autonomy. By adopting a concept of "respect for autonomy" that considers diachronic dimensions, consciously attends to the locus of respect, and conceives *respect* in a dialogic sense, rather than as noninterference, we can identify new locations and practices for respecting autonomy, ones that align with patients' perspective and values. While recent movements in veterinary medicine, such as low-stress patient handling and positive reinforcement training for medical procedures, are typically promoted on the basis of a narrowly construed idea of welfare, e.g., decreasing distress and fear, or on the basis of prudential concerns like improved efficiency, these methods can also be employed as a means of respecting animal autonomy.

In this chapter, I will begin by examining the challenge of interpretation: since veterinary patients cannot articulate their values or concerns, how can we determine what these are? How can we ensure that those charged with facilitating their agency do so accurately, rather than projecting their own concerns or self-serving biases? After this, I will present some concrete recommendations for how veterinary professionals can respect patient autonomy that flow from my account. Finally, I will use the

proposed framework of relational autonomy to analyze the practice of training animals for veterinary procedures, a practice that some charge undermines animal autonomy.

Interpreting for Animals

Under my proposed account, respecting the veterinary patient's autonomy entails incorporating her reasons when it comes to medical decision-making and ensuring that her subjective good (her desires, values, concerns, etc.) shapes both *what* she receives in terms of health care and *how* she receives it. Veterinary patients, since they are unable to articulate their desires linguistically, are dependent on human caregivers to be their interpreters. These caregivers are faced with translating the animal's subjective experience and values so that they can enter the veterinary care discussion. Is such an endeavor even feasible? What if different caregivers offer different interpretations of what matters most to a patient, or what her behavior signifies? And, how can we ensure we are not merely projecting onto animals our own wishes, attributing assent or refusal to them when it really stems from our own perspective? As D & K put it, "if we can't interpret [animals'] subjective good, then the goal of human-enabled [animal] agency is an incoherent one."³¹⁵

This epistemic challenge is one that is often used to justify relying solely on "objective" measures of welfare. These are generic criteria, targeted at the level of species or perhaps the animal's "function," as defined by humans, i.e., guide dog or food animal. Such lists are also available in veterinary medicine, for example, the "Rule of 20" lists twenty essential parameters to review on all hospitalized patients, to ensure no aspect of their welfare and health status is being neglected.³¹⁶ Under such accounts, as long as health and welfare criteria are met, our ethical duties to the animal are satisfied. It is a moot point whether the individual animal has preferences or idiosyncrasies that deviate

³¹⁵ Donaldson, S. & Kymlicka, W. (2016) "Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals." (p. 191).

³¹⁶ "Emergency Department Procedures: Rule of 20." Unknown source, however, discussion available at: <http://vet.ucoz.com/kirbyrule.pdf>

from the “model patient” assumed by the pre-determined criteria. Asking whether her hospital stay aligns with her own values is also out of bounds. If we cannot reliably determine a veterinary patient’s desires and values, or if our assessments are likely to be contaminated with self-serving bias, relying purely on objective criteria may be preferable to attempting to introduce her subjective perspective into the discussion.

Before examining what interpretation tools we may have available, it is worth noting that this challenge is not unique to animals. People with cognitive disabilities (CD) and children are also often dependent on others to interpret their subjective good, and the risk of “bias, self-interest, projection, and well-intentioned error by those charged with interpreting” for them has also been used as an argument for relying on objective criteria rather than attempting to solicit their perspectives.³¹⁷ Yet, advocates for people with CD, including self-advocates, maintain that trustees can and should “help in the construction of ‘individual scripts’ of the good life” for such individuals to allow them to participate in shaping the conditions in which they live.³¹⁸ So the existence of epistemic challenges does not mean we must abandon the project out of hand.

As it turns out, we already have a variety of ways in which to determine, with a sufficient degree of confidence, what an animal’s subjective good is, that is, what she values, desires, prefers. And often this permits us to project, in situations beyond that animal’s intellectual ken, what course of action she would likely prefer, had she a more comprehensive understanding of the situation. These interpretive methods include reading body language and vocalizations the way behaviorists³¹⁹ and ethologists do, “asking” the way animal welfare scientists do in preference and motivation tests, and drawing on one’s

³¹⁷ Donaldson, S. & Kymlicka, W. (2016) "Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals." (p. 176).

³¹⁸ *Ibid.*, (p. 179).

³¹⁹ It should be noted that I am using the term “behaviorist” to refer to modern professionals in the animal and veterinary behavior fields who presume conscious experience attends behavior, not behaviorists like BF Skinner in days of yore who denied this.

knowledge of the animal's established patterns of behavior and communication the way those in close personal relationships with animals do.

We saw in Chapter Three that a first step is acknowledging that animals often have *reasons* for choosing or acting as they do. An animal's reason is not an articulated statement about logical relationships or an appeal to universal and necessary principles, but it does answer the question, "Why decide in this way?" Since we count inherently motivating desires and volitions as reasons when the agent is human, we ought to do the same for other agents who have a subjective experience of their lives and preferences about what happens to them. When it comes to *giving* reasons, animals may not be able to articulate their preferences and concerns linguistically, but this method of communication is also but one of many that humans employ. Relational autonomy theorists point out that part of (human) caregiving involves responding to "unspoken needs or unexpressed discomfort" and "picking up on situational cues that extend [one's] knowledge of patient needs."³²⁰ While such talents may be a natural by-product of their socialization for some, caregivers in human medicine can also:

"cultivate perceptual skills appropriate to identifying features of situations that can enrich their understanding of what the patient is undergoing... [and] expand opportunities to strengthen patients' sense of their own agency, encouraging them to relate to surrounding others in ways that support their own aims and ends."³²¹

Part of the job of being a caregiver, then, is identifying and understanding one's patients' reasons, whether articulated or not, and at times even having additional insights about these reasons that her standpoint as caregiver affords her. Increasingly, those who carefully study animals are identifying considerations which may be less obvious to us because of our own sense modalities or cognitive abilities are less developed than those of the species in question;³²² once these differences are taken into account, we may be better able to identify the animal's reason for acting a certain way.

³²⁰ Donchin, A. 377.

³²¹ *Ibid.*

³²² For example, sense of smell in dogs (Hoffman, J. (2016). Learning From Dogs as They Sniff Out Their World, New York Times. Retrieved from: <https://www.nytimes.com/2016/10/11/science/dogs-can-train-us-to-have-a-better->

The evolving scientific fields of ethology and animal behavior increasingly seek to understand what an animal's behavior says about her subjective states, including emotional states. While such questions were previously considered outside the realm of science,³²³ they are now considered fully valid topics of scientific exploration. The veterinary school curriculum and the line-up at many veterinary continuing education conferences now include coursework about understanding animals' postures, facial expressions, and behaviors as these relate to underlying emotion states and desires. In addition to behaviors whose significance might be easily identifiable by a casual observer, we can now identify more subtle expressions of emotion. Lip-licking and yawning when not sleepy, for example, indicate anxiety in dogs.³²⁴ Tucking all paws under the body and fluffing up the hair coat indicate pain in cats.³²⁵ Eye and ear position, pupil diameter, body tension, tail position and movement, degree of brow furrowing, and other facial expressions are now all considered indicative of underlying emotional and other subjective states. Recent research using functional MRI to study the brains of awake, unrestrained dogs shows striking similarities in patterns of brain activation, compared with what is found in humans, in response to situations designed to elicit certain emotions or pleasure;³²⁶ in supporting an analogous similarity in subject experiences, this serves to validate ethological findings and open avenues for further research.

When it comes to assessing animal desires and volitions, we can often “ask” patients by offering options and they can “answer” through their subsequent actions. Indeed, part of the focus of the field of

[sense-of-smell.html?mcubz=1](#)) and working spatial memory in chimpanzees (BBC Earth. Chimp vs human! - Working Memory test - Extraordinary Animals – Earth. Retrieved from:

<https://www.youtube.com/watch?v=zsXP8qeFF6A>)

³²³ Rollin, B.E. (1998). *The Unheeded Cry: Animal Consciousness, Animal Pain, and Science*.

³²⁴ Veterinary Behavior courses at University of Florida, College of Veterinary Medicine.

