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EDITORIAL

Recognising the boundary between heroism and futility in veterinary intensive care

Increasingly, there is concern that veterinarians are 'going too far', performing 'heroic' procedures or 'overtreating' animals: in both treatment of potentially curable disease (Jarvis 2010; Corr 2013; Yeates et al. 2013; Clark 2015; Yeates 2016) and palliation of incurable disease (Noakes 2016; Flecknell et al. 2016). The former uncertainty, often articulated as the question 'we can, but should we?', should be of major concern to veterinary anaesthetists because many are likely to be involved in 'heroic' surgical procedures. Indeed, it may be argued that the ability 'to go too far' is only made possible by the involvement—willing or otherwise—of skilled veterinary anaesthetists. The potential for veterinary anaesthetists to facilitate overtreatment probably exists in veterinary intensive care (VIC) as well: it was at the 7th World Congress of Veterinary Anesthesiology (Berne, 2000) that the inauguration of the European College of Veterinary Emergency and Critical Care (ECVECC) was proposed. At that meeting, I asked what ethical guidelines would be put in place by the new college, to protect animals destined to receive intensive 'care', given that many human intensive care problems were ethical rather than medical. The question was not answered, and since then, the ethics of VIC does not seem to have received much attention. Of seven textbooks published over the past 24 years and devoted to veterinary critical care (Murtaugh & Kaplan 1992; Mathews 1998; Wingfield & Raffe 2002; King & Boag 2011; Burkitt Creedon & Davis 2012; Macintire et al. 2012; Silverstein & Hopper 2015), only two (Murtaugh & Kaplan 1992; Wingfield & Raffe 2002) list the term 'ethics' in their indices. None refer to 'quality of life' (QOL). Oddly, it is the two older texts that raise concerns with unnecessary suffering caused by overtreatment, although both subjugate these concerns by focusing more on the ethics of client–veterinarian relationships. Indeed, Rollin (2002) opines that the most problematic/conceptual dimension one confronts in (veterinary) critical care medicine is whether veterinarians owe primary moral obligation to the animal and its interests, or to the client. Nevertheless, these older citations contrast favourably with a recent textbook (Silverstein & Hopper 2015) that features sections devoted to neuromuscular blockade, animal management after cardiopulmonary bypass, and even complementary and alternative therapies. While it includes a section on client communication and grief counselling, it fails to index ethics and QOL. In 2002, Rollin proposed that '…the specialty of critical care veterinarians should adopt as a principle of professional ethics, that they are committed to not prolonging the life of an animal when suffering is uncontrollable, or when the prognosis is permanent suffering, pain, distress or disability. The details of such a professional ethical position should of course be worked out by the professionals involved'.

A recent (November 2016) examination of the American College of Veterinary Emergency and Critical Care (http://acvecc.org/blog/about-us-who-we-are/ for nondiplomate access) and ECVECC (http://www.ecvecc.org/ for diplomate access only) websites reveals that these details have yet to be worked out.

Therefore, Peter Fordyce's (2016) article appearing in this issue of *Veterinary Anaesthesia and Analgesia,* entitled 'Welfare, law and ethics in the veterinary intensive care unit', is overdue.

The article begins with, but does not dwell on, the veterinary 'trilemma' (FAWC 2012)—the relationship between the animal, its owner and the veterinarian (or business)—which complicates the ethical solution of many veterinary challenges. Fordyce then explains that an animal's welfare (at the hands of a veterinarian) is protected by statutory legislation and is not automatically subordinated to owners' property rights. However, while the animal's welfare remains protected under law in the veterinary intensive care unit (VICU), its optimisation becomes less probable as opinions among veterinarians as to what constitutes 'heroic' and 'unfair' treatment begin to differ. In these circumstances, McKeegan's advice is that actions should be based on 'what the animal wants' (Jarvis 2010), which, as Fordyce (2016) proposes, may best be identified by veterinary anaesthetists acting as 'animal advocates'. This recommendation is based on the fact that veterinary anaesthetists are often involved in VICUs, have specialist skills in

