Handling difficult euthanasia discussions

Disagreements about euthanasia are not widely discussed within the profession, writes Caroline Hewson MVB PhD MRCVS (The Pet Loss Vet), CJ Hewson Limited, Somerset, UK. This article reviews psychosocial aspects of those cases where clients are reluctant to agree to euthanasia. It also outlines some ethical and practical points that may help vets prevent or allay disagreements

Veterinarians take their responsibilities to clients and patients at animals' end-of-life (EOL) very seriously. However, most of us were not taught how to proceed when we recommend euthanasia on humane grounds, and a client is reluctant to consent. This article attempts to bridge that gap, by reviewing reasons for disagreement and offering some practical signposts.

THE CURRENT SITUATION

When clients are reluctant to agree to euthanasia, the conversations are made more demanding because:

- The veterinary curriculum has not traditionally provided integrated training in the ethical, psychosocial and communication aspects of euthanasia or EOL decision-making;
- Continuing veterinary education offerings do not routinely review the topics, even though available data suggest that, in the UK, 50% of vets may encounter euthanasia dilemmas and potential related client disagreements twice a week or more;[1]
- Unlike human hospitals, veterinary practices do not have a clinical ethics committee that could rapidly review a case, and help the vet and client agree on the best way forward for the animal. Neither can the parties appeal to the courts for a definitive ruling on the animal's best interests;
- Professional guidelines are necessarily general; and
- Practices lack their own more detailed policy.

Faced with these constraints, vets must rely on some combination of:

- Their experience, values and comfort zone;
- The similarly untrained approaches that were modelled or recommended to them when seeing practice;
- Case discussions (eg. in publications); and
- Professional guidelines.

This normative approach poses a risk of harm to some or all parties.

For the animal, it can mean avoidable suffering and a wrongly delayed or otherwise distressing death. Conversely, it may mean euthanasia being premature – a harm inasmuch as animals may be said to have some interest in being helped to flourish and enjoy their days in our care.

For the client, their animal's euthanasia may also seem premature. This perception may be correct, for we do not see the animals' daily lives at home during their EOL phase. Typically, we may only see them for crises, at our clinics, and our focus is often biased towards clinical facts. Also, some clients' personal and situational circumstances may make then too burdened by grief at the impending loss to agree to euthanasia when we first recommend it.[2]

For such reasons, some clients leave without making a decision. They take their animals home and wait until they judge them to be suffering. Many then experience the isolation of the unsupported caregiver. They feel reluctant to consult a vet again for fear of further pressure to euthanase and for want of the option of at-home palliative care and support first. Lacking the knowledge, tools and detachment to assess their animal's welfare fully, these clients unwittingly neglect their pets. This subsequently causes them great remorse.

For the vet, unresolved conflicts about euthanasia can cause worry that the animal is suffering, and feelings of frustration, powerlessness and self-reproach. In a survey of 58 UK vets, 50% rated 'the client wishing to continue treatment despite compromised animal welfare/quality of life' as maximally stressful (the median rating was 9 on a 10-point scale).[1] This was not related to their level of experience.[1] Such stress contributes to low job satisfaction, professional burnout and mental health problems,[3,4] with related sick leave and high staff turnover. The latter are a direct cost to the practice and may indirectly lose turnover due to client attrition.

LESSONS FROM HUMAN MEDICINE

When clients disagree that euthanasia is in their animals' best interests, it is natural to assume they either cannot see what is in their animals' best interests or are in wilful denial. These assumptions are often mistaken however, because:

- Those clients' primary consideration is normally their animals' best interests;
- It is natural to be reluctant to want your animal companion to die. This follows from the well-documented phenomenon of attachment to members of one's social group. It is adaptive to form strong

social bonds with those who provide a sense of comfort, security and reliability, and such attachment to animals is automatic, and well described;[5-7]
- Making decisions about animals' EOL therefore involves more than a detached weighing of facts – it typically has strong emotional resonances; and
- Denial is not usually a choice, but an automatic psychological response to any situation that might otherwise be overwhelming.[8] This is highly adaptive, but can also make the situation (eg. imminent death of their pet by euthanasia) seem unreal and thus to be resisted.