³²⁵ Colorado State University Pain Score in Cats. Retrieved from:

www.humanealliance.org/elearning/Acute_Pain_Scales.pdf

³²⁶ Berns G.S., Brooks A., & Spivak M. (2013). Replicability and heterogeneity of awake unrestrained canine fMRI responses, *PLoS One*, 8:e81698. Retrieved from:

<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0081698>

Berns G.S., Brooks A.M., & Spivak M. (2015). Scent of the familiar: an fMRI study of canine brain responses to familiar and unfamiliar human and dog odors. *Behavioural Processes*, 110, 37–46.

Andics A., Gábor A., Gácsi M., Faragó T., Szabó, D., & Miklós, Á. (2016). Neural mechanisms for lexical processing in dogs. *Science*, 353 (6303), 1030–2.

animal welfare science is experimentally assessing animals' preferences and degrees of motivation. "Preference tests" are experiments are devised to ask animals to choose between two or more different options, while "motivation tests" assess how strong a motivation to satisfy a given preference is, by determining how hard an animal is willing to work fulfill her preference.³²⁷ These are basically controlled and systematic methods of gaining the same type of information that animal caregivers continually collect in their daily interactions with animals.

Finally, as many "pet parents," zoo keepers, and sanctuary workers will attest, the familiarity that is developed through providing long term care to individuals allows the development of what D & K label "personal knowledge" of an animal's subjective experience and preferences:

"Personal knowledge is knowledge of an actual individual, her personality and temperament, her idiosyncratic behaviors and habits, her likes and needs as revealed over time, her individual communication repertoire, and our shared history of interaction, social codes, and systems for mutual understanding."³²⁸

They liken an animal caregiver's personal knowledge to the ability of parents to interpret an infant's cries or that of an intimate caregiver to detect meaning in a multiply disabled person's subtle movements. In all of these cases, a communication system has developed between individuals that gives the caregiver a level of understanding that is different from that of a behavior expert or other individual unfamiliar with the individual. Surely most of us who live with animals have such examples: to indicate his wish to go for a walk, my dog Henry grabs ahold of my socks as I put them on and tries to pull them off and run off with them; this behavior quite startled my visiting mother-in-law who perceived a large black dog rushing toward her and "attacking" her feet out of the blue as she got dressed. Similarly, veterinarians must often rely on a client's assessment of what is "normal" for the patient at home or at

³²⁷ Heleski, C. Preference and Motivation Testing as They Relate to Animal Welfare. Retrieved from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKewiAlenK1aTTAhUKLSYKHdaNAzEQFggxMAE&url=https%3A%2F%2Fmsu.edu%2Fcourse%2Fans%2F305%2FMarch_14%2FANS305.ppt&usg=AFQjCNEM4at-0ui--Lph0osVbdRxcHx_MQ&sig2=NtcdKnsjWWrOGZFimEQjTw&bvm=bv.152479541,d.eWE

³²⁸ Donaldson, S. & Kymlicka, W. (2012). Citizen Canine: Agency for Domesticated Animals, 20.

other veterinary visits to determine whether certain behaviors (trembling, urinating inappropriately, reaction to handling) is an expression of emotion or a symptom of illness.

With these means of identifying the emotions, preferences, volitions, and desires that comprise an animal's subjective good and can serve as reasons for her to act or choose in a certain way, we can now tackle one of the potential complications of interpretation. When caregivers' own interests are at stake, there is the risk that they may impose their own perspective on a patient, as their own needs or desires crowd out their ability to "listen" to the patient and speak for her. One example is the pet-parent with such a deep attachment to their pet, that they feel the need to stay near the animal or keep her alive at all costs. In practices, I have seen this play out, sometimes seemingly because of the person's social isolation and other times when the pet represents a connection to a human partner or family member who has passed away. Another example may be a caregiver, perhaps in a zoo or research setting, who has competing interests, such as seeing an experimental treatment succeed or a captive endangered animal breed. In both cases, such caregivers may be more prone to self-serving bias or projecting their own desires onto the patient. Here, the patient has very limited ways to "speak up" if her perspective is being misunderstood or misrepresented.

These are among the "pathologies" that can arise from relationships that are inherently unequal in terms of power and communicative ability.³²⁹ One potential defense against such pathologies is merely being aware of the potential for self-serving bias and projection, and seeking ways to correct for it, perhaps by enlisting the input of a trusted confidant. Veterinary professionals can respect their patients' autonomy by guarding against such pathologies in their own lives, and by helping clients to become aware of them. In some cases, it may be effective just to give a reminder that the patient's perspective is separate and different from the client's, and matters in its own right. At times, the clinician might even gently challenge a caregiver whose interpretation of the patient's subjective good

³²⁹ Personal conversation, Katie McShane. Verkerk, M., 367.

seems questionable. Knowing the client's emotional distress is likely intense, she might still be able to lead by example, saying perhaps: "As a veterinarian, even when I know we're taking the best care we can of a pet here in the hospital, sometimes I still have to stop and ask, is this situation one the animal would choose for herself? And if not, how do we change things to make it right? I think maybe it's time for us to do that in Fluffy's case." Providing the caregiver herself with emotional or social support may remedy a caregiver's inability or reluctance to consider the patient's own wishes and values.

Some degree of objectivity in assessing what matters most to the veterinary patient might also be achieved through intersubjective agreement among interpreters. In zoo and sanctuary environments where animals receive care from multiple individuals, free discussion among dedicated caregivers and outside observers of their different interpretations may lead to a general consensus on what the animal's values, concerns and preferences are and how best to incorporate them. Another approach, common in large human hospitals but currently rare in the veterinary field, is to employ an ethics officer or board to help handle challenging ethical cases and hold regular "ethics rounds."³³⁰ If the practice philosophy incorporates respect for patient agency or autonomy as a distinct value, consideration of the unique concerns and perspectives of individual patients may come to permeate the practice culture, alongside extant considerations such as pain management, infection control, and client communication.

Respecting Patient Autonomy in Veterinary Practice

In this section, I offer some practical guidelines for respecting veterinary patient autonomy that spring from the framework I have presented. Some of these have already been briefly described, but receive further elaboration here. To be clear, I am not arguing for the primacy of respect for autonomy. Rather, I am indicating concrete ways in which the autonomy of veterinary patients can be respected throughout their experience of health care.

³³⁰ Moses, L. (2017). What Happens When You Can't "Do the Right Thing?" A Workshop on Everyday Ethical Dilemmas in Veterinary Medicine. Presented at International Veterinary Emergency & Critical Care Symposium.

Undoubtedly, a practitioner who accepts respect for patient autonomy as a value will still find herself at times frustrating a patient's attempt to exert agency because other ethical obligations, such as beneficence, are greater or more pressing. In some cases, we will need to determine what constitutes an acceptable balance, knowing that this may vary with context, such as available social and material resources, and will likely shift during a patient's lifetime. However, employing a relational account of autonomy will often help us identify approaches that bring these values into harmony. It suggests ways of shaping the practice of veterinary medicine so that these two values effectively pull in the same direction more often. This involves both paying attention to how we can minimize the need to override autonomy in the name of beneficence and considering how can we incorporate the patient's subjective good – what she prefers, what matters to her – in veterinary decisions and approaches. Using this model, a veterinary patient's autonomy can be respected on two distinct levels: 1) selection of veterinary interventions, such as diagnostic and treatment procedures, and 2) methods of delivery of veterinary care.

At the level of intervention selection, it is clear that we must rely on surrogates when it comes to selecting which, if any, treatment or diagnostic procedures should be undertaken for a given patient. As discussed in Chapter Two, our patients are unable to understand, and we are unable to explain to them, crucial medical concepts like vaccination, the rationale behind diagnostic tests and treatment options, statistics related to success or failure of an intervention, and prognosis. Thus, while they accept or decline, say, an injection, their lack of understanding means that they are not accepting or rejecting the procedure or measure. Beneficence and nonmaleficence require, in most cases, a surrogate who can make a decision based on understanding the associated benefits, costs, and risks. This surrogate might be the patient's primary caregivers, a veterinary client, a curator/animal care supervisor, or sometimes the veterinarian herself, in the case of a stray animal brought into a shelter or emergency clinic. However, surrogates can and often should go beyond the best interest standard put forth by B & C.

Respect for the patient's autonomy means surrogates incorporate the patient's distinctive values and concerns into medical decision-making, seek ways of delivering the selected care that promote rather than deny autonomy, and – when possible – attend to developing patients abilities to exercise agency continually, rather than only in crisis situations.