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clinical assessment and prognosis, and are motivated to recognise and treat pain. However, he emphasises that the advocacy is valuable only if based on both sound ethical principles and evidence found within animal welfare science. It is not valuable when based on whim. He also emphasises that recognising suffering, rather than 'just' pain, is necessary in determining when 'heroic' treatment becomes 'unfair', and consequently commends Morton et al.'s (1990) 'critical anthropomorphism' and Mellor & Beausoleil's (2015) 'five domains' model to facilitate identifying where this boundary lies. He then proposes that until: 1) adequate data regarding the nature and extent of animal suffering in VICUs are available; and 2) welfare assessment methods are validated, we must accept that 'it is morally incumbent upon us to give the animal the benefit of the doubt and to protect it as far as is possible from conditions that may be reasonably supposed to cause it suffering, though this cannot be proved' (Brambell 1965). Fordyce then encourages veterinary anaesthetists to establish the evidence base needed to justify 'best practice' in VICUs by doing research, arguing that the authority arising from peer-reviewed contributions to welfare science would strengthen the right to advocacy. The questions, 'when is suffering unnecessary?' and 'when does treatment become futile?', are then raised and partially answered by examining the relevant provisions of the Animal Welfare Act (2006) and highlighting the inadequate development of veterinary, compared with human intensive care ethics, respectively. In proposing a 'way forward', Fordyce then proposes that components of Directive 63/2010/EU (European Union 2010) may provide a basis upon which decisions related to futile treatment may be made. He further suggests that incorporating Mellor & Beausoleil's (2015) five domains into Wolfensohn et al's (2015) extended welfare assessment grid—a graphical representation of an animal's accumulated suffering—may reveal the welfare trajectory of animals in VICUs and provide another objective basis for deciding when treatment should end.

I found the article to be challenging, stimulating, provocative, evocative and incomplete. To the best of my knowledge, it is the first commentary on VIC ethics that prioritises concerns with animal suffering over the veterinarian–client relationship and other niceties. Having recognised that veterinary anaesthetists have many of the attributes necessary to solve VICU problems, Fordyce challenges us to gain the credentials to become animal advocates, with the authority to show other clinicians where heroic treatment becomes futile. It would be regrettable if this opportunity were ignored because of its potential to raise the specialities' profile. (After all, it only follows the same route being taken by medical anaesthetists whose supervision of patient care is extending throughout the whole perioperative period, rather than just during surgery.) Importantly, the task is not insurmountable: animal pain scoring systems have been established by veterinary anaesthetists, so creating 'welfare' or 'suffering' measures based on Fordyce's recommendations should not prove difficult, particularly if there is collaboration—as he suggests—with animal welfare scientists. Laboratory animal veterinarians may also prove useful collaborators; their practice is heavily governed by legal, ethical and animal welfare considerations. Furthermore, they are frequently required to recognise and quantify pain and suffering with respect to established humane end points, and make potentially controversial decisions based on their convictions. Some grounding in bioethics or consultation with bioethicists would also be advantageous. However, an effective advocate cannot ignore the potential usefulness of dedicated, experienced and compassionate veterinary intensivists whose skills in prognostication and assessment of other affective experiences, such as nausea and exhaustion, may be lacking in veterinary anaesthetists. Neither can they ignore—for these or other reasons—the views of experienced cardiologists and oncologists, because such specialists—not anaesthetists—are in the best position to identify 'futile' thresholds, which shift as new therapies are applied and evaluated. While this indicates the need for a multidisciplinary or team approach, such a group, acting as a clinical ethical review committee (CERC), may nevertheless be led by a veterinary anaesthetist with advocacy skills and the authority to make the final decision. Things appear to be moving along these lines, but not in this direction: at last year's BSAVA Congress, the question, 'we can—but should we?', was debated by a panel consisting of an oncologist, an orthopaedic surgeon, a veterinary nurse, a representative of an insurance company and the Chairman of the RCVS Standards Committee. The nursing representative asserted that 'new techniques would be needed for nursing animals that had novel procedures', indicating some disinclination to stop going too far. Further, the representative emphasised 'the importance of a team discussion—between the vet, veterinary nurse and owner' (Clark 2015), implying that the skills to

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