Animals and Ethics: An Overview of the Debate

Angus Taylor
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The root of the evil lies, as I have throughout asserted, in that detestable assumption (detestable equally whether it be based on pseudo-religious or pseudo-scientific grounds) that there is a gulf, an impassable barrier, between man and the animals, and that the moral instincts of compassion, justice, and love, are to be as sedulously repressed and thwarted in the one direction as they are to be fostered and extended in the other.

– Henry S. Salt, 1892 (1:102)

I haven't read John Gray's popular book *Men are from Mars, Women are from Venus*,(2) and I don't expect I ever will. But I'm not going to let that stop me from referring to it in this review of an entirely other book, *Animals and Ethics*, ably written by Canadian philosopher Angus Taylor.

From the title of Gray's book (the only bit I've read), it seems that he is using a metaphor of planetarily-independent (if that means anything) evolution to illustrate the apparently profound psychological (and probably physical) differences between the human sexes. By my limited understanding of evolution and of the relative gravitational and environmental conditions on Mars and Venus, Gray appears to be making a very significant claim indeed.

I was reminded of this metaphor many times while reading *Animals and Ethics*. After all, if such an extreme metaphor was deemed necessary by Gray to illustrate the differences between two sexes of the same species, the gulf between two species ought to necessitate an even more extreme metaphor. 'Humans are from this universe, animals have migrated from some other one', perhaps. Clumsy as it is, this metaphor points to a fundamental question which underlies much discussion of animal ethics: What is life like for an animal? Because we have no direct access to the experiences of animals, and because they are generally unable to communicate their experiences verbally (possible exceptions include some higher primates, which have learned to use human language in a limited fashion), it is exceedingly difficult to determine what kind of mental faculties animals possess and therefore how they experience life. Taylor introduces this subject at the beginning of the first chapter of *Animals and Ethics*, in which he mentions the importance of mental faculties in determining the status of animals within the moral community.

Much of the moral theory relating to animals discussed in the book rests on empirical assumptions about the mental capacities of animals. These capacities can be variously interpreted as: the ability to suffer or experience pleasure in the case of Bentham's and Singer's utilitarianism; to be 'subjects-of-a-life' in the case of Regan's rights-based theory (which requires a host of mental faculties, ranging from the ability to feel pain to having an emotional life and possessing beliefs and desires); and to possess rationality in the case of Kantianism. Taylor briefly discusses feminist and virtue ethics but no consistent themes with regard to the moral import of animal attributes (mental or otherwise) emerge. Indeed, only contractarianism, as it is presented by Taylor, appears to place no direct moral importance on the mental qualities of animals, except insofar as they may be of benefit or harm to the individual contractor—which appears not to be very far, according to Taylor's portrayal.

Contractarianism aside, questions pertaining to the existence and quality of animal mental faculties are arguably central to discussions of the moral status of animals. These questions should therefore receive significant attention in the early chapters of a book such as this. As I have previously stated, Taylor is cognisant of the importance of this subject, mentioning it in the first chapter and prologue, in-between briefly addressing relevant issues as they arise in his overviews of the major ethical theories as they relate to animals. However, a significant, dedicated discussion relating to this subject doesn't occur until the beginning of the second half of the book, where one issue, the question of whether animals can suffer, is addressed (Chapter 4 pp. 88-92). It may have been an editorial decision not to present a more complete and rigorous review of this area in an introductory work such as this, however it is a relatively short book (178 pages excluding the extensive references and bibliography, which are invaluable in a book of this type), so it is doubtful that a chapter on this subject would have tipped any editorial scales. Moreover, it could be argued that the introductory nature of the book demands that such fundamental issues are given their due, perhaps at the expense of other issues (such as the chapter exploring the troubled relationship between environmentalism and liberationism).

