**The role of disciplinary cases in effecting changes to professional ethical guidance: a case study of informed consent and the veterinary profession**

**Article Summary**

Changes to professional ethical guidance are often achieved through a combination of findings from relevant judicial decisions and evidence from concerns and complaints about the profession. For the veterinary profession, input from the legal arena is minimal due to the paucity of veterinary negligence case law. Using informed consent as a case study, Royal College of Veterinary Surgeons (RCVS) disciplinary hearings from 2018-2020 were analysed to unpack aspects of consent that led to charges of professional misconduct. Case findings were evaluated to determine their effects on subsequent changes to professional ethical guidance, specifically changes to the RCVS’s ‘Supporting Guidance’ on consent. The Disciplinary Committee interpreted informed consent as a means of protecting the interests of the parties involved, with emphasis on protection of the client’s interests. Case reasoning that focused on protection of the animal patient’s ‘best interests’ could in turn influence professional ethical guidance in regarding these interests as pivotal.

**Introduction**

The veterinary profession in the United Kingdom (UK) is regulated by the Royal College of Veterinary Surgeons (RCVS) which, as a statutory regulator, is responsible for “*keeping the register of veterinary surgeons eligible to practise in the UK, setting standards for veterinary education and regulating the professional conduct of veterinary surgeons*.”[[1]](#footnote-1) As a result, the profession remains “*heavily self-regulated and largely untouched by judicial scrutiny.*”[[2]](#footnote-2) The latter can be ascribed to the to the animal’s legal status as property, which limits the damages awarded in claims of negligence to the market value of the animal concerned. The relatively low financial value of most animal patients leads to many animal owners being reluctant to pursue these claims in court.[[3]](#footnote-3) The sparse case law that exists on veterinary negligence, which usually involves expensive equine patients,[[4]](#footnote-4) appears to have had little influence on professional ethical guidance. As Schnobel highlights, this absence of direction from the courts leads to the maintenance of the status quo rather than the elicitation of aspirational changes to professional guidelines.[[5]](#footnote-5) In the search for alternative influences on these guidelines, RCVS disciplinary hearings involving veterinary professionals could be investigated as potential sources. This study’s aim was therefore to evaluate to what extent changes to the veterinary profession’s ethical guidance are informed by findings from disciplinary hearings.

First, it may prove useful to review the RCVS’s disciplinary processes to uncover how changes may be produced. In the UK, claims of veterinary negligence are often resolved at a lower level than the courts; for example, by involvement of the recently formed Veterinary Client Mediation Service (VCMS)[[6]](#footnote-6) or through settlement by professional indemnity insurers, often in the absence of court proceedings.[[7]](#footnote-7) Claims settled under either route do not automatically trigger investigation by the RCVS, therefore clients with serious complaints about standards of veterinary treatment must raise their concerns directly with the RCVS. The College *“can only deal with the most serious concerns that relate to a veterinary surgeon's professional conduct,”* such as *“(v)ery poor professional performance where there are serious departures from the standards set out in the RCVS Code of Professional Conduct.*”[[8]](#footnote-8)

Complaints about standards of veterinary practice are considered by the College’s Preliminary Investigation Committee (PIC) and Disciplinary Committee (DC) and progress through the stages outlined in Table 1.

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| **Stage** | **Process and Personnel** |
| Stage 1 | *examined by Case Manager (from RCVS Professional Conduct team) and two Case Examiners (one veterinary, one non-veterinary, both members of Preliminary Investigation Committee)* |
| Stage 2 | *Preliminary Investigation Committee (10 members, 6 veterinary and 4 non-veterinary)* |
| Stage 3 | *Disciplinary Committee (20 members – 10 veterinary and 10 non-veterinary; usually 5 members hear each case)* |

***Table 1: stages in the RCVS disciplinary process following submission of a complaint, adapted from RCVS.[[9]](#footnote-9) Most complaints are dealt with at Stages 1 and 2.***

The topic of consent was chosen as the ‘case study’ for this study for two main reasons; first, a reasonable number of cases involving a failure to obtain consent reach Stage 3. Stage 1 Case Examiners are advised that *“failure to obtain informed consent to treatment or to discuss treatment options and possible complications”*[[10]](#footnote-10)are grounds for referring a case to the Preliminary Investigation Committee. Most complaints are dealt with at Stages 1 and 2; for example, out of 539 concerns about veterinary surgeons raised in 2017-18,[[11]](#footnote-11) only 29 cases progressed to hearings by the Disciplinary Committee from 1st April 2018 to 1st June 2019.[[12]](#footnote-12) Nevertheless, a sufficient number of cases involving failure to obtain consent progressed to hearings by the Disciplinary Committee to allow interrogation of the substance and outcomes of these cases.

Second, and perhaps more importantly, the RCVS’s guidance on communication and consent underwent major review in March 2018, with further updates in October 2019 and June 2020.[[13]](#footnote-13) Furthermore, a direct link exists between the disciplinary processes of the College and the committee that reviews professional ethical guidance; specifically, membership of the liaison committee that serves to report findings from the PIC and DC includes the Chair of the Standards Committee, the latter being responsible for producing guidance on standards of professional conduct.[[14]](#footnote-14) Thus, any disciplinary cases that were proceeding through Stages 2 and 3 immediately prior to, or during, the review of the consent guidance were available for analysis to determine their potential to directly influence the revisions.

