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ARTICLES

Strong Patient Advocacy and the Fundamental Ethical Role of Veterinarians

Simon Coghlan[1,2]

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Abstract This essay examines the fundamental role of veterinarians in companion animal practice by developing the idea of veterinarians as strong advocates for their nonhuman animal patients. While the practitioner-patient relationship has been explored extensively in medical ethics, the relation between practitioner and animal patient has received relatively less attention in the expanding but still young field of veterinary ethics. Over recent decades, social and professional ethical perspectives on human-animal relationships have undergone major change. Today, the essential role of veterinarians is not entirely clear. Furthermore, veterinarians routinely face pressure, often insidious, to refrain from pursuing their patients' vital interests. In exploring the concept of strong patient advocacy, this essay investigates the increasingly common suggestion that veterinarians have 'primary obligation' and 'first allegiance' to their animal patients rather than to other parties, such as their clients or employers. The related concept of a fiduciary duty, which is sometimes encountered in medical ethics, is similarly explored as it applies to companion animal practice. The resultant idea of a strong patient advocate places companion animal veterinarians conceptually and ethically close to human health professionals, not least pediatricians.

Keywords Veterinary ethics · Patient advocacy · Pediatric ethics · Fiduciary duty · Animal welfare · Medical ethics

✉ Simon Coghlan
sarcy3@hotmail.com; simon.coghlan@deakin.edu.au

[1] School of Medicine, Deakin University, Geelong Campus at Waurn Ponds, Geelong, Australia

[2] Melbourne, Australia

Introduction

This essay examines the essential or fundamental role of veterinarians in companion animal practice.[1] It develops the notion of veterinarians as *strong patient advocates* (SPA). Although we frequently hear that veterinarians, like human doctors, are advocates for their patients, this important notion remains unclear. Compared to the larger field of medical ethics, the youthful discipline of veterinary ethics has paid less attention to the fundamental role of practitioners.[2] This essay aims to provide more content to the moral idea of veterinary patient advocacy and to illuminate the triadic relation between veterinarian, client, and patient.

Plato wrote in *The Statesman* that a doctor is a physician to his patient

> so long as he exercises authority over them according to rules of art, if he only does them good and heals and saves them. And this we lay down to be the only proper test of the art of medicine. (p. 112)

For Plato, the 'physician' who does not exercise his expert authority for the sake of his patient, but instead seeks some other goal or interest,[3] is like the ruler who fails to rule his subjects with 'wisdom and justice'. In each case, the physician and ruler are 'not genuine or real; but only imitations of…[these], and some of them are better and some of them are worse' (p. 113). A genuine medical art, one that is not a 'mere imitation' of that disciplinary practice, requires, on this view, practitioners' unyielding dedication to the patient and her interests. Morality defines the role. Further, the requirement of steadfast devotion to the patient's wellbeing constitutes, as Plato might say, the *nobility* of medical arts. Medical expertise, while indispensible, is not enough. When *mis*directed, medical expertise is not noble, but base; and it is base in, as Plato says, greater or lesser degrees. Medical art's nobility rests on its proper employment, and that is to 'do good' to the patient.

Some, like the AVMA (2018a), speak not of nobility but of the veterinary profession's *dignity*. In this essay I want to ask: What basic moral orientation and behavior upholds the dignity or the nobility of the veterinary profession? What is the deepest way of understanding the companion animal veterinarian's role? By focusing on the concept of strong patient advocacy (SPA), and by contrasting SPA with weak patient advocacy (WPA), I will be indirectly attempting to characterize the source of the veterinary profession's nobility and dignity.[4]

[1] Hereafter, 'veterinarian' means 'companion animal veterinarian'. The majority of veterinarians are of this type.

[2] Although things are changing. For scholarly work on veterinarians' moral role, see e.g. Tannenbaum (1995), Rollin (2013), Yeates (2012), Bones and Yeates (2012), Sandøe et al. (2015), Legood (2000), Wathes et al. (2012), McCulloch et al. (2014), Fawcett and Mullan (2017) and Hernandez et al. (2018).

[3] In *The Republic*, Plato (1987, p. 83) writes that the 'doctor *qua* doctor prescribes with a view not to his own interest but that of his patient. For we agreed that a doctor in the precise sense controlled the body and was not in the business for profit, did we not?… It is his subject and his subject's proper interest to which he looks in all he says and does'.

[4] Once again, I mean in relation to companion animal practice.

Overview of the Strong Patient Advocate (SPA) Concept

Distinguish two types of advocate:

1. A veterinarian who supports and promotes, perhaps publicly, a particular moral cause (e.g. nonhuman animal welfare) or policy (e.g. outlawing puppy farms).
2. A veterinarian who acts for, and puts a case on behalf of, her patient and his/her interests.

Type 2 is our focus. Minimally, a patient advocate (PA) recognizes obligations regarding her patient and uses her position, medical knowledge, and clinical training to try to improve the patient's health. In ethical terms, however, this description is vague. For example, it is compatible with acting only weakly for a patient's sake and with sometimes seriously harming and subordinating the patient's vital interests to the interests of others. In human medicine and biomedical writing, it is typically held or assumed that doctors will act (almost) always for their patients, subordinating their personal interests and the interests of others to those of the patient. This norm stretches back millennia to the Hippocratic Oath.[5]

That veterinarians also have powerful moral duties towards their patients is increasingly recognized. Historically, companion animals received little protection. Now, in veterinary contexts, we more frequently hear words and phrases like these: *the animal's interests are central, primary or paramount; a veterinarian's first duty, loyalty, obligation, and allegiance is to the patient; veterinary medicine is patient-centered and patient-focused*. For example, veterinary ethicist Bernard Rollin (2002, p. 1147) claims that as 'a clinician, the veterinarian's primary obligation is to the best interests of the animal', not to the client. In a similar vein, a writer in a veterinary ethics book (Legood 2000, p. 68) says that 'Primarily, animals are…[the veterinarian's] clients'.