These considerations illustrate the importance of understanding clients better, and maintaining relationships with them. Parallels can be found in paediatric medicine. When doctors recommend that treatment be withdrawn from a terminally-ill child, there is growing emphasis on not 'abandoning' parents when asking them to give final permission.[9-12] Among the points recognised are:
- To agree to the death of your child is not something that can be undertaken lightly or quickly;
- Collaborative communication enables the load of the decision to be shared; and
- Parents need, most of all, to know they have been good parents right to the end (eg. 'still able to be her mum'), and are making the right decision for their child.

This comparison with paediatric medicine does not imply companion animals are primarily child substitutes or should be treated like children. The parallel arises purely from the attachment phenomenon, noted above. Companion animals' mentational limits enable their apparent lack of judgment of us, and their acceptance of us, much like those of young children. The impact of deciding about animals' EOL is, therefore, not unlike the case with children.

A further reason why clients may resist imminent or in-clinic euthanasia is due to the common desire for our own deaths, ie. to die peacefully at home, not in a hospital. In the UK Department of Health's national survey of the recently bereaved, 49% were either certain or concerned that the patient had not had enough choice about where they would die, and 18% similarly thought the patient did not die in the right place.[13] These concerns were lowest where patients had died at home or in hospice. Many respondents had also felt unable to discuss their fears and worries for the patient with their GP. Of those who had matters to discuss, 17% wanted more discussion, 8% tried to discuss but were unable to, and 19% didn't try.[13]

Because veterinary CPD does not routinely cover EOL matters, many practices are unaware of these emerging contexts and therefore cannot not show clients appropriately nuanced understanding. Most practices do not offer closely tailored palliative care for elderly or terminally ill animals, or at-home support to clients giving palliative care. Few offer pre-euthanasia consultations, through which clients might review the euthanasia decision, explore their particular fears, or plan for the event. Instead, clients are often expected to decide upon euthanasia within a 10-to-15-minute consultation, and not speak to the vet again until the euthanasia appointment. Others will have memories of that, and present to us feeling resistance to any discussion of PTS (put to sleep). In light of all the above, it is unsurprising that some clients resist our PTS recommendation and, anecdotally, feel abandoned by their veterinary practices for wanting a different approach to their animals' last days. It may also partly explain why, in an online survey of 500 self-selected respondents whose animals had been euthanased, around 28% of the two-thirds who got another animal 'couldn't face going back' to their former practice (Alison Lambert Onswitch, pers comm January 4, 2015).

ETHICAL ASPECTS OF DISAGREEMENTS

Veterinary medicine has traditionally followed a paternalistic model, whereby the compliant client takes the advice of the omniscient professional who knows best for the animal, and the client ('I know my clients'). Professional guidelines indicate that we must respect clients' autonomy, however, and not presume to know what is in their best interests.[14] Moreover, because clients know their animals in ways we do not, their assessment of present and future quality of life is essential information for our assessment of patients' best interests.

We are also told we must recognise clients' freedom of choice, and thus avoid influencing their choices of action.[14] Yet, most clients do not come to us for a neutral list of clinical facts and options. As with human medicine, most appear to come with 'the expectation of a beneficent recommendation based on the facts and the doctor's experience'.[11,15] It therefore seems some influence is advisable – by way of recommendation – and humane, for it is surely unfair to expect an owner to take full responsibility for the death of their pets, while we withhold our professional view of the animals' best interests.[10]

However, a different challenge arises when a client 'chooses an unacceptable option'.[14] 'Acceptability' does not necessarily equate to what the clinician thinks is in their patient's best interests.[12,14] Thus, in paediatric medicine the court is the ultimate judge of what is best for a child, based on wider family circumstances and legal precedents, not just the clinical facts or medical opinion.[12] In veterinary medicine, acceptability also rests on precedent, being 'relative to the decisions other owners have made in similar circumstances'[14] – a perhaps subjective and undocumented standard that is largely reliant on the vet's memory. Nevertheless, though we may disagree with a client's decision about their animal's EOL, it cannot be gainsaid if animal welfare is not adversely affected.[14]

If welfare is at issue, 'influence may be justified to help the client make an acceptable decision, but not beyond this point.'[14] For example: for a client to insist on natural

death for an animal in organ failure is relatively extreme and absolutely harmful to welfare. We may then exercise some influence to have the owner consent to euthanasia. Yeates and Main[14] list 22 likely forms of influence. Some examples are proposed cautiously below, as legitimate possibilities where clients are making 'unacceptable' choices. The examples would be unethical as a routine way of obtaining client consent for euthanasia.