Obviously, relationship between the patient and her caregiver(s) is especially important, for caregivers are often the “interpreters” for the animal, permitting her specific concerns and values to be recognized and often “translating” to her what is needed for her to participate in her health care. Caregiver-animal relationships must go beyond providing food and basic husbandry. Far in advance of any actual medical decision-making, caregivers must be observant and attentive enough to understand the individuals in their care and identify what each individual values, fears, etc. When the surrogate is different from caregiver(s), such as in a sanctuary or zoo, caregivers with intimate knowledge of the patient should be directly involved in decision-making, be they crisis or house-keeping ones.

When there is a medical decision to be made, the veterinarian explains what is entailed in various interventions and their implications for prognosis, recovery time, expected degree of pain or discomfort, whether hospitalization or frequent recheck appointments are required, how often blood will need to be analyzed, required activity restrictions, expected side effects, etc. In addition to assessing traditional welfare trade-offs, surrogates must broaden their assessment to include the patient's particular values and concerns. Where multiple options may offer similar improvements in welfare, as far as decreased pain and increased feelings of well-being, the decision of which one to choose may be based on autonomy considerations.

Once an option is selected that is believed to best accord with duties of beneficence and respect for patient autonomy, veterinary professionals, surrogates, and caregivers must still “listen” to the patient as she responds to what in fact turns out to be involved in the medical intervention. Feminist ethic-of-care theorists have pointed to the practice of attentiveness, “a kind of discipline whose

prerequisites include attitudes and aptitudes such as openness, receptivity, empathy, sensitivity, and imagination.”³³¹ As a decision regarding care is implemented, caregivers can be encouraged to cultivate attentiveness and their subsequent feedback can be incorporated, along with objective measures like weight, blood counts, and other medical parameters, to determine whether the chosen intervention continues to reflect respect for the patient’s autonomy.

Taking a dialogic approach to respect means subjecting our own commitments to criticism or rejection by the patient. During implementation of a selected veterinary intervention, all those involved in that patient’s care must continue to be sensitive to what matters to her. At times, we may come to question veterinary interventions we initially deemed necessary based on the duty of beneficence, potentially considering a change in intervention choice or means of implementation.

This was something I faced with my own dog, Howie. When he was older but in very good health, I discovered he had developed a malignant tumor that was still at an early stage. It was removed, but unfortunately the resection margins were insufficient for surgery to be considered curative. Therefore, I opted for him to receive a course of chemotherapy, which was expected to have minimal adverse effect at the dosages used, but likely to provide him with years of a good-quality, cancer-free life. After three or four visits to the hospital where he received the treatment, he began to refuse to enter building, even with gentle coaxing. Knowing his personality and previous willingness to enter veterinary clinics, his new and steadfast refusal to pass through the clinic doors was a clear expression of his wishes. In Howie’s case, I ended up switching to acupuncture and herbal therapy that, though not as well studied in research trials, could be given at home and had no noticeable adverse effects – in fact, Howie enjoyed the acupuncture treatments and would typically fall into a deep sleep after the first few

³³¹ Donovan, J. (2006). *Feminism and the Treatment of Animals: From Care to Dialogue*. 322. Quotes Jaggard, A. M. (1995). *Caring as a Feminist Practice of Moral Reason*. In Ed. V. Held *Justice and Care: Essential Readings in Feminist Ethics*. Boulder, CO: Westview. (p. 190).

needles were inserted. In the end, his cancer never returned and he enjoyed several more years of good-quality life as a “senior citizen.”

When it comes to respecting patient autonomy, just as important as *which* interventions to pursue are the issues of how care is provided and how the patient experiences veterinary interventions. In pediatric bioethics, this issue is sometimes framed in terms of obtaining the “assent” of young children for their medical treatment. Emerging in the late 1970s, the idea behind assent in pediatrics is to acknowledge that children, over time, develop in their level of understanding and decision-making abilities such that the capacity of most older teenagers resembles that of adults who can give informed consent.³³² Thus, respect for autonomy requires that children be able to participate in their medical decision-making to the extent that they are willing and able to do so. What qualifies as “assent” therefore varies with decisional capacity. For young children, whose understanding may be similar to that of most veterinary patients, obtaining assent may be limited to “soliciting an expression of the patient’s willingness to accept the proposed care.”³³³ It might also involve letting the child choose which arm to draw blood from or what time to take a medication.³³⁴

Similar to the concept of assent is that of “acquiescence” articulated by the Institute of Medicine Committee on the Necessity of the Use of Chimpanzees in Biomedical and Behavioral Research. While this Committee deemed chimpanzees unlikely to understand the concepts of assent, consent, and giving permission, they used the concept of acquiescence to articulate the fact that chimpanzees can make decisions about whether or not they are willing to participate in a given “research procedure” and can express their willingness or lack thereof.³³⁵ My own experience with chimpanzees is that sometimes they seek medical assistance from their caregivers. For example, while a

³³² Committee on Bioethics, 315.

³³³ *Ibid.*

³³⁴ Unguru, Y.T., (p. 30).

³³⁵ Kahn, J. (2014). Lessons learned: challenges in applying current constraints on research on chimpanzees to other animals. *Theoretical Medicine and Bioethics*, 35, 99.

chimpanzee may initially need to be trained to show a wound to a caregiver, she may subsequently present her wounds spontaneously; one chimpanzee I know even signs the word “hurt” when presenting a wound.³³⁶ Given that their level of understanding in such cases is likely similar to that of a young child, I believe that the term “assent” is sometimes more accurate than “acquiescence.”

In early writings on assent and child patient autonomy in dentistry, practitioners working with children who refuse to undergo a treatment voluntarily are encouraged to start by reconsidering “the urgency of the dental needs and determine if treatment can be delayed or avoided with no lasting ill effects.”³³⁷ This is often a good piece of advice in the case of veterinary patients, as well. Their willingness to accept a given procedure may vary greatly with their emotional state and, while we may not expect them to become more accepting of interventions due to maturation, a similar change may occur through other means, such as training, which is discussed below.

In subsequent discussions of assent, pediatric ethicists go farther, claiming that “there are clinical situations in which a persistent refusal to assent (i.e., dissent) may be ethically binding,” such as in research from which the patient will not directly benefit and “when the proposed intervention is not essential to his or her welfare and/or can be deferred without substantial risk.”³³⁸ In line with the dialogic approach I have discussed, medical professionals are urged to pause to “gain a better understanding of their situation or to come to terms with fears or other concerns regarding proposed care.”³³⁹ As the discussion about assent has matured, it has taken on additional relational components, such as the importance of truly knowing the child and appreciating both her preferences and the “spectrum of [her] life experiences” when considering how to work toward the ideal of assent.³⁴⁰

³³⁶ “Noelle” at Center for Great Apes in Wauchula, FL.

³³⁷ Griffen, A.L. & Schneiderman, L.J. (1992). Ethical issues in managing the noncompliant child. *Pediatric Dentistry*, 14:3, 178.

³³⁸ Committee on Bioethics, 316.

³³⁹ *Ibid.*

³⁴⁰ Unguru, Y., Coppes, M.J., & Kamani, N. (2008). Rethinking Pediatric Assent: From Requirement to Ideal. *Pediatric Clinic of North America*, 55, 212 & 217.

Because of their level of understanding and their tendency to live “in the moment,” what typically matters most to veterinary patients is their immediate experience rather than anything more distant in time or space.³⁴¹ This immediate experience may be comprised of being touched during an examination, receiving injections and other medications, undergoing anesthetic induction, and being restrained during procedures like catheter placement, venipuncture, and radiography. Most aspects of care delivery offer opportunities for veterinary professionals to avoid or minimize the denial of a patient’s autonomy by ensuring that she acquiesces rather than dissents.

Sometimes, determining acquiescence/assent is easy: the biting, scratching, struggling, growling/hissing patient is clearly saying, “no,” while the puppy who wags her tail and joyfully licks a treat while failing to notice that she is receiving a vaccination or having her rectal temperature taken is assenting to the full extent that her cognitive understanding of the situation allows. However, a patient experiencing great pain may resist *any* intervention, even one that will rapidly alleviate it; in such cases, a sufficiently strong pain injection is surely what is called for, whether we justify it on the grounds of beneficence or “future assent,” as the paternalistic conception of autonomy we saw in Chapter One might suggest. Another more complicated scenario is that of a severely debilitated patient who is *unable* to resist interventions. Here, careful observation is necessary to detect subtle signs of anxiety and distress that indicate we must modify our approach to secure acquiescence.