Yet, the basic moral role of veterinarians, especially compared to the role of human health professionals, remains unclear and contested. Furthermore, there are often strong pressures (from clients, peers, employers, etc.) on veterinarians to refrain from pursuing their patients' interests. Such pressures can be overt and obvious, or subtle and insidious. Indeed, veterinarians often wish to pursue their patients' wellbeing, but in practice they may not always speak up for them (Hernandez et al. 2018). For all these reasons, it is important for veterinarians to be clear about their fundamental ethical role. What is this role? Discussing the veterinarian-client relation, Yeates and Main (2010) suggest that veterinarians may influence clients when client choices fail a test of 'reasonableness'.[6] 'Reasonableness', they say, is not defined in terms of the veterinarian's judgement about the best for the patient. Rather, it involves assessing the

[5] For example (quoted in Degrazia et al. 2011, pp. 69–70): 'I will…benefit of the sick according to my ability and judgment; I will keep them from harm and injustice'. Of course, the Hippocratic Oath also recognizes powerful duties to *non*-patients, namely the physician's own teacher and pupils.

[6] It should be noted that Yeates and Main are just raising this proposal for consideration, not necessarily endorsing it.

> reasonableness of a client's choices relative to the decisions other owners have made in similar circumstances. If the owner has made an extreme decision, relative to choices made by others, that is deleterious to the animal's welfare, then the veterinarian may legitimately exercise some influence (p. 266).

This test certainly legitimizes advocacy for the patient in many situations. However, we should observe that sometimes a veterinarian may judge or guess that a majority of clients *would* allow consequences to occur that are 'deleterious to the animal's welfare'. Thus, this proposal permits veterinarians, at least sometimes and in principle, to acquiesce in or even cause harm to their patients, even when they are in a position to attempt to prevent that harm. Christiansen et al. (2016) raise several contending answers to the question of when veterinarians may seek to influence clients. Should a veterinarian, they ask, who has a client with a chronically ill or aged animal companion

> Share his or her preferred option in similar situations? Offer an opinion on the best decision for the animal and the client? Inform the client of the options but refuse to offer any guidance on decision-making? Or initiate a dialogue with the client about what to do? (p. 2)

A possible role for veterinarians, the authors suggest, is to respect client preferences and promote client autonomy through a process of shared decision-making with them. These two proposals, while arguably patient-centered in some senses of the term, fall short of describing the kind of strong patient advocacy this essay explores.

Bernard Rollin (2013, p. 20) claims that the 'fundamental question of veterinary ethics' is: 'To whom does the veterinarian owe primary obligation—animal or owner?' How should we answer this question, and what precisely do phrases like 'primary obligation' and 'first allegiance' mean? Rollin (2013, p. 20) asks: 'Ought the model for the veterinarian be the pediatrician or the car mechanic?'[7] His answer is the pediatrician. The pediatrician advocates for her patient's interests, including when those interests conflict with family/parent/guardian wishes and demands. For Rollin, such advocacy is also incumbent upon veterinarians. By developing Rollin's simple comparison in this essay, we may see that there is in fact a range of possible caring behaviors and stances available to veterinarians.

Rollin contrasts veterinarians with car mechanics because many people have no serious qualms about destroying or not fixing their damaged automobiles. Of course, some owners do have strong feelings about their cars, not least, perhaps, about vintage or classic cars. Similarly, a vintage car mechanic might care quite strongly, in a certain sense, about the cars themselves. Such a mechanic not only repairs cars to please concerned owners, he also lovingly restores neglected cars and is upset when vintage models are 'mistreated' or discarded for convenience. He may try to

[7] Childress and Siegler (1984) identify several models or metaphors of the *human* doctor-patient relationship. These are the paternal, partnership, rational contractor, friendship, and technician models. The doctor-as-technician is like a plumber, or better, an expert engineer who, fallaciously, regards the provision of options to customers as a purely 'scientific', morally neutral exercise. Unsurprisingly, they reject this model. Earlier, Veatch (1972) identified engineering, priestly, collegial, and contractual models.

persuade owners to have more 'respect' for them and to fix and salvage them where possible. Some sort of 'sentimental' or emotional value attaches to these car models. Maybe a few veterinarians still have attitudes to animals that are very roughly like this.

Very many contemporary veterinarians, in contrast, hold that animals have a significant moral value. Although these veterinarians believe their role is partly to benefit human clients, they also feel a moral duty to benefit their patients for the patients' own sake. Animal patients have, for these health professionals, an *intrinsic* ethical value, not merely (like vintage cars) an *instrumental* ethical value. However, there are, ethically speaking, multitudes of ways in which an animal patient may be treated and regarded. First, there are many *categories* of moral behavior—we might list here action, principle, duty, thought, virtue, attitude, disposition, emotion, and care.[8]

Second, there are *stronger and weaker* forms of such behavior directed at furthering the patient's wellbeing. Here, the concepts of 'strong' and 'weak' do not have an entirely determinate denotation. These concepts encompass a range of possible actions, attitudes, and dispositions that may escape exhaustive enumeration. Pediatricians, we might in any case say, are strong, not weak, advocates for their child patients. Pediatricians do not see their role primarily as facilitators of guardian/parent preferences, or the interests of other parties, unless that is consistent with patient interests. Pediatricians believe their 'primary obligation' is to the children in their care, and they muster their resources and use their position to enhance those patients' health and wellbeing. Where on the scale of ethical, protective, and caring behaviors, between the pediatrician and the vintage car mechanic, do veterinarians fit?