- Value-loaded terms ('The fluid in his lungs is killing him. He is suffering');
- Societal influence ('Normally, when my clients realise this, they don't want it for their pet and they feel able to consider euthanasia');
- 'Guilt-tripping' ('It would be cruel to let her die naturally');
- Coercion ('If you don't consent, I'll have no choice except to report you to…').

Influence is better exerted with genuine empathy: understanding what a client is experiencing (eg. fear, etc. at the impending death of their pet), and reflecting that understanding back to the client.[16] Examples are given in the next section.

POINTS FOR WHEN CLIENTS ARE RELUCTANT TO CONSENT TO EUTHANASIA

Each end-of-life dispute is different. In human medicine, the Royal College of Paediatrics and Child Health has published a framework to help doctors and parents make 'decisions to limit treatment in life-limiting and life-threatening conditions in children'.[12] To help vets avoid or navigate through euthanasia disputes, it would help if each practice had its own practical policy, eg. routinely offering a separate longer pre-euthanasia consultation, having a dedicated quiet room, and empathic guidelines for cases in dispute. Details of such a policy are outlined elsewhere (Hewson, in press).

Even without a policy, the following points may be helpful:

1. The client's assessment of their animal's quality of life and best interests is an essential part of our assessment of the animal's best interests.
2. Clients have a legitimate interest in knowing they have made the right decision about euthanasia: they have to live with it in ways we do not.
3. Under virtue ethics, a 'virtuous' vet has compassion for the client as well as the patient. S/he seeks to understand why the client disagrees with their EOL advice or wants 'futile' treatments. Such understanding builds trust, helps to clarify perspectives on the patient's best interests and facilitates agreement on how to achieve those.[9,16] When animals are very elderly or ill, a client's factual question may often be underlain by an unspoken fear, negative memory, or other emotional resonances. For example, the factual answer to 'How long has Muffin got to live?' may be: 'Based on her blood results and my experience of other cats in her situation, about six weeks.' However, the client's real concern may be whether there is sufficient time for a child who grew up with Muffin to return from travel abroad to say goodbye. 'I don't want her to have any needles' may relate to a traumatic memory of the death of a parent in hospital. Empathic communication skills help in these situations. Thus, instead of giving a factual answer or arguing factually ('I'm afraid we will need to inject Muffin. There's no easy way around that'), take time to find out what the underlying concern is. The rationale here is that by encouraging clients to talk freely, we can better understand them, and together negotiate the best way forward for the animal and help the client in their legitimate desire for peace of mind. Gray and Moffett[17] provide an introduction to such communication at EOL. Tone of voice and body language are critical. Examples of wording (not as scripts, but to work with) are:

- Empathic exploration (especially if client's body language or voice indicate possible disagreement, eg. folded arms, gaze aversion, hesitant or very quiet verbal responses): 'I realise we're talking about very difficult things here, and I'm so sorry we're having to do that. What's most on your mind just now?';
- Reflection and exploration: 'You don't want Treacle to

have any needles. Tell me more about that';
- Influence in an unacceptable decision: 'Thank you for telling me what happened with your mum, Mr Hawkins. It really helps me to understand your concerns for Treacle. I'd really like her to die peacefully in her sleep at home too. [Pause] But I'm very concerned that it won't be like that because of the fluid in her lungs. Even with her medication, it is building up and I'm concerned that soon she'll start to feel as if she's drowning. [Pause] I wish we weren't having to have this conversation, but I don't think it would be fair to Treacle to let her die like that. What do you think?'