Oftentimes, “passive” measures are sufficient and superior options for delivering care in a way the patient will accept. Flavoring, compounding, or otherwise disguising oral medications, for example, may prevent “pilling” (forcing the patient to swallow a pill) or darting from being the only options for medicating. One of my favorite instruments for working with chimpanzees is an infrared thermometer which allows me to assess a patient’s temperature without even touching her. Other passive measures may be structural: building a scale into the floor of the animal housing area (in a sanctuary) or of the

³⁴¹ The main exception to this I have seen is in nursing bitches, whose behavior sometimes suggests they are preoccupied with returning to their puppies even when they are not physically present.

clinic, so that patients can be weighed opportunistically, without the need for immobilization or restraint. Veterinary clinics can be constructed with the future olfactory and auditory experiences of patients in mind, such as having separate wards and waiting areas for cats and dogs. Calmer, more relaxed patients have better welfare, in terms of decreased psychological and physiological stress, and are more able to voluntarily participate in veterinary procedures.

Another potential focus is educating caregivers about early signs of disease progression. Prompt recognition of such signs makes it possible to intervene early and more minimally and avoid crisis situations, which often require extensive handling by veterinary professionals and more potentially objectionable diagnostic and treatment interventions. For example, caregivers of patients with asymptomatic or controlled cardiac conditions can be training to monitor patients' sleeping respiratory rates, which increase gradually with progression of the condition. Early detection of progression means a better chance of managing the patient's condition at home, rather than waiting until she is in acute distress and the only options are euthanasia or emergency hospitalization.

Adopting a relational account of autonomy is also useful in a chimpanzee sanctuary or other situation in which a patient is part of a strongly-bonded social group of conspecifics. In such cases, consideration of both the patient and others with whom she has close relationships may be needed in evaluation options for medical interventions as well as the means of providing them. For example, sometimes isolating an individual seems ideal as a way to carefully monitor weight, intake and eliminations, and ensure successful medication administration. However, strong social bonds mean that such isolation may be experienced by the patient as more objectionable than the illness. Welfare considerations alone might lead to a recommendation like "pair-house with a compatible individual during medical treatment." But if we are consciously aiming to respect the animal autonomy, we might additionally ask questions like: Which group member(s) would the patient choose to remain with? What about the preferences of this social partner? How might the choice of social partner affect the degree to

which the patient can voluntarily participate in her own care? Are there reasonable alternatives that don't require periods of separation from the group? However skilled they might be, veterinary professionals need the insight of caregivers to interpret for the animals in their care.

Training for Veterinary Procedures

As previously noted, another practical approach is anticipating veterinary interventions that are likely to be needed in the future and providing the patient with opportunities to develop skills and knowledge that will make voluntary participation to be an option. For example, when working with captive chimpanzees, we can likely anticipate that many individuals will at some point in their lives suffer a severe wound that will require evaluation and possibly surgery. The standard approach has been to wait for the situation to arise and then make a punctate decision about whether the emotional distress and medical risk of darting and anesthesia is justified by the need to manage the wound. Considering the diachronic dimensions of respecting patient autonomy, we might consider far in advance, how to create a situation where the wound might be evaluated without anesthesia and how the animal might voluntarily participate in the process of receiving an anesthetic injection if surgical treatment is needed. A caregiver who makes an everyday "game" out of having an animal in her care "show" her various body parts is effectively enlarging that individual's potential for exercising her autonomy. Similarly, training patients to present a limb for a voluntary anesthetic injection greatly expands their potential to exert agency as a veterinary patient and decreases the likelihood that their autonomy will need to be overridden through involuntary darting.

Such training for voluntary participation in veterinary procedures is an example of what D & K refer to as the "'scaffolding' of meaningful choice."³⁴² Scaffolding, or structuring, choice involves providing opportunities for learning skills and abilities that would lead to greater options or an

³⁴² Donaldson, S. & Kymlicka, W. (2012). *Citizen Canine: Agency for Domesticated Animals*. 15.

expanded scope of agency.³⁴³ As with the scaffolding used to construct a building, this support is gradually removed as the individual acquires the skills being taught, or makes it clear she is not interested in learning them. It begins with basic socialization into “particular norms and relationships which help to define the familiar and the trustworthy, and which provide a benchmark from which incremental alternatives become meaningful.”³⁴⁴ For example, in a sanctuary situation, basic socialization might involve establishing a relationship with animal residents in which the caregiver observes them and learns their preferences for certain conspecifics, foods, toys, and other items or activities.

After such an attentive foundation is in place, caregivers can begin introducing some “training games,” in which small food treats are provided when the animal offers a certain behavior in response to a verbal or gestural cue. Usually, these are short sessions which the animal can choose (or decline) to participate. Once an animal comprehends the idea behind the training game, they are often eager to expand their repertoire of cues – there are even accounts of animals using similar methods to teach their human caregiver the meaning of a cue.³⁴⁵ Depending on the anticipated veterinary needs, the animal’s personality, and her level of interest, caregivers may teach simple cues, such as opening the mouth for inspection of the teeth and tongue, or very complex ones, such as presenting a limb and remaining still for blood collection from a vein.

In some ways, training can be viewed as an extension of the socialization process, as it effectively expands the amount and specificity of communication that is possible between animals and human caregivers. Communication is constantly occurring, whether we mean to “say” anything with our behavior or not. Training, in requiring careful attention to the structure of our interactions and precisely

³⁴³ *Ibid.*, 14.

³⁴⁴ Donaldson, S. & Kymlicka, W. (2016) "Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals." (p. 185).

³⁴⁵ Reiss, D. (2015). Who is Training Who? *Story Collider: True, Personal Stories About Science*. Retrieved from: <https://www.storycollider.org/stories/2015/12/31/diana-reiss-who-is-training-who>

what we are communicating, permits increasingly complex “translation”: previously meaningless cues come to have clear meanings.

In positive reinforcement training (PRT), as was mentioned in Chapter Three, only rewards are used to shape behaviors, so the worst that can happen for a “mistake” is not receiving the desired treat and having the opportunity to try again. At times, the goal of training may simply teach a patient that she need not fear or feel threatened by a certain stimulus, for example, short-term separation from other members of their social group, the approach of an unfamiliar individual (like a veterinarian), unfamiliar objects (like a stethoscope), or objects associated with fear or pain from past experience (nail clippers, for some dogs, for example). Techniques include desensitization, in which the stimulus in question is presented at a very low intensity but gradually increasing intensity, always below the threshold that would trigger fear or anxiety, and counter-conditioning, in which the feared stimulus is consistently paired with something pleasant or desired, so it comes to predict something good.

Through such training methods, a host of veterinary procedures can be performed on non-anesthetized patients who voluntarily – even enthusiastically – participate in them, even animals like apes and elephants who require protected contact, i.e., mesh or other caging material between the patient and humans. I have observed or worked with apes who presented wounds for visual cleaning, accepted application of transmucosal medication to their lips and tongue, presented their arm or leg for an injection, urinated into a cup, and even inserted their arm into a “sleeve” made of cage mesh for blood collection and blood pressure measurement.

PRT is associated with a more relaxed atmosphere surrounding veterinary interventions and lower physiological measures of stress.³⁴⁶ Since it has the potential to improve animal welfare, we might ask why not advocate for it strictly on beneficence grounds, why invoke respect for autonomy at all. But

³⁴⁶ Behringer, V., Stevens J.M.G., Hohmann, G., Moestl, E., Selzer, D., & Deschner, T. (2014). Testing the Effect of Medical Positive Reinforcement Training on Salivary Cortisol Levels in Bonobos and Orangutans. *PLoS ONE*, 9(9). Retrieved from: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0108664>

at times, these two duties may suggest different courses of action. For example, some zoos currently engage in very intensive training regimens,³⁴⁷ aiming, for example, to have every gorilla reliably trained for every medical behavior. This is presumably promoted out of a desire to maximize the animals' health and welfare. But D & K caution that people with CD speak out against an excessive focus on efforts to increase agency, as this can leave less time for simply being oneself and enjoying life.³⁴⁸ Grounding training programs in welfare considerations *and* respect for autonomy might lead us to *offer* training to all, but allowing individuals to choose how much to participate. For individuals with little or no interest in PRT, our attention may fall to finding other methods of providing beneficent interventions while minimizing the routine overriding of their autonomy.