Pediatrician ——————————Veterinarian?—————————— Vintage Car Mechanic

Adding further complexity to our question is the fact that the precise meaning of having 'primary obligation' to the patient is disputed even for *pediatricians*.[9] In sum, the increasingly used notions of 'primary obligation' and 'advocacy' are ambiguous. They need elaboration, clarification, and defense.

Sorting Through Some Qualifications of the SPA Concept

It cannot be right that veterinarians must *always* strive to promote their patients' important health needs. Unconditional beneficence is not even required of human doctors (Beauchamp and Childress 2001). The interests of other parties matter too, and so do other values. As an example of another (and sometimes conflicting) value, recall that the medical profession was traditionally highly paternalistic towards patients. Exalting in this way the value of beneficence, medicine for centuries

[8] This list reflects behaviors variously emphasized in some standard bioethical theories, e.g. ethics of care, virtue ethics, 'principalism', utilitarianism, neo-Kantianism. It is not necessary to take theoretical sides. I simply note that actual applications of different theories will yield a large range of possible, and sometimes conflicting, normative stances that veterinarians should take towards their patients. Our main concern in this essay, however, is with the basic moral orientation of veterinarians and with the *strength* of ethical duties toward patients.

[9] A fact that is unsurprising given the moral complexity and importance of health professional roles.

systematically overlooked the crucial value of *autonomy*.[10] (Plato also effectively believed the genuine or true physician would override the patient's wishes in order to 'do them good and heal and save them'.) Modern challenges to paternalistic practices (Degrazia et al. 2011, p. 59) have required doctors to act at times in plainly non-beneficent ways. So revolutionary were these challenges that medicine now recognizes the autonomy-based right to refuse even life-saving treatment.

Autonomy, like beneficence, is an important value. Granted this, a 'traditionalist' about veterinary medicine might feel emboldened to insist that a veterinarian's fundamental role is to respect *client choices* even at the expense of patients' health needs (short of violating cruelty/welfare laws and rules). This traditionalist may of course acknowledge that genuine respect for autonomy mandates ensuring that clients truly understand the expected consequences to the patient of relevant (non)interventions. After all, many people love and need their animal companions. Nevertheless, a traditionalist's rejection of superficial accounts of client autonomy is consistent with assigning the nonhuman animal little intrinsic ethical value.

Most bioethicists believe that autonomy's value is not *absolute*. So-called 'liberty-limiting principles' (Degrazia et al. 2011, p. 46) significantly restrict some varieties of human freedom. John Stuart Mill (1966) claimed that liberty is rightly limited when free acts *harm* other people. Animal cruelty and welfare laws and guidelines effectively extend Mill's harm principle to animals, at least to some degree. Society thus morally approves of some legal constraints on autonomy. The next question is whether client autonomy trumps strong veterinary advocacy for patients. We should note that clients are legally free (within the constraints of animal cruelty/welfare legislation and legal precedents) to refuse veterinary advice that would save their animals from harm. Additionally, interventions are not possible without obtaining client consent which is adequately (not merely nominally) informed.[11] In these senses, veterinarians must heed guardian autonomy. So, to some extent, must pediatricians. Pediatricians may rightly advocate strongly for children, and sometimes they must threaten the parent with child protection services. But, morally and legally, pediatricians may not physically threaten, seriously mislead, or coerce parents to protect children from harm. Some people think *lying* to guardians/clients to protect patients is (almost) always wrong. Lying also threatens to undermine client-professional relationships. It thus potentially harms future patients, human or animal.[12]

Autonomy's value is not absolute, but it matters, and veterinarians ought to respect it in certain ways. That is another reason why obtaining true informed consent for significant interventions and non-interventions is important.

[10] Of course, medicine did not always have the ethico-conceptual resources that were developed in recent times.

[11] Professional regulatory bodies typically require veterinarians to obtain informed consent from clients. A veterinarian who eschewed sound practices of informed consent would be diminishing her power as an SPA and, indeed, risking her career.

[12] Some bioethicists distinguish the bald act of lying from the (similarly beneficent) withholding of information, as when a doctor does not immediately reveal to vulnerable human patients the full extent of their cancer—the latter being potentially more justifiable. I do not address the issue of truthfulness in veterinary medicine further here.

Furthermore, promoting patient interests will often be compatible with respecting the autonomy of clients who share with the veterinarian a deep commitment to that goal, and, perhaps, to the same means of achieving it. A model of shared decision-making—or (to borrow a term from pediatric ethics) a 'family-centered' approach to health, in which the mutual interests of patient and human family are treated as having great importance—is entirely possible and desirable in veterinary practice.

Nonetheless, SPA implies 'primary obligation' to the patient. And this will at times require something other than unwavering dedication to enhancing the autonomous choices of clients. For such dedication is compatible with neglecting patient advocacy when client choices—or the wishes and interests of other parties—imperil patient wellbeing. In these cases, veterinary SPAs will instead devote their professional efforts and resources toward securing informed consent from clients for health-promoting actions or omissions. And sometimes, SPAs (veterinary or pediatric) will need to argue against, override, or refuse to follow client wishes. That is part of what I mean by 'strong patient advocacy'.

We must now mark several salient limits to SPA. Veterinarians do not merely have duties to one individual, but to multiple parties. There are duties to clients, to self, to family, to public, to employers, and so on. Again, it will often be the case that these duties can be reconciled with a resolute commitment to patient wellbeing. Still, the duty to promote or maximize patient health is not absolute but *prima facie*—it admits of exceptions. *Some* duties to individuals other than the current patient, then, can 'override' loyalty to that patient. Furthermore, there are identifiable special cases in which health professionals may or must prioritize the interests of others over the interests of the patient. Indeed, in some special cases, the practitioner may arguably put her own interests ahead of the patient's. Consider these medico-ethical examples (A), paired with roughly analogous veterinary ones (B):

A. Just allocation of scarce medical resources (e.g. kidney dialysis machines, transplant organs) requiring distributions that deprive individual patients.
B. Emergency triaging of animal patients with more or less life-threatening conditions (e.g. car accident or wildfire burn victims).