With this substantive issue aside, this book achieves its objective admirably, providing a concise and well-reasoned overview of ethics as it relates to animals. The first chapter provides a brief introduction to a notion of the moral community, which is basically defined as the community of those that count in our moral reckoning (p.21). It then describes the various ways in which different moral theories seek to include animals in this community. This leads into a brief discussion of the criteria each theory propounds for determining inclusion in the moral community—sentience for utilitarians, the 'ability to conduct one's life through the conscious pursuit of goals' (p.26) for rights-based philosophers, and so forth through contractarianism, feminism and virtue theories. The latter two are relative newcomers to the animal ethics scene, and the time devoted to them is proportionally brief. This is particularly the case for virtue ethics, which receives a meagre total of six paragraphs divided between two sections and a sentence on page 109 for good measure. The use of the concept of virtue within the sphere of animal ethics has received little attention compared to the current heavy-weights of utilitarianism and rights-based theory, and its inclusion in this book serves as both a timely introduction to this area of moral thought as it relates to animals, and hopefully as a stimulus to encourage its development, as suggested by DeGrazia in his review of future directions for animal ethics.(3) Feminist ethical theory (another area flagged by DeGrazia (3) for more attention within animal ethics) receives more attention, and Taylor does a good job of articulating the basics of the feminist method. However, the somewhat disparate conclusions reached by philosophers using this approach to animal ethics (those presented by Taylor, at least) leaves one with a slightly chaotic perception of the field. This is also the case with Taylor's brief discussions of virtue, and are likely a product of the relatively early developmental stages of these philosophies in the area of animal ethics, when slight chaos is probably inevitable, useful, and kind of exciting.

Taylor then takes the reader on a broad whirlwind tour of historical treatments of animals within philosophy, religion and, in a minor way, science. Darwin's theory comes off worst here, seeming rather speculative and conjectural, mostly due to the brevity of its presentation in a chapter covering so much material.

Covering less material, but in a more in-depth fashion, Taylor devotes a chapter to discussing the basis for attributing rights to animals, and reviews counter-arguments from the other moral theories, resulting in a very thorough exploration of this major branch of animal

ethics in an introductory work. Subsequent chapters address the eating and hunting of animals, and their use in scientific research, again providing a good, balanced overview of arguments in these areas, and plenty of reference material for the interested reader to pursue. A section on the genetic modification of animals is useful, but makes no mention of Alan Holland's writing in this area. (4,5) The arguments of Bernard Rollin dominate this section, and Taylor might have been wise to eschew the work of Henk Verhoog in favour of that of Holland, which presents a more effective argument to counter Rollin's largely permissive position on modifying animal natures or *telos*.

Animals and Ethics concludes with a chapter that seeks common ground between the seemingly incompatible positions of liberationists and environmentalists, and finds some. This provides the slight air of a happy ending, which carries on through an epilogue of sorts reviewing the progress of the animal liberation movement. However, Taylor ultimately concludes with the sombre observation that most people are unable to accept the idea that animals are not simply resources to be exploited.

Animals and Ethics achieves its aim of providing an introduction to this often undervalued area of ethics; moreover, it does so in a clear and balanced way, which easily holds the readers' interest. It would make a worthy book for courses addressing animal ethics, or a useful reference book for those with an interest in this area.

References

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Mrs AP is a 28 year-old married woman with three children aged two to six. Following successful chemotherapy for acute myeloid leukaemia, Mrs AP proceeds to bone-marrow transplantation.

On admission she is advised that her treatment will make her very vulnerable to infection and that she should minimise contact with her children so as to reduce her risk of exposure to community viruses. However, on the day before transplantation she insists on seeing her children as she is extremely anxious and reports an impending sense of doom. Her three children visit the ward and spend three hours with her. Their visit coincides with a period of heavy absenteeism on the ward, with a number of medical and nursing staff suffering from upper respiratory tract symptoms. In this situation staff are counselled that if unwell they should avoid working with immuno-compromised patients. Despite this, a number of staff continue to attend work while symptomatic because they are aware of the existing severe depletion of staff.

Unfortunately, five days after transplantation, Mrs AP develops a respiratory infection identified as Respiratory Syncytial Virus (RSV). This is a common community virus that generally does not cause significant illness, but in the post-transplant period may cause RSV pneumonia, a condition that has a ~80-100% mortality rate.

The male consultant overseeing Mrs AP's care decides to treat her RSV with ribavarin (taken through a nebuliser). This is the only known effective therapy, having been demonstrated in non-randomised studies to improve outcomes in situations such as Mrs AP's.

But there is a problem: a potential side-effect of ribavarin is teratogenicity (birth defects) in those exposed to the drug. This is not a problem for patients, most of whom are already infertile, but presents a risk to male and female staff, particularly nursing staff. The hospital is aware of this, and has a protective protocol for the administration of ribavarin. This protocol includes the recommendation that the staff administering the drug should not be pregnant or become pregnant in the three months following exposure.