Does training really enhance autonomy, or undermine it?

Despite the potential of training to enhance veterinary patients' ability to voluntarily participate in their care, my experience with the ape sanctuary community is that a significant proportion of sanctuary workers who are committed to respecting the autonomy of animal residents oppose training of any kind. D & K make a similar observation, noting that "many animal rights abolitionists [who advocate minimizing rather than reforming human-animal relationships] jump to the conclusion that all ... forms of training are unjust, an illegitimate attempt to compel [animals] to engage in unnatural acts that serve human purposes."³⁴⁹ Even zoo workers, who are typically not "animal rights abolitionists," raise the question of whether training might be "a constraint on the creature's autonomy."³⁵⁰

As previously mentioned, this sentiment may stem from a visceral dislike of training due to its historical association with methods based on fear and physically violent punishment and with its use in

³⁴⁷ Personal communication, Dr. Francis Cipullo

³⁴⁸ Donaldson, S. & Kymlicka, W. (2016) "Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals." (pp. 195-196).

³⁴⁹ *Ibid.*, (p. 187).

³⁵⁰ Maple, T. L., & Perdue, B.M., (p. 75).

circuses and Hollywood movies to get animals to perform “tricks.” Although PRT for veterinary procedures utilizes exclusively rewards, it stills strikes many as manipulative or even coercive, and counter to respecting animal autonomy. After all, the reward for which that patient is working is under human control and she has no way to secure it independently of performing the acts that are asked of her – so how can her choice be meaningful? Undertaking such training with humans would seem to be demeaning, an affront to their dignity, and a denial of their autonomy, one might argue, so why is the case any different for animals? Minimizing our interactions with them and allowing them to live their own lives with others of their kind might be the best way to respect their autonomy.

Such a perspective is grounded in an account of autonomy like that offered by B & C. As we saw in Chapter Two, personal autonomy, for B & C, requires self-rule that is free from controlling interference by others.³⁵¹ Indeed, voluntariness, or acting without being under the control of another person or condition, is one of the three conditions that must be fulfilled for an action to be autonomous. Since, in following the “command” of a trainer, the animal seems to be under the trainer’s control, it follows that she is not behaving autonomously when engaging in training or when, in the context of veterinary care, she performs a previously trained behavior.

When we look more closely at B & C’s account, however, it is not clear that training must necessarily be classified as a form of influence that undermines autonomy. B & C distinguish three categories of influence: coercion, persuasion, and manipulation, noting that not all of them qualify as controlling.³⁵² Coercion involves the use of a “credible and severe threat of harm or force to control another.”³⁵³ Training methods that utilize punishment would certainly qualify as coercive, even if undertaken for a beneficent ends. The same can be said for training that involves “negative reinforcement,” or compelling a behavior by linking its performance with the removal of a stimulus the

³⁵¹ Beauchamp, T.L., & Childress, J.F. (2013). *Principles of Biomedical Ethics* (7th ed.). (p. 137).

³⁵² *Ibid.*, (pp. 138-139).

³⁵³ *Ibid.*, (p. 138).

animal finds aversive. For example, I have observed a veterinarian “show” the dart gun to a chimpanzee who had previously been trained for hand-injection, in an attempt to get her to “choose” to accept the hand-injection rather than be darted. This does seem to meet B & C’s definition of coercion. However, the positive reinforcement-based training that I have described would not qualify as coercive under their account unless perhaps the patient was compelled by hunger or thirst to participate.

Some forms of training might be classified under the type of influence explicitly sanctioned by B & C, that of persuasion. Persuasion, as defined by B & C, occurs when one individual successfully influences another’s beliefs or actions through appeals to reason.³⁵⁴ In Chapter Three, I presented an example of using the training methods of desensitizing and counterconditioning to decrease fear of a syringe, suggesting that this might qualify as a dialogue between patient and caregiver. In this scenario, while we may not be using linguistic statements about logical relationships (i.e., *reasons*, in the traditional sense) to persuade the patient that the syringe is not a cause for alarm, we are gradually providing her with new information (e.g., nothing bad happens when the syringe is 50 ft. away, nothing bad happens when it is 45 ft. away, etc.) which makes it rational for her to change her assessment.

Desensitization and counter-conditioning are both types of *classical conditioning*. The positive reinforcement training used to shape veterinary behaviors, such as presenting a limb for a hand-injection or offering a wound for visual inspection, constitutes *operant conditioning*. With operant conditioning, the animal’s behavioral response produces a consequence; if we use exclusively PRT, the animal’s behavior in response to a verbal or gestural cue will either produce a reward (if “correct”) or nothing at all (if “incorrect”).

This type of training seems to fall most naturally under B & C’s category of *manipulation*: “swaying people to do what the manipulator wants by means other than coercion or persuasion.”³⁵⁵

³⁵⁴ *Ibid.*, (p. 139).

³⁵⁵ *Ibid.*

Manipulation can involve “the effect of rewards, offers, and encouragement,”³⁵⁶ which are obviously involved in PRT. B & C do not bar all types of manipulation in health care as unethical, noting that manipulation is at times morally justified. In some cases, manipulation may even be unavoidable, as the physician’s word choice, whatever it may be, frames the information she is presenting in ways that affect the patient’s interpretation.³⁵⁷ Manipulation, on B & C’s account, is problematic when it impairs autonomous choice. A standard example of manipulation is offering an inducement (e.g., a needed medication or extra income) to someone in desperate need in exchange for participating in a research trial); the person effectively lacks any meaningful choice about what decision to make.³⁵⁸ Compelling an animal to engage in training by making it her only option for obtaining something she desires would be a clear example of manipulation that diminishes her ability exercising autonomy. Depriving her of food or water to compel her to engage in training would even be considered coercive. But neither manipulation nor coercion need apply to all training situations.

An illustration of what this could look like may be helpful. Consider a group of animals who live in a complex, captive environment, where they have many options for how to spend their time. Favored food items (“treats”) beyond their standard, nutritionally complete diet are made available occasionally in various contexts, including that of training; that is, training is one way among several to secure these desired treats. The trainers care about the animal and are motivated by the desire to impart skills that expand her ability to exercise agency and that minimize the frequency or likelihood of situations where overriding autonomy is the only option for providing needed medical care. Training sessions are offered a few times per day, and it is up to the individual animal whether to approach and participate in the session, or whether to engage in another activity. An animal may have a training session focused on voluntary separation, but she is not separated from the others to compel training. When she loses

³⁵⁶ *Ibid.*

³⁵⁷ *Ibid.*

³⁵⁸ *Ibid.*, (p. 140).

interest, she can rejoin her groupmates or move on to participating in another activity. Even on B & C's traditional approach to autonomy, it is not at all clear that this constitutes an objectionable form of manipulation.

PRT for veterinary procedures seems even less of a threat to animal autonomy when we adopt a relational conception of autonomy. Relational accounts recognize that the causal conditions for autonomy – socialization, available resources, institutional supports, etc. – are social. Since causal conditions in part determine each individual's desires and commitments, *no one* is completely self-determining. As Friedman puts it:

“...autonomy is a matter of degree and requires agents simply to harbor the capacities for certain sorts of reflection and agency, however these were acquired or are interconnected with the agency of others.... Self-determination may, ontologically speaking, be merely an intermediate causal process in a causal sequence extending backward and forward to infinity. Such causal embeddedness does not undermine its character as the kind of causal stage in the process that it is: the part determination by a self of her own behavior.”³⁵⁹

In other words, if someone chooses to act in a certain way because doing so aligns with her own values and concerns, then the fact that it was someone else or a certain circumstance that introduced her to this option does not make her choice less autonomous – *all* her potential options are the product of social circumstances to some degree. As applied to the veterinary case, we might say that, while the animal did not initiate the training process, she is acting autonomously as long as she forms a persistent desire to participate in training.

D & K go further, suggesting that for at least some animals who are part of our society and dependent on us for care, it is not only morally permissible but morally required that we offer training because it expands the scope of agency, *increasing* autonomous capability. This is the case when the behavior or skill that is taught is one that increases ability to exercise autonomy but is not a behavior that would emerge spontaneously. They point out that the disability rights movements advocates for

³⁵⁹ Friedman, M. (2003). *Autonomy, Gender, Politics*. (p. 37).