A. Violating confidentiality to warn other parties of imminent, grave risks posed by the patient.[13]
B. Advising the rehoming of a fear-aggressive canine patient posing high risks of injury to particular human and/or animal family members.

A. Refusing to treat Ebola patients due to personal risk of infection.
B. Refusing to treat a dangerously aggressive or dangerously contagious animal patient.

[13] A well-known example is the Tarasoff case, in which a mentally ill patient told a psychologist of his intention to kill Tatiana Tarasoff (and did kill her). Similarly controversial is the example of health professionals warning, directly or indirectly, the sexual partners of patients about the risks of contracting HIV in situations where those patients are unwilling to disclose their HIV-positive status (Steinbock et al. 2009).

A. Declining to enter a war zone or other violent situations to treat patients.

B. Declining to treat an animal patient with an abusive, threatening owner.

A. Reporting to authorities an infectious disease with public health implications, knowing the infected patient will be coercively quarantined.

B. Reporting a nonhuman animal for the same reason, knowing the infected patient may possibly be killed.

This list suggests that the *prima facie* duty to promote/maximize human or animal patient interests arguably may lapse in serious and exceptional circumstances. Our examples underline this 'exceptional' or 'special' circumstance aspect. Health professionals *ordinarily* should prioritize patient interests over others' interests and over personal interests, including economic interests in treating patients.[14] Indeed, this moral expectation is arguably inherent in the concept of 'health professional' (and is, furthermore, consonant with relevant Platonic and Hippocratic claims). However, we might feel that veterinarians are an exception here, since veterinarians may and do commonly accede to *owner* wishes that are harmful to patients,[15] whereas pediatricians (we may assume) do not and must not acquiesce in parental demands at the expense of children's best interests. For several reasons, this view is too simple.

Like veterinarians, pediatricians work within triadic healthcare relationships in which parents/guardians, patients, and professionals have greatest involvement. Pediatric ethicists have emphasized not only *patient-centered* but also *family-centered* models of professional practice (e.g. Bamm and Rosenbaum 2008). These two ethical models are supposed to be compatible and mutually reinforcing, but the family-centered model also highlights the needs of the whole family of which the patient is just one member. In both medical and veterinary contexts (leaving aside now the patient herself), it is the 'family' that typically has most at stake in the provision of health care. Observe, for instance, the onerous consequences for families of the following actions: prescribing a daily regimen of 6-h of feeding for a neurologically disabled child (Rosenbaum et al. 2016, p. 12); instructing families to uproot from their communities to be near medical facilities; insisting parents pay $100,000 for an innovative treatment, thereby forcing them to neglect educational opportunities for their other, healthy children. A pediatrician, therefore, may

[14] For example, veterinarians should not order (or fail to order) tests or treatments that, while personally advantageous, may harm the patient. Difficult questions arise when clients cannot or will not pay for necessary interventions. Baillie et al. (2012, p. 80) say (of human doctors) that 'a person is unworthy of the name of health care professional who refuses to see an individual based upon ability to pay'. But, at least for many veterinarians in private practice, duties to self, loved ones, staff, and future patients militate against undermining practice sustainability. Although we cannot address this issue here, we might suggest that strong patient advocates are constitutively prepared to incur some financial losses to prevent significant harm to patients.

[15] Indeed, sometimes veterinary associations and regulatory bodies advise practitioners not to 'impose their moral judgments on clients', or words to that effect. Such words may have various possible interpretations, including the reasonable one that veterinarians ought not be judgmental, condescending, blaming, etc. But they may also be understood by some veterinarians as being at odds with forms of strong patient advocacy.

arguably accept *certain* (not all) guardian wishes that effectively harm patients while protecting other family members.

Yet, to accept these qualifications and still retain a genuine sense of that important phrase 'primary obligation', we should appreciate here that two conditions must obtain: First, the harm to non-patients must be serious enough to outweigh professional duties to the patient; second, this situation should be the exception and not the rule in daily practice. If we do not insist on these conditions, it will become difficult to retain the senses of 'primary obligation' and 'patient advocacy' that we ordinarily assume apply to human health professions.

A genuine sense of *animal* patient advocacy is, perhaps, dependent on similar caveats. Patient advocacy need not entail insisting on life-saving treatment that, say, financially impoverishes an unwilling animal 'owner' and destroys the educational opportunities of their children. But arguably, it will involve professional attempts to protect the patient from real harm in a great many circumstances, including those circumstances in which there are potentially negative impacts on client interests.

Best Interest Standard Versus Harm Standard

Rollin (2002, p. 1147) claims that 'the veterinarian's primary obligation is to the *best interests* of the animal' (italics added). Some bioethicists favor a Best Interest standard for pediatricians. Other bioethicists reject this standard (Diekema 2004). McDougall et al. (2016) argue that although pediatricians have a *general* duty to collaborate with parents/guardians to meet children's best interests—a moral disposition that is indeed fundamental to their professional role—nonetheless they ought to aim only at ensuring children are *not harmed* in cases where substantial disagreements with parents arise over health plans. 'Harm' here means 'significant setback' to the patient's interests. To illustrate, consider two medical options:

Option A: 80% chance of cure and 30% risk of adverse side-effects.
Option B: 75% chance of cure and 25% risk of identical side-effects.