**Informed consent in veterinary medicine**

Informed consent is a professional requirement for veterinary treatment. As the RCVS stipulates in its Code of Professional Conduct (CoPC), which sets out professional responsibilities, registered veterinary surgeons must *"ensure informed consent is obtained before treatments or procedures are carried out."*[[15]](#footnote-15)The details of what that informed consent should entail are expanded in the Code’s Supporting Guidance, which provides further information and suggestions on the standards of professional practice.[[16]](#footnote-16) Whereas the language of the Code conveys that its contents are an overriding professional requirement, with all statements including the word “must,” the language used in the Supporting Guidance, for example, “should” or “have a responsibility to,” implies that its contents may not apply in certain situations. In summary, the Guidance offers ways of meeting the professional recommendations contained in the Code.

Consent in veterinary medicine has several similarities to its human medical counterpart. For example, to give informed consent, the patient/client must be provided with a range of options for treatment, including risks and benefits.[[17]](#footnote-17),[[18]](#footnote-18) Both professions need to ensure that the person giving consent has the capacity to weigh up the information and to make and convey a decision.[[19]](#footnote-19),[[20]](#footnote-20) However, there are important differences when the consent is given on behalf of an animal.

**The ‘best interests’ of the animal patient**

‘Third party’ consent, as given by the owner of a veterinary patient, differs markedly from the autonomy-based consent of an adult human patient.[[21]](#footnote-21) Unlike the latter, who can refuse even life-saving treatment,[[22]](#footnote-22) the animal owner’s ability to decline options for veterinary treatment is valid only until the animal’s welfare is compromised. Legal sanctions under the Animal Welfare Act 2006 then compel the owner either to seek treatment, to agree to euthanasia of the animal to prevent ‘unnecessary suffering’[[23]](#footnote-23) or to relinquish ownership.[[24]](#footnote-24) Frequently, the financial burden of treatment may dictate which of these options is chosen by the animal owner.[[25]](#footnote-25) Thus, in veterinary medicine, the wishes and interests (including financial) of the animal owner are sometimes in conflict with the ‘best interests’ of the animal patient, a dilemma that is reinforced in professional ethical guidance.[[26]](#footnote-26) The balance, however, appears heavily weighted in favour of the client, with consent in the veterinary context appearing to be constructed primarily to protect the client’s interests. Here, I use a definition of best interests that encompasses the maintenance of the human-animal relationship, where this has positive benefits for the animal, maintaining well-being and quality of life, and the avoidance of harm, including pain and suffering.[[27]](#footnote-27)

Sometimes veterinary treatment decisions are made to reflect other interests, such as the owner’s financial interests or the owner’s desire to have an animal that is capable of working or competing. Where the interests of animal and owner collide, it is the asymmetry between a decision that safeguards the ‘best interests’ of the animal patient and one made in the owner’s interests that is responsible for much of the ‘moral stress’ felt by veterinary surgeons.[[28]](#footnote-28) An additional aim of this study of disciplinary ‘consent’ cases therefore was to evaluate any reference to the interests of the owner and the animal patient contained in the decisions reached by the Disciplinary Committee.

**The construction of consent in veterinary medicine and human medicine**

Underpinning this study is the assertion that consent in human medical and veterinary medical settings is constructed differently. In human medicine, professional ethical advice on consent, together with the normative guidance that emanates from medicolegal judgments has gradually become more focused on the patient’s right to be informed, particularly about risks. Starting with *Bolam v Friern Hospital Committee*,[[29]](#footnote-29) then developing through *Sidaway v Board of Governors of the Bethlem Royal Hospital*,[[30]](#footnote-30) *Chester v Afshar[[31]](#footnote-31)* and most recently *Montgomery v Lanarkshire Health Board,*[[32]](#footnote-32) the narrative on consent has afforded increasing weight to patient autonomy. This is reflected in human medical professional guidance, leading to the latest General Medical Council publication “Decision Making and Consent” advising that when discussing risks, “… *you should tailor the discussion to each individual patient, guided by what matters to them*…”[[33]](#footnote-33) In human medicine, therefore, the guidance on consent has been steered towards the needs of the ‘individual patient’, closely following the similar direction taken by the law.[[34]](#footnote-34) In contrast, the narrative in veterinary medicine still relies on the test of ‘reasonableness.’ For example, the RCVS guidance on consent advises that “*Informed consent …(…)… can only be given by a client who has had the opportunity to consider* ***a range of reasonable treatment options***…..”[[35]](#footnote-35)

Furthermore, human medical guidance requires that those without capacity to consent for themselves have decisions made that will protect their ‘best interests’ or that will be of ‘overall benefit’ to them.[[36]](#footnote-36) Veterinary guidance on consent makes little reference to the ‘best interests’ of the animal patient, instead referring to the animal patient’s ‘welfare’ throughout.[[37]](#footnote-37) There are, however, two notable exceptions. First, when referring to wildlife patients, “*it is …. a matter for the veterinary surgeon to decide what treatment is in the animal’s best interest……*.”[[38]](#footnote-38) Second, advice concerning a client who lacks the mental capacity to give consent suggests that a legally appointed representative should be sought, but *“(i)f there is no such person, veterinary surgeons should act in the best interests of the animal.”[[39]](#footnote-39)* Accordingly, it appears that professional ethical guidance protects the ‘best interests’ of unowned animals or animals whose owners lack capacity, but not those of animals whose owners have capacity to consent, raising the question of whether this ethical stance is reflected in disciplinary hearings.