“opportunities to engage in appropriately structured interaction (i.e., interactions which challenge our skills ‘*just enough*’) [that] expand the self, and the scope for agency,” so it stands to reason that this prescription holds for animals who are similarly depend on others for exercising their agency.³⁶⁰

D & K’s distinction, discussed in Chapter One, between micro agency and macro agency also helps to clarify when training enhances autonomy and when it only improves welfare. Using training to enhance micro agency but not macro agency, i.e., providing control over the details of one’s life when major facets are governed by human interests, ignores a central aspect of animal autonomy. This is the problem with using PRT to facilitate procedures such as blood collection or injection in the course of most animal research. In this context, PRT surely does improve animal welfare, in that the animal subjects experience less emotional distress and perhaps less physical pain if experimental procedures do not require them to be caught, “squeezed” in a squeeze cage,³⁶¹ or forcibly restrained; they will have the *experience* of having their agency thwarted. All things being equal, training in this context aligns with the duty of beneficence. However, if the animal’s subjective good has played no role in selection of the experimental procedure being performed on her, and it will be performed whether or not she willingly participates in it, then training fails to respect for her autonomy. If anything, training makes it easier to overlook her denial of autonomy because she does not protest the way she likely would without training. With no real options, such training gives merely “the veneer of agency and consent.”³⁶² In veterinary medicine, training can serve to enhance both macro and micro agency, because the patient’s values and concerns inform decisions about which veterinary interventions training is used to facilitate. A dialogic approach to respect, in which the patient herself is our locus of respect, keeps macro agency front and center.

³⁶⁰ Donaldson, S. & Kymlicka, W. (2016). Rethinking membership and participation in an inclusive democracy: cognitive disability, children, animals. (pp. 187-188).

³⁶¹ A “squeeze cage” is a cage with a sliding, often motorized, back wall that is used to press the animal up to the front of the cage for injections and other procedures.

³⁶² Donaldson, S. & Kymlicka, W. (2012). Citizen Canine: Agency for Domesticated Animals, 11.

Summary

In this final chapter, I have attempted to flesh out what a relational approach to patient autonomy might look like in practice. Importantly, respect for patient autonomy would come into play not just in determining which veterinary interventions to choose, but also how they are provided. In order to determine what options align with a nonlinguistic patient's values and concerns, we must first address the challenge of interpreting her subjective good. Fortunately, we have several tools for interpretation which are already being utilized in science, veterinary medicine, and animal welfare fields: insights from the fields of animal behavior, ethology, and animal welfare science, as well as the discernment of caring and observant caregivers. While problems like self-serving biases and projected values can arise, we also have socially-constructed remedies such as seeking intersubjective consensus and providing a forum within the practice for identifying and addressing ethical issues.

I provided some practical guidelines for incorporating respect for autonomy in veterinary practice. Mostly, I have considered examples set in companion animal practice and ape sanctuaries – both because of my clinical experience and because animal autonomy and agency are already valued, to various extents, in these contexts. The concepts of “assent” and “acquiescence” to medical procedures, as have been used to protect patient autonomy in pediatrics for several decades, can be usefully extrapolated to veterinary medicine. Oftentimes passive measures like flavoring medications and conscientiously constructing animal housing and veterinary buildings are the simplest and most convenient ways to enable veterinary patients to voluntarily participate in their care. Various positive reinforcement training methods, such as sensitization, counter-conditioning, and reward-based operant condition, hold the potential to expand animal agency, as well as to undermine it. A relational account of autonomy is useful both because it can handle the issues that arise in cases of highly dependent agency, and because it suggests ways to deploy the practice of training that ensure it truly promotes patient autonomy rather than being unduly manipulative or coercive.

CONCLUSION

With this thesis, I hope to initiate a conversation about why and how we might value and protect patient autonomy in veterinary medicine. Chapter One provided a general look at the question of whether we ought to attribute autonomy (or something similar, like agency) to animals and, if so, whether enabling and protecting autonomy is a relevant value in animal ethics. Chapter Two surveyed the discipline of veterinary medical ethics and found that it has largely remained silent on – and at times outright rejected – respect for patient autonomy is a relevant value. Furthermore, my attempt to extrapolate the principle of respect for patient autonomy from mainstream (human) biomedical ethics led to the conclusion that animals, because they inevitably lack adequate understanding of medical issues and interventions, would belong to the class of “never-competent” patients, whose medical care is rightly determined by welfare-based standards, with no requirement to respect their autonomy.

In Chapter Three, I described some ways that veterinary patients’ autonomy is routinely overridden, both in the selection of veterinary interventions and in their delivery. I also identified some recent trends in veterinary medicine that suggest a nascent and unarticulated concern with respect for patient autonomy among some in the profession. I then presented criticisms leveled by feminist bioethicists and other scholars at the mainstream account of patient autonomy, and their suggestion that a relational account of autonomy is both more accurate and more appropriate for use in medicine. Adopting such a relational conception enables respect for patient autonomy to be coherently incorporated as a value in veterinary medicine, suggests ways of doing so that are meaningful to veterinary patients, and permits us to take advantage of relevant conceptual resources deployed in similar fields. I emphasized the need to conceive “respect” in dialogic and diachronic terms.

Finally, in Chapter Four, I describe ways of “interpreting” what constitutes an animal’s subjective good (her values, concerns, preferences, and desires) and elaborate on practical methods for respecting

patient autonomy that spring from taking a relational approach. I close by addressing the objection that training patients for veterinary procedures undermines animals' autonomy by unduly manipulating them, concluding that a relational approach I present has the conceptual resources to distinguish instances when training promotes autonomy from instances when it may improve welfare, but adds only a veneer of enhancing agency or enabling autonomy.

Adding another value to the already complicated ethical landscape of veterinary practice means inviting new conflicts between values, e.g., respect for autonomy v. non-maleficence/beneficence. Recognizing respect for patient autonomy as an important ethical consideration makes veterinary practice more complicated. This, in itself, is not a reason for continuing to disregard it; what constitutes properly managing a disease also often becomes more complicated as our understanding of the condition's complexity increases. But given that our time and powers of critical reflection are finite resources that adopting the framework outlined here will consume, it is important to show that taking this approach is truly justified.

With this in mind, I would like to end by replying to a key objection that may remain in the reader's mind, whose answering will also suggest areas for future research. Namely, is invoking autonomy really the simplest and most straightforward way to arrive at these substantive recommendations? What does introducing autonomy into the veterinary ethics conversation really add, that couldn't be obtained in a simpler way?

One way of advancing this objection is to claim that my account, while coherent, violates Occam's Razor, the injunction not to multiply entities unnecessarily. If I am creating complexity, it must be *necessary* complexity, it must add something philosophically and/or practically. What does invoking autonomy, and requiring it be relationally conceived, add beyond what we could achieve by claiming merely that *veterinarians should practice in a way that their patients won't resist and that doesn't hurt them*? Or, what does this account provide that couldn't or wouldn't be accessible by sticking with the

paradigm of animal welfare but stipulating that providing opportunities for choice is part of ensuring psychological well-being?

This objection can be countered on several fronts. First of all, judging from the dearth of publications on the subject, veterinary medical ethics is underexplored and undertheorized as a discipline; we have good reason to welcome the infusion of conceptual tools that bioethicists have developed for patient populations who are vulnerable in many of the same ways veterinary patients are. Relational autonomy theorists in bioethics successfully argue that autonomy is ethically relevant for human patients even when they do not qualify as Kantian agents, even when they lack the capacity for split-level autonomy, and even when they fail to reach the competency threshold argued for by mainstream autonomy theorists. Just as human and veterinary medicine inform one another when it comes to specific types of tumors or infections that affect both groups of patients – and ignore one another’s findings to their peril – so too with ethical issues. If we invite discussion on this subject, we can expect to learn from both the similarities and the differences between veterinary and human medical practice.