The nurse looking after the patient tells the doctor that all the female ward staff where Mrs AP is being treated are of reproductive age. The doctor argues that the patient will die without treatment and that the nursing staff have an obligation to treat Mrs AP unless they are actually pregnant. But the doctor then hears from the Occupational Health and Safety Officer that due to safety concerns she will not approve the use of ribavarin in Mrs AP's case.

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Are any medically qualified hospital staff, in any department – whether they be men or women, and whether they be doctors or nurses—willing to volunteer to administer the drug with the hope of saving the life of the young mother? If so, then there is no real dilemma. If a health care professional is willing to take the largely unknown risk of exposing himself or herself to ribavirin, then the patient should be treated by this volunteer with or without the blessing of the Occupational Safety and Health (OSH) Officer. Losing the patient would be worse than displeasing OSH staff.

If there are no volunteers, then things are more complicated. Should staff (especially those, presumably available at least somewhere in the hospital, who have passed reproductive age) be expected to administer the drug under the circumstances? This looks like a classic case where a medical professional's 'duty to treat' comes into play. If the idea of a duty to treat is taken seriously, then it is not immediately clear that there is anything exceptional about the case under consideration. The risks of human exposure to ribavirin are unknown and have never been demonstrated through systematic study. Health care workers expose themselves to unknown risks like these on a daily basis (whenever they are exposed to potentially contagious – or psychopathic – patients, for example). Exposing oneself to such risks is arguably just part of a health worker's job. The duty to treat is not, of course, an absolute. If it was known with confidence that 1 in 1000 or 1 in 10,000 or even 1 in 1,000,000 of those exposed to ribavirin experienced negative side effects (or had children with birth defects) then this might be a different matter. One thing revealed by the case of Mrs AP is the ethical importance of learning more about the likely risks – and benefits – of ribavirin to humans.

If health workers do have a moral professional duty to treat someone like Mrs AP, should they be instructed to do so by supervisors? This looks like a conflict between 'the duty to treat', on the one hand, and a health care workers' professional autonomy – or 'right to refuse' – on the other. Despite what was said in the previous paragraph, the moral duty to treat in this situation is debatable. Because the health care worker is an autonomous professional, in any case, perhaps she shouldn't be coerced even if a moral duty to treat in the circumstances *were* taken as given.

This apparent conflict between the 'duty to treat' and 'right to refuse' might not have occurred to begin with if more attention had already been paid to other relevant rights and duties: the duty of the hospital to provide medical care, for example, and the rights of health care workers to safe working conditions. The case before us has much to do with resource constraints. The risks to health care workers from administering ribavirin, for instance, would surely be reduced if special protective clothing, breathing equipment and/or negative pressure room ventilation were provided by the hospital.

If cases like that of Mrs AP are foreseeable or arise sufficiently often, then hospitals have a duty to provide reasonable care when they do occur. This may mean providing more in the way of safety equipment – especially if it would be cost-effective to do so. Otherwise it is the hospital's duty to employ sufficient numbers of staff that will be *willing to treat*, or that will more likely be *able to treat safely* (i.e. in virtue of their reproductive status), when such cases do arise. Rather than expecting unwilling or reluctant staff to treat in such cases, hospital administration might ask prospective staff *before they are hired* about their reproductive status or willingness to provide treatments like ribavirin. Willingness to administer such treatment and/or ability to administer such treatment safely should perhaps be considered job qualifications (at least for a limited number of positions).

If this *duty to provide* has not already been satisfied ahead of time by the hospital responsible for Mrs AP, then a crucial wrong has perhaps already occurred. Harm might nonetheless yet be avoided. Rather than expecting unwilling hospital staff to treat, and rather than denying Mrs AP the treatment she needs, if no medically qualified staff at *this* hospital will volunteer to administer the drug (as assumed above), then a qualified volunteer should be sought from outside the hospital. Surely a willing soul can be found somewhere.

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A sense of self-sacrifice may have been an important nursing value through much of the last century but has no place in contemporary nursing ethics. Nurses have an obligation to take care of themselves and their co-workers. Managing risks posed to themselves and to others is a basic responsibility carried by every nurse.