In summary, this study aimed to examine findings of the Disciplinary Committee in cases of failure to obtain consent, to relate these findings to concurrent changes to the ‘Communication and Consent’ section of the Code of Professional Conduct and to evaluate how the relative interests of the animal patient and the client were considered in each case.

**Methods**

Publicly available documents detailing RCVS disciplinary hearings[[40]](#footnote-40) were accessed and analysed, with relevant cases downloaded for further scrutiny. All cases between 31 January 2018 and 31 January 2020 that involved charges relating to informed consent were studied, with charges, decisions and sanctions analysed in detail. Relevant guidance underpinning the CoPC was matched to the charges in each case in order to clarify the components of consent involved. Cases were examined to evaluate the Committee’s interpretation of the interests of both the animal patient and the client. Finally, the findings in each case were matched to recent changes in the Guidance on informed consent.

The search of disciplinary hearings for the selected two-year period produced 6 cases (from a total of 20) that contained reference to a failure to obtain consent. Five cases involved consent to veterinary treatment, with one of these pertaining to consent to euthanasia; one case involved consent to post photographs and videos of veterinary patients and colleagues on social media platforms. As the latter case did not involve informed consent to veterinary treatment, it was excluded from the analysis. The charges and findings for the selected cases are detailed in Table 2. The following section examines each case in more detail.

**Case Analysis**

**Case 1,** whichinvolved a veterinary surgeon who performed a home visit to examine an elderly arthritic dog, turned on whether he had consent to perform euthanasia (there was no debate that the canine patient would have required euthanasia at some point in the near future). Despite being asked by the family member who was present to wait until the owners could be contacted, he proceeded with the euthanasia, relying on a defence that there had been a discussion about possible euthanasia during a previous consultation with the owners. His defence was undermined by a lack of any record of this discussion. The Disciplinary Committee relied on Section 2.4 of the main CoPC regarding the lack of consent, but also referred to the supporting guidance, specifically outlining the requirement to “*obtain the client's consent to treatment unless delay would adversely affect their animal's welfare.*”[[41]](#footnote-41) The Committee rejected the defence that the dog was suffering to the extent that required immediate euthanasia. In this case, the client’s interests in making an autonomous decision about the timing of the patient’s euthanasia seemed to be the main focus. No reference was made to the patient’s ‘best interests’ in being euthanised sooner to prevent any suffering, as his suffering was deemed not to be sufficient to require immediate euthanasia (thereby acknowledging that he was suffering to some extent). The sanction applied, a reprimand and advice, was considered appropriate as the case involved a single isolated incident of lack of consent with a perceived low risk of repetition.

**Case 2** involved a veterinary surgeon’s failure to obtain informed consent for the treatment of a canine surgical patient over a prolonged period of time. Following the removal of a tumour, the surgical wound failed to heal and required further surgery. Although consent had been obtained for the initial surgery, it was not sought for the subsequent multiple surgeries required in an attempt to repair the wound. The case rested on failure to provide estimated fees for repeat surgeries, failure to inform the clients of the repeat surgeries and the risks involved, and failure to suggest referral to another practice when the wound was failing to heal; finding all three proved led to the charge of failure to obtain informed consent. In deciding that this amounted to serious professional misconduct, the Committee “*was satisfied that the treatment administered required options, risks, prognoses and costs to have been discussed with* [dog]*’s owners before each further surgical procedure and general anaesthetic; particularly because* [the veterinary surgeon] *was aware of* [client 1] *and* [client 2]*’s concern about general anaesthesia.*”[[42]](#footnote-42)The reprimand given was accompanied by a warning as to the veterinary surgeon’s future conduct, specifically:

*“keeping full and accurate clinical records; offering referral on appropriate cases without undue delay; communicating fully and accurately with clients and colleagues; giving estimates of treatment whether or not any payment will be required (and) obtaining informed consent.”[[43]](#footnote-43)*

It is worth pointing out that the Committee’s reference to the veterinary surgeon’s awareness of these particular clients’ concerns regarding anaesthesia resonates with the ‘particular patient’ basis to consent that is now promoted in the human medical arena post-*Montgomery*. However, this is a rare example of a post-*Montgomery* response in the veterinary context. In this case, the patient survived after extensive surgery at a specialist hospital. However, the clients’ interests in making an informed decision about whether to persist with treatment and in being kept informed about fees etc. seemed to be prioritised, with no mention of the ‘best interests’ of the animal patient.

**Case 3** involved two veterinary surgeons who provided dental treatment to a canine patient; charges were dropped against one veterinary surgeon due to lack of evidence. The Committee relied on Section 11.1 of the Supporting Guidance to the CoPC, which refers to reasonable treatment options*.* In this case, the canine patient had underlying health problems, and died soon after surgery. The charge therefore required that the client should have been offered the alternative option of delaying the dental surgery. This was accepted by the Committee, which found that there had been inadequate discussion about delaying the surgery in view of the dog’s pre-existing health problems. In finding a second charge of failure to discuss risks proved, the Committee noted the failure of the consent form to make specific reference to the dental surgery itself, or to the associated particular risks of the procedure in the patient’s situation. These two charges led to the failure to obtain informed consent. In this case, the patient’s ‘best interests’ were not considered. It could be proposed that undergoing general anaesthesia was not in the patient’s interests, however, the dog may have been in considerable pain from dental disease. These aspects were not discussed. The case instead turned on the client’s interests in making an informed decision about the proposed surgery, particularly in being informed about risks and the alternative option of delaying surgery. However, the Committee found that while this breach of the CoPC amounted to professional misconduct, it did not amount to serious professional misconduct, therefore the veterinary surgeon was not guilty of disgraceful conduct in a professional respect.