Assume A, not B, is in the child's best interests. Naturally, the pediatrician advises A. But let us imagine the parents disagree and insist on B (perhaps from a keen fear of adverse side-effects). McDougall et al. say pediatricians should respect and accept parents' properly informed wishes and pursue B rather than, say, continuing to persuade parents to elect A, or else taking stronger action such as overriding parental decisions, e.g. by refusing parents' demands or by threatening to call child protection services. This is because although A meets the Best Interest standard, B does not involve comparative harm to the child. That is, B does not significantly set back patient interests relative to A.[16]

McDougall et al. call this the Zone of Parental Discretion (ZPD). The ZPD idea attempts to balance patient wellbeing and parental autonomy. Autonomy's ethical

[16] We can note here that sometimes *several* options are equally medically indicated. Further, health care often requires difficult judgments about a patient's best interests, and there may be greyish areas of legitimate disagreement. In morally tragic cases, moreover, *all* options will seem wrong—as may sometimes occur in end-of-life decision-making.

importance was acknowledged earlier. Parents have a general moral right to make life-affecting decisions for young children without social or 'medical' interference. Parents are also often best placed to know the interests of their children. But equally, parents may not ordinarily make medical decisions that harm their children.[17] Can the ZPD idea be coherently transferred over to veterinarian-client-patient relations?

First, use of the ZPD in some circumstances might be questioned. The ZPD assumes that parents' moral authority to make medical decisions for their children derives in large part from their commitment to their children's wellbeing. We might then query the moral right to make non-best-interest medical decisions when parents appear insufficiently so committed. A major problem with this query, however, is that judging parents to have an insufficient general commitment could be unfair to them, since professionals will often lack adequate knowledge of the family situation and the competing needs and interests that parents must negotiate.

But what if the pediatrician clearly discerns that a parent's *particular* decision, though located *within* the ZPD, is based on obstinate irrationality, selfishness, or even some vindictiveness towards the child? A possible answer to this question is that since objectionable parental motivation will be the infrequent exception rather than the rule, the pediatrician safely may, in virtually all cases, forgo challenging parental decisions that are non-harmful albeit non-optimal. Furthermore, a family-centered approach that accepts parents' non-optimal, non-harmful, yet dubiously motivated decisions may still be in the child's overall interest. That provides a further reason for respecting this area of parental/guardian discretion.

Second, does the *veterinary client* have the moral authority which is internal to the ZPD concept and is requisite for adopting its key features in the companion animal sphere? Increasingly, perhaps, the answer is 'yes'. At least in many places, people now regard their animal companions as *family* and are very willing to seek expensive veterinary care (Podberscek et al. 2005). (Clearly, many people cannot afford expensive care; yet many of these people still regard the animal as family.) If that is true, we could transfer the ZPD concept to companion animal medicine, recognizing a zone of client discretion in which clients' autonomous decisions about animal companion health care are respected and followed. (Complications obviously arise where the 'companion animal' patient is not regarded as family or is not primarily a companion, but is kept for other reasons.)

As with the pediatrician who adopts a family-centered approach, the veterinarian will need to exercise judgment to ascertain when (say) 'forceful' advocacy is, and is not, beneficial to the patient. Indeed, good patient advocacy itself sometimes requires forgoing vigorous petitioning on the patient's behalf. Some humility is also required, since clients who love and live with their animals are (like parents are with their children) often well placed to judge their best overall interests. Nonetheless, veterinarians deploying a family-centered framework may recognize an area of client discretion, analogous to that zone recognized by pediatricians, in which practitioners respect guardian autonomy at the expense of patients' best interests, but without acquiescing in or approving of decisions that harm their patients.

[17] Unless the kind of exceptions discussed earlier apply (in which case it is not 'ordinary').

Justifying Reasons for the SPA Concept

Although the Harm Standard is less stringent than the Best Interest Standard, it is still a strong standard. Whereas the pediatric profession surely embraces it as a minimum standard of care, many veterinarians may view the Harm Standard as too strong. On the one hand, many people now think it is just obvious that veterinarians ought to advocate for patients and to challenge client choices that harm them. On the other hand, some people believe that client interests continue to be 'primary', and that strong patient advocacy is not required or even justified—a weaker commitment to patient wellbeing is acceptable. It was the weaker conception, of course, that prevailed in traditional veterinary medicine. Indeed, some veterinarians effectively were the handmaidens of their clients (some still are.) Let us briefly consider two ethical reasons for a modernized conception of the veterinary role.

First, there is growing recognition that nonhuman animals like dogs and cats have a significant intrinsic ethical value or status (Singer 1995; Regan 1983). To harm or kill them is often to seriously wrong them (Degrazia 1996). As Rollin (2013) says, the social ethic has changed. Like others, veterinarians have a keen sense of their patients' intrinsic value, and this helps to define for them the importance of their profession—indeed, we might say, it helps to explain its dignity and nobility. Furthermore, this role is one that society can rightly approve. Society, of course, ought to protect human members who depend on animal companionship, e.g. by helping regulate veterinary activities. But society's obligation extends also to the animals themselves. Given the significant moral status of some companion animal species, a just society has reason to support a veterinary profession that practices strong patient advocacy.

Second, the practitioner-patient relationship creates strong role-based requirements, as it does in human medicine.[18] Bioethicists have sometimes referred to health practitioners' *fiduciary* duty to patients. Veterinary and medical bodies recognize practitioners' special responsibilities toward animals 'committed to their care', i.e. their patients.[19] Doctors possess expertise to administer comprehensive health advice and treatment.[20] A practitioner may be all that stands between the

[18] Baillie et al. (2012, p. 112) write that 'in most encounters the primary purpose of medicine and the other health care professions is to treat *the particular patient*. Once having entered into a relationship with this specific and identifiable patient, the health care professional has an obligation to that patient' (original italics). A principle in the World Medical Association's Declaration of Geneva is that 'the health of my patient will be my first consideration'.