Related to this responsibility but standing in apparent opposition in its practical demands on nurses in this, and indeed many cases, is the primary commitment to protect the health and welfare of the patient. This commitment has always been considered by nurses as central to their practice and remains so today.

What are the factors to consider in deciding upon the best action?

1. Mrs AP may have become infected after choosing to have contact with her children against the advice of staff, or she may have been infected by nurses who chose to work when they were symptomatic.

The cause of Mrs AP's infection is not relevant. The obligation on nurses and other health professionals is to provide effective care to Mrs AP simply because she needs care. Any role she or others may have played in her developing that need does not diminish or enhance this obligation.

2. Nebulised Ribovarin is the only known effective treatment in situations such as Mrs AP's. A potential side effect of this treatment is birth defects in offspring of individuals exposed to the drug. All female staff on the unit are of reproductive age. The health and safety officer will not approve use of the drug in Mrs AP's case.

Mrs AP must receive effective treatment and it must be delivered effectively and safely. Safety often requires the evaluation of competing risks and in health is often not an absolute condition. The essential problem in this case is how to deliver the effective treatment in the way that poses least risk to Mrs AP and to staff.

Who should solve this problem?

In the scenario the occupational health and safety officer has made the decision that the only effective treatment will not be given. While that decision provides the best health protection to staff and protects the employer against any risk of liability for failing to protect employees from avoidable risk of harm, the decision should not be made from this perspective alone. The health and safety officer has a role to play in the decision making process; to provide information and an occupational health perspective, but should not make the treatment decision.

The nurses on the transplant unit are best placed to evaluate information from the consultant and the health and safety officer together with their own knowledge, to decide how to give the treatment safely. The problem of safe delivery of effective care should be made by those who normally carry out the treatment that poses the risk and whom are most subject to that risk. The most significant judgment to be made in resolving this particular problem is evaluating who, among staff competent to carry out the treatment, is least likely to be exposed to the risk of teratogenicity by administering the drug. While all the nurses are of child-bearing age some are likely to know they are at minimal risk of personal involvement with pregnancy within the three month risk period and are likely to be willing to declare this amongst their peers. If there is no one fitting this condition within the immediate unit staff, consideration may be broadened to a wider group of suitable staff. The consultant and other medical staff should not be excluded from this group but in doing so it is important to know if administration of nebulised medicines is something they commonly do. It is well known that when health systems depart from normal procedures the risk of error is significantly increased. This fact argues in favour of the drug being administered by the nurses who usually work on the unit.

A further issue is very relevant to a review of this dilemma and that is the obligation upon society, through the agency of the health service provider, to minimise the degree of risk carried by health professionals as they seek to fulfil their obligation to provide care. In this example,

when the number of nurses working on the unit was depleted by illness, an inadequate system of staff replacement resulted in ill nurses exposing their co-workers and their patients to infection. Furthermore administration of Ribovarin is a foreseeable occurrence on a bone-marrow transplant unit and staffing arrangements should allow for its safe delivery.

Health service administrators and health unions have an obligation to support individual health professionals who identify unsafe conditions, to resolve them. Nurses are entitled to have their obligation to care balanced by society's obligation to ensure nurses work in conditions of reasonable safety. Most of all this requires that nurses have the authority to manage their own practice and conditions of work so that conflicting demands are met safely. The failure of a provider to ensure that conditions necessary to enable nurses to meet their obligation to provide care without exposing themselves to undue risk should be seen as a failure by society to meet its responsibility under the implicit social contract between nurses and the wider community.

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This case illustrates how in medicine, few things, if any, are ever as straightforward as they should be. The most obvious tension in this case is that between the public protection that the OSH Officer is trying to enforce, and the personal harm that not receiving ribavirin will do to Mrs AP (AP). The OSH Officer is merely trying to fulfill what she sees as her duty or role to protect all the staff. Ribavirin however, may increase AP's chance of survival.

There are other, perhaps more subtle tensions that prevent this from being a simple problem. There will be nurses involved in caring for AP, who may feel a direct obligation to treat her. They may be torn between this feeling and the need not to undermine the OSH Officer or to go against hospital policy. They may have partners who don't want them to be put at risk (even if they are willing).