**Case 4** involved two veterinary surgeons charged with failure to obtain informed consent from the owners of a cat which suffered complications following a routine neutering procedure. Although much of the case rested on the veterinary surgeons' failure to realise that there had been a subsequently fatal mistake made during surgery, there were important aspects of consent that contributed to the case. First, the owners had opted for pre-anaesthetic blood tests and intravenous fluids on consent forms signed before both surgeries, but these procedures were not carried out for either surgery (on the second occasion, blood tests would have indicated the presence of disastrous kidney injury). Next, the second surgery was identified as a "hernia repair" when the cat was in fact suffering from blocked ureters[[44]](#footnote-44) due to a serious mistake made during the initial neutering surgery. Finally, during the hearing, it came to light that the admission and consent process for the routine neutering surgery were performed by a receptionist. The veterinary surgeon who performed both procedures admitted not reading the consent forms before commencing surgery, and was found guilty of failing to obtain the owners' informed consent to the second surgery on the basis of failing to take a medical history and to assess the cat's condition before commencing the surgery. The second veterinary surgeon had supervised both surgeries and communicated with the owners on several occasions. He was found guilty of failing to obtain the owners' consent for overnight hospitalisation of the cat and failing to disclose that she would be left on intravenous fluids overnight with no supervision. The first veterinary surgeon received a reprimand, with evidence that he had been open and honest, shown insight into his behaviour and *" learned from his mistakes, matured in his practice and shown he is most unlikely to repeat his conduct."*[[45]](#footnote-45)The second veterinary surgeon, however, had made the subsequently fatal mistake of placing the cat on fluids overnight with no supervision; he was suspended from the Register for a period of four months. The debate over whose interests were prioritised in this case will be addressed in the discussion.

**Case 5** alsoinvolved overnight care, this time of a canine patient following surgery to correct a gastric dilation-volvulus.[[46]](#footnote-46) Both the practice owner, a veterinary surgeon, and the assistant veterinary surgeon who performed the surgery were charged. The practice owner was charged with failing to clarify the practice’s arrangements for overnight care in previous dealings with the client, and the assistant with failure to obtain informed consent to overnight care that was unsupervised. Although the charges against the practice owner were dismissed, the assistant admitted several charges, including failure to obtain informed consent from the owners. The Committee found that this failure fell below the conduct expected of a reasonably competent veterinary surgeon in general practice but did not amount to disgraceful professional conduct. However, the charge that she left the dog alone in the practice for seven hours without adequate monitoring or postoperative aftercare was proved and *did* amount to disgraceful conduct in a professional respect, for which she received a reprimand. The dog died during the period that he was left unsupervised, however the case did not make any reference to the patient’s ‘best interests.’

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| **Case no:** | **Charges relating to informed consent** | **Decisions and sanctions** |
| 1 | “euthanased [dog] without the owner’s consent” | Conduct amounted to disgraceful conduct in a professional respect  **Reprimanded** |
| 2 | “failure to obtain informed consent from [client 1] and [client 2] to a number of procedures performed on [patient]” | Conduct fell far below the standard to be expected and therefore amounted to serious professional misconduct  **Reprimanded and warned as to future conduct** |
| 3 | “(failure) to:  (i) discuss with [client 1] and/or [client 2], adequately or at all, alternative treatment options to dental surgery under general anaesthetic; (ii) discuss with [client 1] and/or [client 2], adequately or at all, the risks of dental surgery under general anaesthetic;  (iii) obtain informed consent from [client 1] and/or [client 2] to dental surgery under general anaesthetic” | The Committee decided the conduct of [vet] was in breach of the Code because he failed to inform [client 2] of all the treatment options and risks on 10 July 2017. It found his conduct fell below the standard to be expected but not far below the standard to be expected because some discussion had taken place albeit an inadequate discussion given [dog]’s changing clinical picture. **Not guilty of disgraceful conduct in a professional respect** |
| 4 | Vet 1:  a) Failed to read the anaesthesia consent form completed by [client]  b) Failed to undertake an adequate assessment of [pet]’s presenting condition  c) Performed surgery to [pet]’s abdomen, in particular to repair a hernia:  (i) Without taking the steps identified at (b);  (ii) When that surgery would not address the illness from which [pet] was suffering;  (iii) Without providing intravenous fluids to [pet]  In the circumstances described at each or all of (a) to (c) above failed to obtain the owners’ informed consent to the surgery  Vet 2:  (f) Admitted [pet] for surgery to her abdomen, in particular to repair a hernia, and supervised that surgery:  (i) Without taking the steps identified in (b);  (ii) When that surgery would not address the illness from which [pet] was suffering;  (g) For the purpose of the surgery described at (f) permitted [pet] to be anaesthetised:  (i) Without any or any adequate regard to the seriousness of her illness and the deterioration in her condition since 5 August 2016;  (ii) Without providing intravenous fluids to [pet];  (h) In the circumstances described at (f) and (g) above failed to obtain the owners’ informed consent to the surgery; | Vet 1:  Conduct fell far below the standard expected of a reasonably competent veterinary surgeon and amounted to disgraceful conduct in a professional respect  **Reprimanded**  Vet 2:  (T)he Committee was in no doubt that his entire course of conduct fell far short of that which is expected of a member of the profession, would be considered deplorable by fellow members of the profession and amounted to disgraceful conduct in a professional respect.  **Registration suspended for four months** |
| 5 | 1 (i) failed to obtain informed consent to the entirety of the surgical process and management, to include post-operative aftercare | Conduct did not amount to serious professional misconduct, but found guilty on another charge  **Reprimanded** |