[19] Bioethicists recognize cases where the health professional-patient relationship arguably is absent in medical work, as in military and industry employer contexts (e.g. Baillie 2012, p. 124). Similarly, a veterinarian employed, say, in public health or food inspection, may not have professional-patient relationships with the animals she examines or performs tests on.

[20] Disagreement has occurred over whether *human nurses* can or should be patient advocates. Amongst other actions, this role would require nurses to sometimes challenge doctors' authority. Some commentators deny nurses are properly positioned for that moral role, partly because they must rely heavily on doctors' expertise (Newton 1981). Others argue that nurses' expertise, even if less comprehensive and authoritative than doctors' in many (though not all) areas of healthcare, nonetheless authorizes or demands such advocacy (Kuhse 1997). An interesting parallel question is whether *veterinary nurses* are/should be patient advocates. The germane point here, however, is that veterinarians have professional power over many, and major, patient health outcomes.

patient and disability, suffering, or death. The patient's great vulnerability stems not only from poor health, but also from lack of power. This relative powerlessness is especially acute for children, the disabled, and nonhuman animals (Nussbaum 2009). Such considerations help explain the strength and scope of fiduciary duties. Finally, recent work on relational ethics has stressed the importance of context, role, and relationships on our duties to animals (Palmer 2010; Donaldson and Kymlicka 2011).

Together, these two reasons arguably ground a requirement for strong patient advocacy. On this view, there is a veterinarian-patient fiduciary relationship that is similar to the doctor-patient fiduciary relationship.[21]

Animal Harm and Wellbeing

Our investigation of patient advocacy requires having some idea of animal wellbeing and its determinants. Wellbeing is conceptually linked to the notions of harms, benefits, and interests. While veterinarians aim most proximately at enhancing patients' physical and mental *health*, they usually do this because it ultimately improves patient wellbeing in a wider sense. Now, value theory standardly distinguishes three basic accounts of human and animal wellbeing: mental state, preference/desire, and objective list accounts (Degrazia 1995). These accounts propose basic features that are morally evaluative and thus ought be respected by moral agents. For example, moral agents should sometimes refrain from actively harming interests and should sometimes actively promote them.

An influential objective list account is Martha Nussbaum's *capabilities approach*. Morally evaluative determinants of animal wellbeing on this approach include life, bodily health, bodily integrity, varied sensory experience and activity, expression of emotions, pursuit of goals, relationships with conspecifics and/or other species, play, and control over environment (Nussbaum 2009, pp. 392–401). Animals can be harmed or benefited in these morally relevant ways. The capabilities approach is not universally accepted. However, for many practical purposes it is possible to roughly reconcile Nussbaum's list of interests with contending mental state and preference-based accounts of value.

Thus, many value theorists agree that animals have interests similar to many of those on Nussbaum's list. Some (though not, of course, all) animal welfare scientists and others, however, apparently deny that 'life' is an interest for nonhuman animals (e.g. Webster 1995). Since veterinarians have power over animal life and death, this denial is significant. The denial that animals can be harmed by death is often connected with a *quasi-technical* notion of animal 'welfare'. 'Welfare' is a term used within animal welfare science as well as beyond it. A claim found within that discipline is that 'welfare' refers only to actual experiences or

[21] 'Fiduciary' has connotations of the beneficiary's *confidence* in the professional carer. But can veterinary trustees (animals) have such trust? Two points: (a) Medical ethics and professionals sometimes use 'fiduciary' to describe special role-responsibilities irrespective of patient cognitive ability, e.g. 'incompetent' adults, young children. (b) It is not a foregone conclusion that animals can possess *no* forms of confidence or trust in health professionals.

states of an animal, not to potential ones. If so, an animal's 'welfare' logically cannot be worsened through death per se, e.g. via painless killing.[22] It then seems impossible to wrong animal patients by killing them instantly (Yeates 2010).

One possible reply to this position is to challenge its controversial use of the term 'animal welfare'. A simpler strategy, however, is to sidestep the quasi-technical use of the term 'welfare', speaking instead of the cognate terms harm, interests, benefits, and wellbeing, in their familiar morally evaluative senses.[23] Our ordinary ways of talking about companion animal death imply that losing a life and a future is, *ceteris paribus*, a serious harm to the animal.[24] In this way, we do not need the quasi-technical concept of 'welfare' for our ethical investigation of patient advocacy, including advocacy concerning animal life and death (which is *not* to say that animal welfare science is irrelevant to all judgments about health and wellbeing). If, then, *potential* as well as actual states and experiences constitute patient wellbeing, we can accept what already seems obvious to veterinary clients who love their companion animals—that death can seriously harm animal patients.[25] Further, this acceptance of the moral relevance of potential states allows us to make sense of other ethical judgments. For example, we might claim that a surgical procedure, while painful and debilitating at the time, is nonetheless good for an animal who will, as a result, regain valuable capabilities and satisfactions.

In sum, an adequate conception of strong patient advocacy holds that veterinarians have special duties towards animal patient health insofar as this affects, to recall Nussbaum's list, longevity, comfort, bodily integrity, capacity for varied sensory experience and activity, expression of emotion, relationships, ability to play and pursue goals, etc. Finally, we should note that much harmful treatment or non-treatment of animal patients is lawful (including causing painless death). Like human doctors, veterinarians' obligations exceed merely advocating for patients who may suffer unlawful harm.