4. Use some formal assessment of quality-of-life and pain: these help vets and clients monitor change and identify the right time for ending the animal's life. They also help the client with decision-making. There is not yet a valid, reliable tool for assessing the quality of life of terminally ill animals, or a pain assessment tool for cats.[18] Nevertheless, recording specific aspects of animals' behaviour helps clients and vets in their assessments of deterioration. As part of the care plan, the owner can work with the vet or nurse to draw up a list of simple positive experiences that matter to the animal. The owner can then keep a daily diary recording the number of times the animal could enjoy positive experiences, and notable negative experiences. They might also use two shades of marble to compute the respective numbers of 'good' and 'bad' days.
5. Pre-euthanasia consultation. As noted, a standard consultation does not allow many clients sufficient time to talk through points of disagreement. Even when there is no dispute, discussion of euthanasia is usually emotional, making logistical decisions (eg. place of euthanasia, body after-care) difficult. In the UK, an unpublished survey of around 1,600 pet owners found 84% said they would accept the offer of a pre-euthanasia consultation, separate from the one where bad news was first broken, and be willing to pay for it (Douglas Muir, Pet Cremation Services, pers comm April 2, 2014). Moreover, the UK national survey of the human bereaved[13] suggests it's important that vets encourage clients to share – repeatedly, if necessary – their concerns and desires for their animal's euthanasia, including the need, interim palliative support, and personal support.
6. Test out the client's preferred alternative (if not inhumane) instead of pressing only for euthanasia. Thus, the vet would acknowledge the benefits of the alternative for the animal, not just the risks. For example: it is disruptive for animals to have to be brought to the clinic when they are weak and unwell, and hospitalisation can be very stressful for them too. The client's desire for at-home care would enable adequate supervision of welfare while the client and vet made doubly sure of when euthanasia was appropriate. This might mean intensive at-home care with, for example, twice-daily visits from a veterinary nurse to administer subcutaneous fluids or oral medications, and assess clinical signs, all according to a care-plan agreed with the owner, in a collaborative consultation that included the nurse concerned. A critical point here is the importance of mutually agreed, clear end-points. That is: it seems exploitative to support a chronically extended EOL in which the animal is palliated but has a life with few or no opportunities for those positive experiences that mattered to them ('a life worth living'), before their imminent death – all so that the client is given extended time to become ready to say goodbye. Such an approach would breach the unspoken contract of mutuality that we have with companion (and other) domestic animals.[19] This does not mean abandoning a client who wants such time, but having an empathic conversation and advising them of sources of further support so they may not delay euthanasia so long.
7. Hospice care: the above might lead a practice to develop hospice care, which is an emerging field in veterinary medicine.[20] When rooted in a strong ethical framework and a detailed care plan, hospice care can provide a satisfying and sustainable service opportunity, while meeting a legitimate need among some clients and their animals.[21] Hospice care might be provided by the clinic or by:
- Referral to an appropriately qualified mobile veterinarian offering such services (this collaborative approach is growing in the US and the UK);
- Having a dedicated 'community veterinary nurse' within the practice, or through an independent, mobile, veterinary nursing service.

Clearly, when a client is in apparent financial difficulty payment of hospice care must be planned for too. There is no ethical obligation to provide a free palliative service, or credit terms.[22] Many interested clients will be happy to pay for palliative service. Others will not. This is no different from client orientations in traditional practice, and the terms and negotiations of service would be the same. In both cases, important points from client research in Canada include: focusing on the benefit of the service to the animal's and client's interests, not on its features,[23] and soliciting client concerns early in the consultation.[24]

CONCLUSION

This article has summarised the context of difficult euthanasia consultations and suggested approaches to avoid or allay disagreements. The biggest is simply to allow all clients more time. Normally, this is possible while avoiding harm to the animal. It is best achieved by an extended consultation that is separate from the one where bad news is broken. At-home hospice care and support is also likely to be helpful in some cases, because some clients may need repeated discussion, or want a less immediate curtailing of their animals' last days. (To be ethical, ie. not presume to know client's best interests or what they would choose for

their animals, practices considering an at-home service, should offer this option to all clients, not just some.) Practices with a comprehensive EOL policy, that includes such features, can better support their vets and clients, for the benefit of the animals, their owners, personnel and the practice bottom line.

REFERENCES AVAILABLE ON REQUEST

Reader Questions and Answers

1: WHY, IN GENERAL, ARE SOME CLIENTS RELUCTANT TO AGREE TO AN INITIAL RECOMMENDATION OF EUTHANASIA?