***Table 2: details of charges, decisions and sanctions in RCVS Disciplinary Committee hearings involving informed consent January 2018 – January 2020.***

Summarising the outcomes of these cases, four veterinary surgeons were found guilty of serious professional misconduct as a result of failing to obtain informed consent, with sanctions consisting of a suspension (one case), reprimand (three cases) and a reprimand plus warning (one case). No cases resulted in the veterinary surgeon being "struck off," that is, having their name permanently removed from the Register. Four of the five patients in these cases died, three as a consequence of the veterinary surgeon’s conduct.

**Effects on professional guidance**

Turning to the influence of these cases on professional ethical guidance, it does appear that their findings have led to revisions to the supporting guidance on communication and consent, primarily during the major review in March 2018 (although there were additional updates in October 2019 and June 2020). As specific examples, the advice that informed consent involves "*Informing the client (where appropriate) that other treatment is available that may have greater potential benefit than those available at the practice,*"[[47]](#footnote-47) reflects the failures to offer treatment at specialist or referral practices that were considered in cases 2 and 4.

Next, the failure to discuss and advise clients regarding blood tests or intra-operative fluid therapy was highlighted in Case 2, where the veterinarians involved neither read the consent forms, nor discussed the additional procedures with the clients. The requirement for proper discussion and advice regarding these additional procedures is incorporated in the revised guidance, which now states:

"*If additional procedures or tests are offered on the consent form (e.g pre-op bloods) the veterinary surgeon should ensure that the client has been advised as to the potential advantages and advised of the associated costs. This should be documented on the consent form*."[[48]](#footnote-48)

Although this case was heard by the Committee in November 2019, the clinical events took place in August 2016; it is therefore likely that this case was progressing through the preliminary stages of the disciplinary process around the time of review of the consent guidance.

Cases 3 and 4 included references to consent forms; the former highlighting the failure to document the dental procedure and its associated risks on the form, the latter identifying the failure to read the consent form before surgery. Case 3 relied on the term "treatment options" as including the option of delayed or no treatment. However, the Supporting Guidance refers to *"a range of treatment options (including euthanasia)"[[49]](#footnote-49)* rather than specifying delayed or no treatment as options. More cases whose judgments recommend the offering of no/ delayed treatment as options may be required to elicit clearer guidance in this area.

Cases 4 and 5 highlighted the failure to inform clients about the level of overnight care provided at the practice; specific advice on this topic is now included in the updated Supporting Guidance on Veterinary Care:

*2.13  Informed consent from the outset should, as necessary, include the arrangements to be made in the event that an animal needs to be hospitalised, including clarity about the level of supervision and possible transfer arrangements.*"[[50]](#footnote-50)

The Disciplinary Committee failed to make specific comment during Case 4 on the fact that a receptionist had obtained consent from clients. This case was heard prior to the 2018 changes to consent guidance, which now stipulates that the most suitable person to obtain consent is the veterinary surgeon who will perform the treatment. Delegation is limited to a qualified or student veterinary nurse who has had appropriate training,[[51]](#footnote-51) thus excluding receptionists from performing this task.

It therefore seems that in the veterinary medical field, findings from disciplinary hearings can produce changes to professional ethical guidance, with cases 2, 3, 4 and 5 linked to changes made to the guidance on consent in the latest review of that guidance.

**Discussion**

In setting out to examine the formation of consent in veterinary medicine, it was expected that the RCVS CoPC would play a key role in stipulating the normative requirements for consent. Indeed, the profession’s ethical guidance was used to demonstrate a failure to obtain consent in all of the disciplinary cases examined. It also appears that disciplinary hearings may influence changes to this guidance, as has been demonstrated.

During the 12-month period selected for this study, a reasonably high ratio of cases (6 out of 20) involved consent. This figure is considerably higher than a similar study in the USA, which examined disciplinary records for selected state Veterinary Medical Boards.[[52]](#footnote-52) None of the cases in the American study involved failure to obtain consent.[[53]](#footnote-53) A possible explanation for the lack of US disciplinary cases involving consent may be that negligence claims are more likely to be taken to litigation in this setting, but as discussed earlier, few cases of veterinary negligence are heard in the UK. For most cases included in the current analysis, failure to obtain informed consent was only one of several charges levelled at the veterinary surgeons involved. However, two of the investigations (Cases 1 and 3) listed a failure to obtain consent as the main charge investigated for serious professional misconduct. Other cases involved failing to obtain consent as a consequence of other misdemeanours, such as failing to refer a case to a specialist or for a second opinion (Cases 2 and 4) or failing to communicate adequately with clients (Cases 2 and 5).