Strong Patient Advocacy (SPA) and Weak Patient Advocacy (WPA)

Pediatricians (and other health professionals) are patient advocates in a strong sense. Their fiduciary duty implies doing professionally what they can—within the range of moral constraints and other duties discussed earlier—to promote wellbeing and prevent health-related harm to patients, even when parents or guardians disagree

[22] One might point out that animals may have interests constituted by *future-directed desires* which, as 'actual states', can be harmed by painless death. The present criticism, however, tends to ignore this possibility.

[23] I do not mean thereby to dismiss philosophical problems concerning death and harm. But I cannot discuss them here. See, e.g., Mcmahan (1988).

[24] Of course, we also say that death (e.g. by euthanasia) can be an overall good for the patient—as when there is prolonged, extreme suffering. But equally, many veterinary acts of 'euthanasia' harm patients, and not just the pure 'convenience' killings.

[25] Those who deny this can also be asked to explain why we are right to believe (assuming we are right) that death can intelligibly harm human babies/infants. Once again, we can also hold that death is sometimes an overall good for a suffering human, or an animal.

with their recommendations. What about veterinarians? The Declaration of the Royal College of Veterinary Surgeons (RCVS 2018) reads: '…ABOVE ALL my constant endeavor will be to ensure the health and welfare of animals committed to my care'. In this way the British Declaration is stronger than the Oath of the American Veterinary Medical Association (AVMA 2018b), which places duties regarding 'the protection of animal health and welfare' and 'the prevention and relief of animal suffering' on the same level as duties regarding 'the conservation of animal resources, the promotion of public health, and the advancement of medical knowledge'. The RCVS declaration, by contrast, appears to endorse strong patient advocacy.[26]

But what in practical terms does this mean? What kinds of responses and responsibilities does SPA entail? We need a better grasp of the nature of SPA and WPA. As mentioned earlier, the concepts of 'strong' and 'weak' advocacy encompass a range of possible and not always determinate behaviors. Ethically desirable behaviors may differ depending on circumstances and context. Still, some conceptual features may now be noted. 'Strong' advocacy could involve such behaviors as high levels of persistency, resourcefulness, creativity, persuasiveness, and sometimes forcefulness, directed at promoting patients' interests (Yeates and Main 2010). By contrast, 'weak' advocacy might involve less strenuous, persistent, resourceful, creative, or forceful recommendations given to clients on behalf of patients. A weak advocate may also conceive of their role as mainly (though not wholly) to facilitate client preferences, even if that sometimes harms patients.

Again, at the weaker end of the advocacy spectrum are actions like 'neutrally' offering several patient care options and allowing clients to choose from them[27]; clearing up medical misconceptions about these options; and exerting stronger influence only when criminal cruelty or legally dubious harm occurs or may occur. At the other end of the spectrum are stronger means of gaining clients' informed consent to prevent or reduce harm to patients. These include refusing to perform harmful procedures (e.g. unnecessary or futile surgeries, some acts of killing, etc.); diligently persisting with recommendations for necessary tests and therapies; summoning the persuasive influence of the veterinary team; invoking the changing public ethic towards animals; issuing commands or demands; and (at the limit) even threatening to terminate the client-veterinarian relationship. Rollin (2002, p. 1146) argues that sometimes a veterinarian is ethically obliged to exert her 'Aesculapian [medical role-based] authority as *forcefully as possible*' (italics added)—not just when criminal law is potentially breached, but also in other circumstances of patient harm, such as when there is a failure to alleviate discomfort, when there are requests for 'convenience euthanasia' or other wrongful killing, etc.

Unlike many WPAs, SPAs advocate for patients even when advocacy may interfere with clients' plans, wishes, and interests. Of course, clients ultimately have

[26] The RCVS Declaration also (rightly) recognizes veterinarians' duties to clients, public, and profession.

[27] I would stress here that health recommendations are never really, or entirely, morally 'neutral'. A 'neutral' (morally unranked) list of options is necessarily selected from a larger option set. Further, the mere presentation of morally unranked options conveys a moral message—namely, that all such options are equally morally acceptable, including the less beneficial ones. Strictly speaking, the idea of wholly morally neutral medical or veterinary advice is a fantasy.

a *legal* right to refuse much good veterinary advice. Coercing or intimidating guardians, as we said earlier, is both illegal and wrong. Further, vigorous advocacy is not always, or even typically, required—many clients will, where they are able to, readily pursue the best for animal companions. Another point I shall stress is that SPA is—and ought to be—consistent with something like a 'family-centered' approach to health. Clients typically care deeply for their animal companions. They may, as we said, see animals as family and depend emotionally on them (Podberscek 2005). Clients' wellbeing and their autonomous choice and input into medical decision-making should be respected and promoted by the SPA. Part of the idea of a 'family-centered' model is to achieve good outcomes for both clients and patients.

I also want to emphasize that much effective patient advocacy will *not* involve 'forcefully' challenging clients and their (initial or persistent) reluctance to promote patient wellbeing, but rather more subtle and gentle actions. I do not mean those actions may be sneaky or deceitful. On the contrary, advocacy might, for example, involve reminding clients of their genuine love for the patient, their shared history, and the animal's important role in the family. Or it might require expressing and encouraging, as some pediatric ethicists recommend (Rosenbaum et al. 2016, p. 100), a realistic and truthful sense of *hope* for improved patient wellbeing. What distinguishes SPAs from WPAs is the *preparedness* to engage in the full gamut of justifiable advocacy options required for preventing harm to patients. Strong patient advocacy involves a disposition and a moral stance orientated toward the goal of improved patient wellbeing and an embrace of the range of justifiable ethical means and resources veterinarians have at their disposal. In all these and other moral ways, veterinary SPAs resemble pediatricians.

