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INTERSPECIES ENCOUNTERS: AN ETHNOGRAPHY OF A VETERINARY HOSPITAL

by

Dana Atwood-Harvey

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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INTERSPECIES ENCOUNTERS: AN ETHNOGRAPHY OF A VETERINARY HOSPITAL

Dana Atwood-Harvey, Ph.D.
Western Michigan University, 2003

There were three broad reasons for this research. The larger goal was to continue to advance the incorporation of 'other' animals and the rest of nature in general in sociological theory and research. The second was to suggest to those who have incorporated 'other' animals into their research, to include them as participants. The third was to redirect the focus of those who have incorporated 'other' animals as participants, to the impact that ideological structures and other social factors have on human-'other' animal encounters. Toward this end, I directed the focus of my study to examine human-'other' animal encounters in a place where these encounters are of everyday central importance: the veterinary hospital.

As such, this research presents an examination of human-feline encounters in a veterinary hospital. To best understand these encounters, I provide a detailed analysis and description of the ideological frameworks of official veterinary medical practices and the consensus or conflict that these medical frameworks have. Specifically, I looked at the conditions within the hospital that were associated with types of encounters. The primary data for this exploratory, inductive analysis came from field notes that I collected by employing the ethnographic method. In other words, I participated in and observed human-feline encounters in a veterinary hospital for a period of nine months. In particular, this research was an attempt to understand what goes on within a veterinary institution, what the official practices were and what they meant to the human participants, how humans and felines encountered one another within the veterinary institution, and in what way these encounters were influenced by the social context. What I found was that social encounters between humans
and felines in the veterinary hospital were influenced by interpenetrating social and social psychological factors.
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INTERSPECIES ENCOUNTERS: AN ETHNOGRAPHY OF A VETERINARY HOSPITAL

I contemplate a tree.
I can accept it as a picture: a rigid pillar in a flood of light, or splashes of green traversed by the gentleness of blue silver ground.
I can feel it as movement: the flowing veins around the sturdy, striving core, the sucking of the roots, the breathing of the leaves, the infinite commerce with earth and air --- and the growing itself in the darkness.
I can assign it to a species and observe it as an instance, with an eye to its construction and its way of life.
I can overcome its uniqueness and form so rigorously that I recognize it only as an expression of the law—those laws according to which a constant opposition of forces is continually adjusted, or those laws according to which the elements mix and separate.
I can dissolve it into a number, into a pure relation between numbers and eternalize it.
Throughout all of this the tree remains my object and has its place and its time span, its kind and condition.
But it can also happen, if will and grace are joined, that as I contemplate the tree I am drawn into a relation, and the tree ceases to be an It. The power of exclusiveness has seized me.
This does not require me to forego any of the modes of contemplation. There is nothing that I must not see in order to see, and there is no knowledge that I must forget. Rather is everything, picture and movement, species and instance, law and number included and inseparably fused.
Whatever belongs to the tree is included: its form and its mechanics, its colors and its chemistry, its conversation with the elements and its conversation with the stars—all this in its entirety.
The tree is no impression, no play of my imagination, no aspect of a mood; it confronts me bodily and has to deal with me as I must deal with it—only differently.
One should not try to dilute the meaning of the relation: relation is reciprocity.
Does the tree then have consciousness, similar to our own? I have no experience of that. But thinking that you have brought this off in your own case, must you again divide the indivisible? What I encounter is neither soul of a tree nor a dryad, but the tree itself.

~ Martin Buber (1970:57-58)
CHAPTER 1

INTRODUCTION

Including Animal Others in Sociological Theory and Research

In the late 1970's, sociologists began to consider that human social reality is inextricably linked with nature. One faction of these sociologists, prompted by Catton & Dunlap (1978), trained their eyes to the relationship that human society has with the natural environment and crafted a distinct sub-area called environmental sociology.\(^1\) Although the field is expansive, and represents many sociological trajectories of thought, the main progress that this area has advanced is a more holistic understanding of environmental problems. This holistic understanding enhanced recognition that while humans have a profound impact on nature through human action and perspectives, both human impacts on nature and nature itself can shape human social experience. On the practical side, this field left us better equipped to handle the complex and interweaving social problems of resource depletion, human social inequality, and sustainability.\(^2\) On the theoretical side, this field has built a bridge between social constructionists and social realists -- a place

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\(^1\) For the early advancements of this sub-area, see Dunlap & Catton 1979; Catton & Dunlap 1978. For later reviews see Buttel 1987 and Foster 1999.

\(^2\) Frey (ed.) 2001; Cable & Cable 1995; Bell 1998.
where the ideal and the material can meet to provide a less reactionary and more holistic understanding of human experience.  