The place of professional guidance in claims of professional negligence is perhaps less transparent. Where there is lack of clarity in the law regarding professional responsibility, courts are compelled to consult non-legal professional guidelines to provide a more complete picture of what that responsibility should entail.[[54]](#footnote-54) As noted by Campbell and Glass, courts will "*challenge professional standards to ensure that they are commensurate with the obligations exacted by law*."[[55]](#footnote-55) In veterinary medicine, the lack of legal input may partly explain the criticism that it has been slow to regulate its own processes. [[56]](#footnote-56) However, this study provides at least a glimmer of hope that disciplinary hearings can lead to changes to professional guidance. Case 3 dealt with a single charge of a failure to obtain consent to veterinary treatment, in not offering the client the options of delaying or not performing the dental surgery that led to the death of the patient. In finding the veterinary surgeon not guilty of serious professional misconduct, the DC considered that his behaviour did not fall *far* below the behaviour expected of a member of the profession. Although a charge of professional misconduct was not upheld, it is interesting to hypothesise whether a failure to obtain consent could be used to support a civil litigation process. Testing such a hypothesis, however, would require an increase in the number of veterinary negligence cases that are heard in the civil courts. As previously discussed, while awards are limited to the economic value of the animal, the number of veterinary negligence cases is likely to remain low.

In comparison, the medico-legal field contains a rich vein of negligence cases that turn on failure to obtain informed consent. These range from *Bolam*,[[57]](#footnote-57) which set the professional standard of care through consideration of which risks would normally be disclosed to patients, through Lord Scarman’s dissenting judgment in *Sidaway* that paved the way for a consent based on what the ‘*reasonable person in the patient’s position’*[[58]](#footnote-58) needed to know*,* to the more recent decision in *Montgomery[[59]](#footnote-59)* that reinforced a consent rooted in patient autonomy and a ‘particular patient’ standard*.* The direction of travel in human medicine has therefore been towards a consent grounded in the patient’s right to self-determination.

Consent in veterinary medicine, however, is set against a backdrop of competing interests. There are the interests of the client/animal owner, the interests of the veterinary professional and the interests of the animal. A consent based on the ‘best interests’ of the animal patient would seem appropriate for a profession that maximises respect for animal welfare throughout its ethical guidance; after all, the veterinary oath includes the phrase “….*ABOVE ALL, my constant endeavour will be to ensure the health and welfare of animals committed to my care*."[[60]](#footnote-60) Nonetheless, the legal status of animals as property, together with the obligation for animal owners to pay for their animals’ veterinary treatment, seems to thwart any idealistic promotion of ‘best interests’ as the central consideration when making decisions about their healthcare. As an example, if the best interests of the animal patient would be served by undergoing an expensive surgical procedure, which the client is unable to afford, either the interests of the client in maintaining ownership of the animal or the interests of the veterinarian in receiving payment for performing the surgery would need to be relinquished to satisfy a ‘best interests’- based decision. Thus, there are problems in grounding consent to veterinary treatment in the best interests of the patient.

In the cases examined, the lack of discussion regarding the animal's best interests is notable, but understandable. The clients’ complaints encompassed a lack of consent to what was done to their animals, based on an entitlement to make decisions regarding treatment of their property and to agree to specific financial obligations. The exception is the report on Case 4, which refers on two occasions to the 'best interests' of the patient. First, when referring to the hernia surgery, the committee noted that it "*would not address the underlying condition that was making [cat] ill and, more importantly, that the hernia surgery would not have been in [cat]’s best interests.*"[[61]](#footnote-61)and later, stating that neither the general anaesthetic nor the operation "*were in her best interests.*"[[62]](#footnote-62)As the only case examined to correlate a failure to act in the patient's best interests with a finding of disgraceful professional conduct, this case could offer a model for case reasoning going forward, demonstrating professional ethical protection of the animal patient’s best interests. Informed consent would then become a mechanism for protection of these interests, while also acknowledging the interests of the owner in making decisions about the animal. Treatment options would be limited to those that protected the best interests of the animal patient, ensuring that standards of veterinary care also reflected these interests. Such an approach would require genuine sharing of information between the veterinary professional and the animal owner, encompassing a valid and informed consent that allowed both parties to reach a decision that maximised the interests of the animal.

In summary, consent in veterinary medicine relies on professional ethical guidance, which is responsive to evidence of failures in the consent process revealed by complaints and disciplinary hearings involving veterinary surgeons. While currently focusing on the relationship between veterinary professional and client, the guidance on consent could usefully advocate for the ‘best interests’ of the animal patient, with wider application to professional standards of care. Although there remain some areas of legal and ethical dispute, such as financial obligations, the adoption of a ‘best interests’-based consent would better reflect whose interests should prevail in a profession dedicated to animal welfare.