A: You raised the matter too late in the consultation
B: You weren't taught about client communication during your vet training
C: These clients are in denial because their pets are substitute children
D: In line with our increasingly individualistic culture, these clients are selfish and care more about their own impending grief than they do about their animals' welfare
E: It's impossible to say without exploring the reasons with them

2: A CLIENT COMES TO YOUR PRACTICE FOR A SECOND OPINION ABOUT HER THREE-YEAR-OLD GERMAN SHEPHERD, WHICH THE PREVIOUS VET AND A REFERRAL CENTRE HAVE BOTH CONFIRMED IS IN IRREDEEMABLE AND PROGRESSIVE PRIMARY RENAL FAILURE OF UNCLEAR ORIGIN. THE DOG'S PHOSPHORUS, UREA AND CREATININE LEVELS HAVE NOW BEEN EXCESSIVE FOR MOST OF THE PAST 14 DAYS, BUT THE NOTES FROM THE CLINICS INDICATE THE OWNER SAYS THE DOG IS STILL POLYDIPSIC AND POLYURIC, EATS TINY AMOUNTS OF HER FAVOURITE FOOD AND DOESN'T VOMIT EVERY DAY. BOTH NOTE THEY HAVE TOLD HER EUTHANASIA IS THE ONLY HUMANE OPTION, AND SHE BECAME ANGRY WITH EACH AND 'SEEMS TO BE IN MAJOR DENIAL'. IDEALLY, WHAT IS THE FIRST THING YOU DO?

A: Have the nurses take blood, so you can see where the renal parameters are today and use those figures to help the owner to see sense
B: Tell the client you've read the other vets' opinions and regret to tell her that if she doesn't consent to euthanasia taking place within the next 24 hours, you will report her to the ISPCA
C: Notify the ISPCA, because the client is permitting her dog to suffer
D: Tell the client you've read the other vets' opinions and that in your experience clients regret leaving euthanasia too late, and you think she is in danger of doing that too
E: Have an initial chat and examine the dog. Then offer a one-hour consultation later that day (or extending out of the present one) so you can build trust and learn more about her context, in order to reach consensus about the dog's best interests (which will be euthanasia)

3: ONCE YOU HAVE RAISED THE OPINION THAT AN ANIMAL IS IN THEIR END-OF-LIFE PHASE, HOW OFTEN SHOULD YOU ASK A CLIENT ABOUT THEIR PERSPECTIVE, CONCERNS ETC?

A: Never: The vet's job is to comment on the animal's best interests, since animals cannot speak for themselves. The client is perfectly capable of looking after their own best interests, which are not the vet's concern
B: Never: The client is the owner under the law and you might influence their decision, which is unethical
C: Once, but early on – as soon as you have broken the bad news. Not more than that, because you wouldn't want to seem nosey or embarrass the client if they start to cry
D: Several times (or as often as the owner indicates they wish). This is a feature of an empathic, collaborative conversation in which you give your view of the prognosis and the animal's best interests, and let your client know you support them as they seek to decide about their animal's best interests
E: Once, at the end – after you've told your client everything about what euthanasia involves, aftercare options for the body, and grief support

4: VETERINARY HOSPICE MEDICINE IS:

A: A sentimental Americanism
B: An emerging specialisation that gives the proper due to the owner's role as final decision-maker
C: A logical development by which practices can help ensure terminally ill or elderly animals are not denied quality of life in their last days, and can have a timely and peaceful death, while helping their owners achieve their legitimate peace of mind about this
D: Don't make me laugh!

ANSWERS

1: E – WHILE THE NUANCES OF YOUR COMMUNICATION AND OF HUMAN-ANIMAL RELATIONS CAN DEFINITELY AFFECT THESE THINGS, THERE IS OFTEN MUCH MORE TO IT THAN THAT. SO FIND OUT MORE

2: E – HOWEVER, IF YOU KNOW YOU ARE EXPERIENCING BURNOUT OR COMPASSION FATIGUE, YOU SHOULD NOT TAKE ON THIS CASE. INSTEAD, TAKE STEPS TO HEAL YOURSELF, EG. CONTACTING VETLIFE, DISCUSSING YOUR SITUATION WITH YOUR PARTNERS/MANAGEMENT AND ARRANGING TIME OFF, ETC.)

3: D

4: C