The hospital also has a duty to AP, to provide her with the best medical care possible. Her infection may even be nosocomially acquired (from the hospital staff). Does this increase their responsibility to do everything possible, even if the benefit from ribavirin may not be great? Does the hospital not have a responsibility to the wider community to provide the best health care for each and every member of that community? Is there a duty to AP's husband and children to do everything to keep their spouse and mother alive? Can an assessment of justice come into this discussion?

The hospital however, also has a duty to provide a safe working environment.

These dilemmas illustrate how your context will influence how you will view a situation. To some, the risk associated with administering ribavirin may appear minimal, but from the OHS Officer's perspective, it is too great to sanction, particularly as the evidence of benefit from this drug is not strong. This case also illustrates the impact of hospital policies and management guidelines on patient care. Clinical algorithms and management protocols may be overwhelming the sophistication of making unique clinical decisions to best care for each patient.

I also wonder whether the hospital has a duty to allow staff the professional freedom to make decisions for themselves about personal risk. These are well educated and often very dedicated staff. Why can't they decide for themselves (and perhaps the hospital should put the potential for legal liability in perspective). Some staff would deem the risk to be minimal or irrelevant, and completely overwhelmed by the need to treat AP. Demanding that staff do not treat someone because they may pose a risk could be seen to be as bad as demanding that they do. What about the human rights argument – shouldn't staff have the right to choose what degree of personal risk is acceptable? What about the importance of allowing the expression of virtues such as compassion and caring and self-sacrifice in hospital staff?

The tensions in this case make discussion bounce around like a pinball. But, as Florence Nightingale herself said, perhaps 'feelings waste themselves in words, they ought to be distilled into actions'. In reality, we just need a practical solution. One that allows AP to have treatment without putting anyone at risk of teratogenesis. There are a number of practical solutions. Maybe someone in AP's family can give it, such as her husband or her mother or a friend (who understands the risk). Why not ask staff for volunteers and accept them only after they have had a

private discussion about the potential consequences of exposure to ribavirin. What about nurses who are not of child-bearing age (or who have taken permanent contraceptive measures), why couldn't they be asked if they are happy to work on the ward? I am sure that if the staff felt that they had the freedom to make a free and informed decision, and support for whatever decision they made, it wouldn't take long to find staff who were happy to administer the drug.

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This case is straightforward (some may say). The patient is at serious risk of potentially fatal respiratory infection and has been warned that her children should not visit her in hospital. She ignored the warning and developed viral pneumonia several days later. The only potentially effective treatment – and evidence for its effectiveness is limited – has potentially adverse effects for staff and is very expensive. Unless the drug can be given without exposure of staff, it should not be used. The hospital has a duty of care to protect staff from harm and cannot afford to risk prosecution under the Occupational Health and Safety (OSH) Act. Although the risk is mainly to pregnant women, staff have a right to privacy and should not be asked whether or not they are pregnant. With a limited hospital budget, the funds required for this treatment would be better spent on more effective treatment for other patients.

But is it so straightforward? What if the patient's children had not visited her and she was infected by member of staff with a 'cold'? Does that make a difference? Surely the consultant – certainly not the OSH Officer – is the only one qualified to determine appropriate treatment. Surely nurses have a duty to care for their patients, even if it does involve some risk; for example, when a patient has an infectious disease. Should they be entitled to refuse, especially if the risk is small? If some nurses are willing to give the drug would their jobs – or right to workers' compensation – be at risk if they ignored the OSH officer? Could the patient's relatives successfully sue the hospital if she died without receiving prescribed treatment? Should the cost of treatment be taken into account?

How can the impasse be resolved? Delay would have determined the outcome, one way or the other, in this case; but complex issues, such as these, cannot be resolved rationally in emotional circumstances – with a patient's life at risk and staff stressed, uncertain and in conflict. Only involvement of the media or a politician could have made the situation less conducive to rational decision-making! Whatever the outcome for Mrs AP, a similar situation must be avoided in future. Strong leadership by senior staff is needed to bring together the stakeholders – medical, nursing, pharmacy, OSH staff and patient representatives to discuss, *inter alia*, the following issues:

How good is the evidence for the efficacy of nebulised ribavirin in this situation and the risk, if any, of adverse effects on staff? Assuming the evidence on both counts is weak, can a policy be developed in the face of uncertainty? What degree of risk to staff, if any, is acceptable? If the potential benefit of nebulised ribavirin is thought to outweigh a very small or theoretical risk to staff, what are the indications for its use and how can the risk be minimised? If nebulised ribavirin were prescribed according to agreed indications, should non-pregnant staff be obliged, or at least asked to volunteer, to administer it? If so, and an adverse effect occurred, would the staff member be entitled to compensation and under what conditions? How can compliance with infection control guidelines, designed to protect the whole hospital community, be improved without unreasonable infringement of the rights of patients, their relatives or staff? What are the relative risks, for the hospital, of a compensation claim by a staff member versus a medicolegal claim by the patient's relatives if she dies without treatment?