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1. Royal College of Veterinary Surgeons. ‘How We Work’ <https://www.rcvs.org.uk/how-we-work/the-role-of-the-rcvs/> accessed 21 August 2020 [↑](#footnote-ref-1)
2. S Schnobel, ‘Regulating the veterinary profession: taking seriously the best interests of the animal.’ (2017) 33 *Professional Negligence* 239 [↑](#footnote-ref-2)
3. M Fox ‘Veterinary Ethics and Law’, in CM Wathes and others (eds) Veterinary & Animal Ethics: Proceedings of the First International Conference on Veterinary and Animal Ethics, September 2011 (Blackwell Publishing 2012) [↑](#footnote-ref-3)
4. See, for example, *Calver v Westwood Veterinary Group* [2000] All ER (D) 1973 and *Glyn v McGarel –Groves* [2006] EWCA Civ 998, both of which concerned expensive sports horses [↑](#footnote-ref-4)
5. Schnobel (n2) at 248 [↑](#footnote-ref-5)
6. The Veterinary Client Mediation Service was set up by the RCVS and an independent firm of solicitors in October 2016 as a trial scheme and was formally established in September 2017. <https://www.vetmediation.co.uk/complaints> accessed 18 May 2020 [↑](#footnote-ref-6)
7. For example, the Veterinary Defence Society, the veterinary profession's largest professional indemnity insurer, paid out over £5million in claims in 2018 <https://thevds.co.uk/reports> accessed 20 May 2020 [↑](#footnote-ref-7)
8. The RCVS provides guidance for animal owners on its web pages < <https://animalowners.rcvs.org.uk/concerns/i-want-to-raise-a-concern-about-a-veterinary-surgeon/>> accessed 20 May 2020 [↑](#footnote-ref-8)
9. RCVS 'Concerns: Information for Veterinary Surgeons' <https://www.rcvs.org.uk/concerns/a-concern-has-been-raised-about-me/information-for-veterinary-surgeons/> accessed 18 May 2020 [↑](#footnote-ref-9)
10. RCVS 'Vet Case Examiner Group Decision-Making Guidelines' <https://www.rcvs.org.uk/document-library/vet-case-examiner-group-decision-making-guidance-stage-1/> accessed 18 May 2020 [↑](#footnote-ref-10)
11. RCVS Facts 2018 p21 <https://www.rcvs.org.uk/news-and-views/publications/rcvs-facts-2018/?destination=%2Fnews-and-views%2Fpublications%2F> accessed 27 July 2020 [↑](#footnote-ref-11)
12. RCVS (n9) 14 months is the maximum time quoted for a registered concern to be taken through to a Disciplinary Committee hearing [↑](#footnote-ref-12)
13. Royal College of Veterinary Surgeons, ‘RCVS Code of Professional Conduct for Veterinary Surgeons- Supporting Guidance: Communication and Consent’ <https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/communication-and-consent/> accessed 3 June 2020 [↑](#footnote-ref-13)
14. RCVS “Who we are: committees and subcommittees: PIC and DC Liaison Committee <https://www.rcvs.org.uk/who-we-are/committees/preliminary-investigation-committee-and-disciplinary-committee/> accessed 2 November 2020 [↑](#footnote-ref-14)
15. RCVS 'Code of Professional Conduct for Veterinary Surgeons' Section 2.4 <https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/> accessed 22 May 2020 [↑](#footnote-ref-15)
16. RCVS (n13) [↑](#footnote-ref-16)
17. J V McHale, ‘Consent to Treatment: the Competent Patient’ in Judith Laing and Jean V McHale (eds), *Principles of Medical Law* (4th edn, Oxford University Press 2017) 8.06, 422 [↑](#footnote-ref-17)
18. RCVS (n13)11.2 [↑](#footnote-ref-18)
19. A Maclean, Autonomy, Informed Consent and Medical Law: A Relational Challenge (Cambridge University Press 2009) 156 [↑](#footnote-ref-19)
20. RCVS (n13) 11.31, 11.32 [↑](#footnote-ref-20)
21. V Ashall, K.M Millar, P Hobson-West, ‘Informed consent in veterinary medicine: Ethical implications for the profession and the animal “patient”’ (2018) 1 *Food Ethics* 247 [↑](#footnote-ref-21)
22. S-L Bingham, 'Refusal of Treatment and Decision-making Capacity' (2012) 19 *Nursing Ethics* 167 [↑](#footnote-ref-22)
23. UK Animal Welfare Act 2006. Under Section 9.2e, the owner has an obligation to provide veterinary treatment when required, and to ensure that the animal is “protected from pain, suffering, injury and disease.” [↑](#footnote-ref-23)
24. G Diesel, D Brodbelt, DU Pfeiffer, ‘Characteristics of relinquished dogs and their owners at 14 rehoming centers in the United Kingdom’ (2009) 13 *Journal of Applied Animal Welfare Science* 15 [↑](#footnote-ref-24)
25. JG DeVries, RG De Vries, 'The Veterinarian’s Burden: The Cost of Ethical Care for Animals' (2018) 18 *American Journal of Bioethics* 60 [↑](#footnote-ref-25)
26. For example, Section 2.2d of the Supporting Guidance states that vets should “recognise the need, in some cases, to balance what treatment might be necessary, appropriate or possible against the circumstances, wishes and financial considerations of the client.” <https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/veterinary-care/> accessed 28 July 2020 [↑](#footnote-ref-26)
27. See, for example, the suggested topics for ‘best interests’ calculations for animals in C Gray, P Fordyce, ‘Legal and Ethical Aspects of ‘Best Interests’ Decision-Making for Medical Treatment of Companion Animals in the UK.’ (2020) 10 *Animals* 1009, and in K Weich, H Grimm, ‘Meeting the patient’s interest in veterinary clinics. Ethical dimensions of the 21st Century animal patient.’ (2018) 1 *Food Ethics* 259 [↑](#footnote-ref-27)