The conceptual tools on offer from relational autonomy theorists and feminist bioethicists are also distinctive because they direct us to broaden the scope of our ethical vision beyond merely our interactions with our patients and their caregivers.³⁶³ Just like human medicine,³⁶⁴ the institution of veterinary medicine not only heals and prevents disease, it also reinforces, produces, and re-produces social norms, be they institutions, power structures, or ways of valuing. Depending on the framework(s) the profession adopts, certain issues will move to the forefront while others will be rendered invisible

³⁶³ Wardrope suggests that human medicine employ a strategy of “preventive ethics,” modeled on public health medicine, that would seek to examine how changes in medical education, social structures of health care, and other social considerations could help “secure the material, conceptual, and affective substrates of autonomy for agents living within a given society.” A similar approach could easily be adapted to veterinary medicine. Wardrope, A (2015). *Autonomy as Ideology: Towards an Autonomy Worthy or Respect*. 64.

³⁶⁴ Cook, R.J. (1994) *Feminism and the Four Principles*. In R. Gillon *Principles of Health Care Ethics*. Hoboken, NJ: Wiley. (p. 95). Quotes Lebacqz, K. (1991). *Feminism and bioethics: an overview*. *Second Opinion*, 17 (2), 16.

and impossible to analyze.³⁶⁵ Given our society's present state of flux with regard to the moral status of animals and what constitutes ethical treatment of them, and its expectation that veterinarians will provide guidance on such issues, it is imperative that we invest in our conceptual resources and tools for critical reflection. Veterinary medicine will always shape society and animals' place in it – the question is whether or not we will do so deliberately and with careful attention to the full range of decisions we are making.

Another way of refuting this objection is to locate situations in which including respect for patient autonomy as a value in our deliberations will lead us to different conclusions than merely adopting one of the “simpler” views, that encourage us to provide care in a way our patients don't resist, or to broaden our conception of animal welfare to emphasize opportunities for choice-making. We will find relevant examples at the level of direct patient care as well as the institutional level.

In particular, adopting one of the “simpler” views will result in accepting some practices that would run counter to respect for autonomy. For example, the simpler views find it unproblematic to create merely choice decisions that are manipulated such that the patient essentially has no option but to choose in the way as we desire. The view I advance places a distinct value on the animal's ability to have input into the general shape of her life, as animals do when they are not dependent on humans for exercising their agency. Ensuring the availability of experiences that “feel like choosing” or that affect only the “micro-frame” of their lives may be sufficient under the simpler views, but not under the one I advance. Relational autonomy also invites scrutiny of the *origin* of desires or values, and makes their authenticity a relevant consideration.

Some concrete examples may help bring out the value of the view I advance, as well as suggest directions for future research. One that springs easily to mind is the issue of euthanasia. I have worked, at various times, as an emergency veterinarian, a wildlife rehabilitation assistant, and an animal shelter

³⁶⁵ Wardrope, A (2015). *Autonomy as Ideology: Towards an Autonomy Worthy or Respect*. 57.

worker, so I have probably performed or participated in more than my “fair share” of euthanasias. In the case of a very sick or hurting animal whose prospects for improvement are poor given her advanced age or the nature of her condition, euthanasia intuitively seems morally acceptable and sometimes required. While usually sad on an emotional level, especially given my close proximity to the patient’s family’s grief, such cases do not cause me – or most veterinary professionals – *moral* discomfort. Contrast this with the euthanasia of (1) generally happy, healthy dogs and cats in an animal shelter that has reached capacity, and (2) animals who are ill but whose conditions are treatable or even curable, but whose caregivers request euthanasia because they cannot or will not incur the financial costs of veterinary care. Such experiences are filled not only with the emotion of sadness, but often also with anger, frustration, and distress. In the veterinary and shelter communities, these types of euthanasias are a source of great moral stress and compassion fatigue, and increasingly figure in explanations for why the suicide rate among veterinarians is several times the national average.³⁶⁶

Can the source of our moral unease be identified by a moral framework that considers only animal welfare – even an expanded sense of animal welfare that includes a recommendation to provide opportunities for choice or to avoid causing animals the *experience* of their choices being overridden? As animal welfare is currently interpreted by the AVMA, if the *manner* of an animal’s death is in accord with the patient’s welfare, that is, if the veterinarian uses a technique that is as “rapid and painless and distress-free” as possible, then our duties to the patient are supposedly satisfied.³⁶⁷ Yet, veterinarians and shelter workers demonstrate by their emotional and moral responses, and by their efforts to minimize the number of such euthanasias, that painless killing is not enough. Considerations beyond welfare must be relevant.

³⁶⁶ Stoewen, D. L. (2015). Suicide in veterinary medicine: Let’s talk about it. *The Canadian Veterinary Journal*, 56(1), 89–92. See also: article and comments at <http://veterinarynews.dvm360.com/myth-compassion-fatigue-veterinary-medicine>

³⁶⁷ Panel on Euthanasia. (2013). AVMA Guidelines for the Euthanasia of Animals.

Using the paradigm I offer here, we may find the conceptual resources needed to explain the source of our moral discomfort with such instances of “humane euthanasia.” It also directs our attention to new ways of at least ameliorating what emerges as an obvious and legitimate moral problem. When we euthanize a healthy dog or cat, one who lets us know through her behavior that she values her life and would not choose to die right now, we violate her autonomy profoundly. We disregard her preference to continue living even if we end her life without hurting her, in a way she seemingly acquiesces to by, say, placing her paw into the hand of the person giving her the euthanasia injection.³⁶⁸

On its own, acknowledging that violating of patient autonomy is at the moral core of such situations will not, on its own, do much practical good. The veterinarian is still confronted with the conflict between respect for autonomy, on the one hand, and non-maleficence (if she fears that refusing to euthanize the animal will result in the client performing the killing in a manner that causes suffering or that shelter overpopulation will cause disease problems and patient suffering). The duty of fidelity notwithstanding, she must also factor in ethical obligations to society or other patients, e.g., the newly arrived shelter animals’ interest in having adequate space or the human community’s interest in not having disease outbreaks. However, a *relational* approach to autonomy, with its attention to the dependence of autonomy on social, institutional, and interpersonal factors, directs us to potential remedies beyond the immediate situation. The reasonable options available in the exam room are often limited by policy choices made at other levels, e.g., the hospital, the community, even nationally.

For example, when it comes to cases of “economic euthanasia,” is our profession perpetuating any policies and incentive structures that contribute to the maintenance of the practice? What steps can we take at the hospital level to connect clients who are struggling financially to the resources that would make feasible a choice besides economic euthanasia? Should veterinary leadership come out more strongly in support of pet insurance, given its proven track record for decreasing the risk of economic

³⁶⁸ I experienced this as the “holder” for euthanasia at the Humane Society of Greater Miami in 1999, and it was one of the few times I saw the euthanasia technician exhibit signs of emotional distress.

euthanasia? Regarding euthanasia of healthy, adoptable animals in shelters, is the AVMA fulfilling its moral obligations merely by issuing guidelines on *how* to euthanize these animals and adopting a policy statement, one sentence in length, asserting its lack of opposition “to the euthanasia of unwanted animals ... when conducted by qualified personnel, using appropriate humane methods”?³⁶⁹

At some level, such approaches are already being considered by some in the profession. But I suspect we would deepen our ability to analyze the problem if we tap into the conceptual resources and practical approaches developed by those in (human) fields where dependent agency and the care of vulnerable individuals are central concerns. For example, feminists ethicists like Susan Dodds note that the “assignment for responsibility” for dependent individuals is socially constructed: rather than it being a given who is responsible for caring for dependent others, this is a decision made by society, whether deliberately or through the unconscious replication of unquestioned norms. Dodds argues that the way such responsibility is assigned may create “pathogenic vulnerabilities,” or susceptibility to suffering and loss of autonomy rooted in institutional structures and interpersonal relationships.³⁷⁰

The term “dependent others” traditionally refers to children, or people with severe cognitive or physical dysfunction, but there is no reason not to consider animals as dependent others as well, as their domestication has made them very dependent on human caregivers for their needs and their ability to exercise agency. Incorporating this perspective may help us identify “pathogenic vulnerabilities” to which our profession contributes or acquiesces. We may question the social practice of assigning financial responsibility for veterinary care exclusively to the “pet-owner,” who may have been the only passer-by kind enough to take in a stray off the street. We may ask whether the veterinary community

³⁶⁹ AVMA. Euthanasia of Animals That Are Unwanted or Unfit for Adoption. Retrieved from: <https://www.avma.org/KB/Policies/Pages/Euthanasia-of-Animals-That-Are-Unwanted-or-Unfit-for-Adoption.aspx>

³⁷⁰ Dodds, S. (2014). Dependence, Care, and Vulnerability. In C. Mackenzie, W. Rogers, & S. Dodds (Eds.) *Vulnerability: New Essays in Ethics and Feminist Philosophy* (181-203). New York, NY: Oxford UP.
Mackenzie, C., Rogers, W., & Dodds, S. (2014). Introduction: What is Vulnerability, and Why Does It Matter for Moral Theory? In C. Mackenzie, W. Rogers, & S. Dodds (Eds.) *Vulnerability: New Essays in Ethics and Feminist Philosophy* (1-29). New York, NY: Oxford UP.

should continue to simply accept that Animal Services departments are funded as their local communities see fit, when the resulting lack of institutional support directly causes the continued euthanasia of healthy, adoptable animals. If we deem that change is called for, then considering the broad view that relational autonomy accounts bring into view may be our best hope of creating far-reaching solutions.