The aim of these discussions will be to develop an ethical, evidence-based policy, which balances the rights and responsibilities of all. In future, development and enforcement of hospital policies and guidelines will need to encompass not only bioethical principles – relating to the rights and autonomy of patients and the traditional duties of healthcare workers – but also broader ethical principles which balance the rights and responsibilities of individuals against those of all members of the community – in this case the hospital community – including fair resource allocation.

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On the one hand, the OSH Officer is right to recognise the hospital's legal obligations to maintain a safe working environment for its staff members, in particular protecting the ward staff where Mrs AP is being treated from potential side-effects of ribavarin including teratogenicity. In New Zealand, under the Health and Safety in Employment (HSE) Act 1992, the hospital is responsible for taking all practicable steps to eliminate, isolate, or minimise significant hazards (including hazards that may result from exposure to ribavarin). In this case, hospital protocol recommends that staff administering the drug should not be pregnant or become pregnant in the three months following exposure. The HSE Act 1992 also confirms an employee's right to refuse to undertake work they believe may cause them serious harm.

On the other hand, the OSH Officer is incorrect in declining outright to approve the use of ribavarin as health professionals have a moral and legal duty to provide care, especially in Mrs AP's case where her condition could develop into RSV pneumonia (a condition with an 80-100% mortality rate) if left untreated. Staff may have a moral obligation to treatment Mrs AP as they failed to heed counselling to avoid working with immuno-compromised patients if they had upper respiratory tract symptoms. The ward staff may have inadvertently transmitted the respiratory infection to Mrs AP causing her to develop RSV. In addition, refusing to treat Mrs AP may breach other professional standards, such as the Medical Association's Code of Ethics, which outlines that health providers have a duty to provide care in an emergency.

Ward staff may have a legal duty to treat Mrs AP as refusing to treat her may breach the Crimes Act 1961. Those who have charge of another person by reason of sickness have a statutory obligation to provide the necessaries of life to that person. If death, endangerment of life or permanent injury to health result from omitting to perform this legal duty, the doctor or nurse could be held criminally responsible and may face charges of culpable homicide. In addition, refusing to treat Mrs AP may breach any legal obligations to provide care to all patients set out in the employment contracts of the medical and nursing staff.

In Mrs AP's case, the ethical and legal obligations the staff may have to treat would need to be balanced against the duty to keep ward staff safe (and the right to refuse to undertake work that could cause serious harm). As the hospital has a duty to treat Mrs AP, it could first consider whether there are any ward staff willing to administer the ribavarin to Mrs AP. Although the OSH Officer is advised that all the female ward staff where Mrs AP is being treated are of reproductive age, not all staff may have the desire to procreate and therefore may not consider administration of ribavarin to be a significant health hazard. Further investigation is required to determine whether any of the nursing staff are pregnant, intend to become pregnant in the three months following exposure, or intend to father children in the near future.

In addition, it may be helpful to review the risks of exposure to ribavarin with the ward staff and remind them of hospital protective protocol before declining to approve the treatment for Mrs AP. Additional precautions to limit exposure and decrease risk can also be undertaken such as administration of ribavarin in a negative pressure room, adequate room ventilation, and wearing an appropriately fitted respirator mask. The OSH Officer may find that when fully informed about the risks and how these can be mitigated there are staff members who would volunteer to administer the drug.

If efforts to find a volunteer to treat Mrs AP are unsuccessful, the hospital could look to other wards in the same hospital or even approach another hospital in the community (which has a full complement of staff) to find nurses willing to administer ribavarin to Mrs AP. Although the health and safety of the staff is important, the duty to treat Mrs AP, and likely prevent her death, holds greater weight.