28. See, for example, C Batchelor, D McKeegan ‘Survey of the frequency and perceived stressfulness of ethical dilemmas in UK veterinary practice’ (2012) 170 *Veterinary Record* 19, and also L Moses, M Malowney, J Wesley Boyd ‘Ethical conflict and moral distress in veterinary practice: A survey of North American veterinarians’ (2018) 32 *Journal of Veterinary Internal Medicine* 2115 [↑](#footnote-ref-28)
29. *Bolam v Friern Hospital Management Committee* [1957] 2 All ER This case set the doctor-centred standard for risk disclosure, based on what a responsible body of the profession would disclose. [↑](#footnote-ref-29)
30. *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 871 AC 1 In his dissenting judgment, Lord Scarman maintained that Bolam did not apply to risk disclosure, and that the UK should adopt the doctrine of informed consent, based on a ‘prudent patient’ centred approach to risk disclosure [↑](#footnote-ref-30)
31. *Chester v Afshar* [2005] 1 AC 134 Although more notable for the dissociation of causation from the failure to warn the patient of risks, this case effectively awarded damages for the failure to be warned of a material risk. [↑](#footnote-ref-31)
32. *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 finally adopted the doctrine of informed consent into UK law, basing risk disclosure on the ‘reasonable patient’ basis, but also applying it to the particular patient; see also R Heywood, ‘R.I.P. Sidaway: patient-oriented disclosure - a standard worth waiting for*? Montgomery v Lanarkshire Health Board* 2015 UKSC 11’ (2015) 23 *Medical Law Review* 455 [↑](#footnote-ref-32)
33. GMC ‘Decision Making and Consent’ November 2020 <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent> , 22 [↑](#footnote-ref-33)
34. A Farrell, M Brazier ‘Not so new directions in the law of consent? Examining *Montgomery v Lanarkshire Health Board’* (2016)42 *Journal of Medical Ethics* 85 [↑](#footnote-ref-34)
35. RCVS (n13) 11.2 - emphasis in original [↑](#footnote-ref-35)
36. GMC (n32), 87 [↑](#footnote-ref-36)
37. There is an ongoing debate over whether ‘animal welfare’ equates to ‘best interests,’ with the consensus being that welfare focuses on an absence of harmful experiences, whereas ‘best interests’ includes maximising positive experiences. The debate comes to a head over whether death is a harm to animals; it is often not regarded as such by ‘welfarists’. See, for example, GL Francione ‘Animal Welfare and the Moral Value of Nonhuman Animals’ (2010) 6 *Law, Culture and the Humanities* 24 [↑](#footnote-ref-37)
38. RCVS (n13) 11.35 [↑](#footnote-ref-38)
39. RCVS (n13) 11.32 [↑](#footnote-ref-39)
40. RCVS 'Disciplinary Committee Hearings' <https://www.rcvs.org.uk/concerns/disciplinary-hearings/> accessed 07 May 2020 [↑](#footnote-ref-40)
41. RCVS (n13) 11.2i [↑](#footnote-ref-41)
42. RCVS (2020) Gunn Decision <https://www.rcvs.org.uk/document-library/gunn-john-january-2020-disgraceful-conduct-in-a-professional/> accessed 21 May 2020, para36 [↑](#footnote-ref-42)
43. RCVS (2020) Gunn Sanction <https://www.rcvs.org.uk/document-library/gunn-john-january-2020-decision-on-sanction/> accessed 21 May 2020 [↑](#footnote-ref-43)
44. The ureters transport urine from the kidneys to the bladder. If they are inadvertently blocked during surgery, the patient will go into kidney failure [↑](#footnote-ref-44)
45. RCVS (2019) 'Kristin and Navarro Decision on Sanction' <https://www.rcvs.org.uk/document-library/kristin-roman-and-salas-navarro-javier-december-2019-decision/> accessed 22 May 2020 [↑](#footnote-ref-45)
46. A life-threatening condition where the stomach inflates with air, twists and cuts off its own blood supply. [↑](#footnote-ref-46)
47. RCVS (n13) 11.2g [↑](#footnote-ref-47)
48. ibid, 11.8 [↑](#footnote-ref-48)
49. ibid, 11.2 [↑](#footnote-ref-49)
50. Royal College of Veterinary Surgeons, ‘RCVS Code of Professional Conduct for Veterinary Surgeons- Supporting Guidance: Veterinary Care’ <https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/veterinary-care/> 2.13 Accessed 6 November 2020 [↑](#footnote-ref-50)
51. RCVS (n13) 11.3-11.5 [↑](#footnote-ref-51)
52. These Veterinary Medical Boards are responsible for individual licensure of veterinary surgeons in each state in the USA. [↑](#footnote-ref-52)
53. SL Babcock, JR Doehne, EP Carlin ‘Trends in veterinary medical board state disciplinary actions, 2005-2011’ (2014) 244(12) *Journal of the American Veterinary Medical Association* 1397 [↑](#footnote-ref-53)
54. A Campbell, KC Glass 'The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research' (2001) 46 *McGill Law Journal* 473 [↑](#footnote-ref-54)
55. Ibid, 467 [↑](#footnote-ref-55)
56. Schnobel **(n2)** [↑](#footnote-ref-56)
57. *Bolam* (n28) [↑](#footnote-ref-57)
58. *Sidaway* (n29) at 889H [↑](#footnote-ref-58)
59. Montgomery (n31) [↑](#footnote-ref-59)
60. RCVS “Declaration on admission to the profession’ <https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/#declaration> Accessed 05 Jun 2020 [↑](#footnote-ref-60)
61. RCVS (2019) 'Kristin and Navarro: Decision on Facts and Conduct' <https://www.rcvs.org.uk/document-library/kristin-roman-and-salas-navarro-javier-december-2019-facts/> para 145, Accessed 22 May 2020 [↑](#footnote-ref-61)
62. ibid, para 146 [↑](#footnote-ref-62)