These examples, and most of those I have presented in this thesis, are focused fairly narrowly on companion animal practice and sanctuary medicine. But the veterinary profession obviously tends to many other types of animals. Most of our patients are in captivity and, in many – maybe most – cases, captivity is a restriction on autonomy. Even if we accept respect for autonomy as an important value in animal ethics, the fact of captivity is likely to persist, perhaps indefinitely. A relational approach to autonomy points to ways that we can nonetheless enhance the autonomy of animals living in captivity and accord it greater respect, and may at times lead us to challenge the perpetuation of captivity.

Incorporating respect for autonomy, rather than adopting one of the “simpler” views, requires that we not turn a blind eye to the shape of our patients’ lives; that is, we must look not only at their pain, fear, and opportunities for enjoyment, but also at whether they can, in any meaningful way, choose the types of lives that they live. While the veterinary profession is but a part of the whole of society that determines this, the fact is that the profession currently helps perpetuate institutions and practices that deny animals virtually *any* opportunity to shape their lives. If we accept that the autonomy of our patients matters, and that their autonomy depends fundamentally on social factors, then we must face difficult and uncomfortable questions about our profession’s role in promoting institutions and practices that require the absolute denial of autonomy to animals.

Relational autonomy theorists have similarly challenged conventional medical ethics to own up to and change its tendency toward myopia:

“Debate has focused on certain practices within [the institution of medicine]: for example, truth-telling, obtaining consent, preserving confidentiality, the limits of

paternalism, allocation of resources, dealing with incurable illness, and matters of reproduction. The effect is to provide an ethical legitimization of the institution overall, with acceptance of its general structures and patterns.”³⁷¹

One place where my view would challenge veterinary medical ethics in this way is in its promotion and perpetuation of intensive animal agriculture, an institution which rests on the systematic denial of animal autonomy. As currently practiced, this institution denies animals any degree of macro agency: their living conditions, daily schedule, social associations – even their ability to physically move – are dictated exclusively by their human owners. Their lives are ended which it suits their human owners. To the extent that intensive agriculture concerns itself at all with micro agency, it tends to be limited to an attempt to decrease the frequency with which highly coercive methods, like electric prodding or physical beatings, are used, via construction of more “animal friendly” physical barriers or holding areas,³⁷² or use of “flight distance” to get animals to move in the direction their handler wants.

Using its current framework of animal welfare, the veterinary profession does not recognize a moral problem with intensive animal agriculture. In fact, in spite of the United Nations’ recommendation that humans try to decrease reliance on animal protein because of environmental concerns,³⁷³ the AVMA puts resources toward advocating for more animal agriculture and promoting “greater reliance on animal-source food.”³⁷⁴ I have yet to attend a veterinary continuing education conference that provided vegan meal options beyond one piece of fruit and a bag of potato chips.

I am not so naïve as to imagine the veterinary profession might begin promoting veganism or refusing to participate in the slaughter of animals who prefer to go on living. After all, veterinary

³⁷¹ Sherwin, S. (1989). Feminist and Medical Ethics: Two Different Approaches to Contextual Ethics, *Hypatia*, 4 (2), 63.

³⁷² Efforts such as those by Temple Grandin have surely had a positive impact on welfare.

³⁷³ Jowit, Juliette. (2008). UN says eat less meat to curb global warming. *The Guardian*.

Hertwich, E., van der Voet, E., Suh, S., Tukker, A., Huijbregts M., Kazmierczyk, P., Lenzen, M., McNeely, J., Moriguchi, Y. (2010). Assessing the Environmental Impacts of Consumption and Production: Priority Products and Materials, A Report of the Working Group on the Environmental Impacts of Products and Materials to the International Panel for Sustainable Resource Management. *United Nations Environment Programme*. 80. Retrieved from: http://www.unep.fr/shared/publications/pdf/DTIx1262xPA-PriorityProductsAndMaterials_Report.pdf

³⁷⁴ Nolen, R.S. (2017). AVMA weighs stepped-up role in global food security. *Journal of the American Veterinary Medical Association*, 250 (8). 822-838.

medicine has its origins in animal agriculture and, as long as animal agriculture exists, the profession has a duties of beneficence and non-maleficence its “food animal” patients, including minimizing their suffering during slaughter. However, if respecting and enabling patient autonomy were accorded a role in veterinary medical ethics, and its social undergirding made more visible, perhaps we would recognize an obligation to: (1) promote a *decreased* reliance on animal-sourced foods, as decreased demand would permit less intensive rearing practices that would likely provide some opportunities for animal autonomy, and (2) explore ways of raising farmed animals that enable at least a degree of macro and micro agency. As it stands, the profession tends to discourage the practice of having “pet” chickens or backyard flocks, citing disease concerns. However, given that many of these animals enjoy good welfare and the opportunity to exercise a significant degree of autonomy, we might consider it a reasonable alternative for keeping these chickens’ caregivers’ families and communities provisioned with eggs.

Animal agriculture is but one example. If we recognize that our profession inevitably shapes, both explicitly and implicitly, the social milieu that constrains the very possibility of respecting animal autonomy, there are many areas ripe for ethical analysis. Among them:

- How medical and veterinary research is conducted. This might apply to both designated “research animals” (another group of animals will little to no say over the macro frame of their lives) or companion animals who are enrolled in research trials from which they stand to benefit. Perhaps we have an obligation to work to change incentive structures and medical record systems to make possible more clinical research on naturally occurring illnesses or injuries. While the practice of keeping “laboratory animals” for experimentation persists, we might look for locations and practices for enabling agency above and beyond the use of PRT to produce compliance with research procedures.
- How zoos implement their PRT programs and to what ends they use them. Currently, many PRT programs *do* seem to operate on the assumption that, if the animal is not resisting and you are

not hurting her, all your duties have been met. An ethical framework that incorporates concern for autonomy or macro agency may require zoo veterinarians to examine whether they can reconcile their provision of reproductive services whose intention is to develop genetically diverse, permanently captive population with the fact that, for at least some species, captivity seems to impose a fundamental limit on the development and exercise of autonomy.

These proposals will seem radical to many; I will be pleasantly surprised if they enter the discussion within mainstream veterinary medicine within my lifetime. But that is part of the usefulness of this approach – it can highlight fundamental ethical problems that our existing paradigms render invisible.

Thus, regarding the objection that a “simpler” formulation would get us the same substantive recommendations as valuing respect for patient autonomy, relationally conceived, I must conclude that it would not. Perhaps, in daily practice, we would reach similar conclusions if we adopted a formulation of animal welfare that asks both *Is the patient well-cared for?* and *Would she choose this intervention and this life for herself?* But, if the answer to either of these questions is “no,” the approach I here recommend will demonstrate its value when we begin the work of remedying the situation.

As I said in the Introduction, when I began writing this thesis, I was employed as a chimpanzee sanctuary veterinarian. After setting up the veterinary program and settling in the first group of ape “retirees,” I returned to a position as an emergency veterinarian. These two branches of veterinary medicine differ substantially. As a sanctuary veterinarian, I worked with the same group of animals and caregivers, often getting to know them very well and having input during the course of their everyday lives, while as an ER clinician I usually work with each patient and client only once, and have little input into the animals’ daily lives or the shape of their lives. Yet, I have found the ideal of protecting patient autonomy to be a useful in both fields, one that helps me provide better care to my patients, better guidance to their caregivers, and better leadership to the practice. My hope is that the ideas presented here are similarly useful to others as, together, we navigate this morally complex field.

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