Two Objections to Veterinary SPA and a Reply

We must now address a moral, and then a practical-conceptual, objection to SPA.

Some medical options conducive to patient wellbeing negatively affect client interests or desires. For example, many veterinary interventions are expensive. It may strike us as ethically dubious for veterinarians to strongly advocate such options when clients lack substantial financial resources, even though any subsequent harm to those clients is unintended. At the same time, we may feel it right for pediatricians to advocate similarly expensive options to financially disadvantaged parents for the sake of children. Parental responsibilities, we feel, surpass the responsibilities of animal owners. I do not want to deny this. However, we should now recall that the SPA idea—even for human health professionals—does include morally justified *exceptions* to pursuing patient wellbeing. These exceptions include interventions that are seriously harmful to non-patients, such as treatments that financially impoverish individuals or families. Thus, SPA already recognizes that veterinarians are not necessarily morally justified in continuing to advocate for patients when they know it will very seriously harm their clients. It is often the case, however, that veterinarians simply will not know the financial capabilities of their clients unless the clients tell them (as they may do). Until they

know that a client is incapable of paying for the advice or intervention, or that doing so would seriously harm them or their families, patient advocacy is not unreasonable.

Perhaps the objection from critics, however, is that veterinary SPA is unjustified even when harm to the patient significantly exceeds harm to the client, as when expensive life-saving veterinary procedures prevent clients having overseas holidays, etc. (Of course, strong advocacy could still be undertaken for other treatments or refusals.) Earlier, however, we noted two justifying reasons for veterinary SPA, namely that companion animals like dogs and cats have a significant intrinsic value, and that the veterinary role creates fiduciary obligations or duties of allegiance. Critics, then, need to explain why veterinarians should, by forgoing a fuller range of advocacy options, allow or cause serious harm to patients to protect less vital client interests. This reply, I should say, does not necessarily entail that animals and humans have equal intrinsic moral worth. Rather, it recognizes that veterinarians have strong role-based advocacy obligations that operate even when clients might consequently be (non-disastrously) financially worse-off. Remember also that while veterinarians may well advocate assiduously and creatively for patients, they are not typically entitled to lie to, seriously deceive, or coerce clients (except by invoking the law), even to protect their patients' vital interests.

The second line of criticism of SPA is practical-conceptual. Pediatricians and veterinarians work in very different settings. Powerful institutional frameworks (e.g. child protection laws and services), social mores (e.g. parent–child relations), and economic conditions (e.g. publicly funded medicine) create viable conditions for effective SPA in pediatric medicine. In contrast, veterinarians work under weaker legal frameworks (e.g. animals are legal property), less powerful social mores, ethical attitudes to animals that are in flux, and economic conditions that place considerable strain on clients. Compared to pediatricians, veterinarians lack effective power. Therefore, this criticism goes, it is *impractical* for veterinarians to be SPAs. Moreover, because the conditions are unfavorable for veterinarians, SPA also makes little *conceptual* sense. A veterinarian could not be a SPA even if she wanted to, it might be claimed, since meaningful and practical veterinary SPA would require social transformation.

Although containing some truth, this criticism exaggerates veterinarians' relative lack of influence and somewhat distorts the respective cultural contexts. First, pediatricians also experience powerlessness over patient wellbeing (Rosenbaum et al. 2016). Some indicated pediatric interventions are not publicly funded or covered by medical insurance and may be onerous on families. Parents may stubbornly resist sound medical recommendations for the child. Sometimes, frustrated pediatricians may even feel it necessary to terminate relationships with intransigent parents (Baillie et al. 2012, p. 223), perhaps partly in the hope that patients may benefit from subsequent parental reassessment and reflection. Once again, securing best or acceptable overall patient outcomes in both human health and veterinary settings may require a family-centered approach in which certain harmful choices by guardians are tolerated. Second, veterinarians too have considerable power deriving from a range of factors, including a changing public

ethic that more strongly respects companion animals, considerable professional status, and increasing public recognition of veterinary fiduciary responsibilities.

Despite this, it remains true that pediatricians enjoy *comparatively* more power over good patient health outcomes than do veterinarians. And this difference in authority is partly connected to the above moral point: that society holds parental responsibilities to surpass client responsibilities to animal companions. For example, we might well expect parents to risk serious financial hardship and social dislocation to help their very ill children. The difference is also connected with the greater reach and power of the law for children compared to animals (which, as mentioned, the law designates as property). Perhaps, then, we may say that pediatricians and veterinary SPAs are not precisely alike. And yet, for all that, the veterinary strong patient advocate, unlike the weak patient advocate, has a fundamental role that ethically resembles that of the pediatrician.[28] The following figure schematizes this position:

Conclusion

This essay has given reasons for concluding that veterinarians can and should be strong rather than weak advocates for their patients. By adding detail to the notion of strong patient advocacy, I have sought to provide a more substantial understanding of what it is for veterinarians to have a 'primary obligation' and loyalty to their patients as opposed to other parties, including clients. As it does for other health care professionals such as pediatricians, this understanding of the professional-patient relation helps to define the fundamental or essential role of veterinarians. Plato, we observed, held that the physician who is true to her role is first and foremost concerned with her patient, and is deeply morally orientated towards that patient's health and interests. The 'genuine and real' role of veterinarians, to use Plato's terms, has at its core a fiduciary obligation and commitment to patient wellbeing. Platonically speaking, this kind of strong patient advocacy underpins the nobility, or the dignity, of the veterinary profession.

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[28] We might here also connect the two senses of advocacy distinguished earlier. If veterinarians are truly strong advocates for their patients, there may be consequent requirements upon veterinarians to advocate in other ways as well, e.g. for stronger companion animal welfare laws, abolition of puppy farms, etc.

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