At about the same time that Catton & Dunlap (1978) began to carve out environmental sociology, Clifton Bryant (1979) began a discourse on the importance of including the influence that ‘other’ species have on human social experiences. Arguing that “there is virtually no area of human social life that is untouched by animals” (403) he suggests that a sociology that neglects this very real part of human experience fails to capture the everyday reality in which we, as sociologists, purport to study. Following his lead, other sociologists began to carve out a sub-field in sociology that is now referred to as “human-animal interaction” and “human-animal relations.”

Although this area is also expansive, it mainly progressed sociological understanding of how humans think about, act toward, use, and benefit from ‘other’ animals. For example, a handful of empirical studies were used to explore the dominant cultural representations (i.e. family members, symbols, objects, nuisances, tools) of various species and indicate that these representations influence how humans think about and rank animal practices. These researchers argue that the cultural labels attached to various species (albeit changing historically and cross-

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1 Bell 1998; Murphy 1995.
2 Adrian Franklin (1999) presents an excellent analysis of the changing nature of “human-animal relations” in the twentieth century and examines how broad social-structural forces have influenced these changes. While she uses the term human-animal relations, she is referring to human use of animals.
3 Various cultural “themes” or labels are used by different researchers, although “pets” or “family members” is used most often. Other labels include “farm animals,” “wild animals” and “wonders.”
4 Lerner & Kalof 1999; Carmack 1997; Paul 1996; Bryant & Snizek 1993; Herzog & Galvin 1992;
culturally) are accorded a “cultural hierarchy” (Hirschman 1994). This cultural hierarchy is based on the species’ perceived similarity with and usefulness to humans.

Inspired by empirical progress in other disciplines that provides strong evidence that having relationships with ‘other’ animals (mostly companions) is beneficial to human physical and psychological health and development, a few sociologists began to explore the social benefits (for humans) of human-animal relationships. From these studies, we learned that dogs can serve as social facilitators in public places. Robins, Sanders & Cahill (1991), for example, observed the activities of dogs and their human companions and noted that the presence of dogs eased the tensions that are often present among human strangers by making the human companion appear more trustworthy.

Finally, the most extensive attention in the study of “human-animal relations” was directed toward the abusive actions that humans take toward ‘other’ species. From this research we learned how humans engage in abusive treatment toward other species, what the nature of the abuse entails, what types of animals are most often targeted and by whom, what the societal factors might be contributing factors in animal abuse, the social psychological dysfunction’s that motivate abuse, what the

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self reported motives are, what the criminal justice response is, what attitudes people have regarding such abuse and how this abuse connects to human abuse. This research aided policy implementation, joining the forces of pediatricians, social welfare, and humane societies in an effort to educate the public and work toward the prevention of both child and animal abuse.

While these two sociological sub-areas made significant advances in understanding of human-'other' natural relations, I argue that, with a few exceptions (which will be presented shortly), they present a partial analysis of these relations. If we really wish to comprehend the nature of human-'other' animal encounters, it is important to do two additional things. First, the researcher must place that ‘other’ in the center – as an actual participant. Otherwise, the study is not a study of encounters, relations, or interactions and therefore the researcher should not employ those terms. Second, these encounters must be examined as they are contextually situated. In other words, it is important to explore the social factors that may (in addition to human perception) play a role in shaping the nature of human-'other' animal social action.

There were three broad reasons for this research. The larger goal was to continue to advance the incorporation of ‘other’ animals and the rest of nature in general in

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sociological theory and research. The second was to suggest to those who have incorporated ‘other’ animals into their research, to include them as participants. The third was to redirect the focus of those who have incorporated other animals as participants, to the impact that ideological structures and other social factors have on human-‘other’ animal encounters. Toward this end, I directed the focus of my study to examine human-‘other’ animal encounters in a place where these encounters are of everyday central importance: the veterinary hospital.

According to a sample survey of 80,000 U.S. households presented in the *U.S. Pet Ownership & Demographics Sourcebook* (2002), over 60% of households in the United States include at least one dog and/or cat. In addition, 66.8% of these households bring these companions to the veterinarian on a regular basis. Given these numbers, one might expect that the veterinary institution and its attendant ideological frameworks would play a major role in the lives of both humans and their companion animals. Yet, very few empirical studies have engaged in the examination of the nature of human-‘other’ animal encounters that occur within this institution.\(^\text{21}\)

In addition, to my knowledge, no research has yet to provide a detailed description and analysis of the ideological frameworks of official veterinary medical practices that are employed explicitly to care for the health and well being of other species that humans come into contact with on a daily basis. I think that such a description and

\(^{21}\) For the exceptions see: Sanders 1999 (chapter 4) who examines social exchanges between canine patients, clients and veterinary doctors to better understand the problems that veterinarians face in these interactions; Arluke & Sanders 1996 (chapter 3) whose analysis focuses on clinical exchanges between patients, clients, and veterinarians to suggest that the animal mind is a social accomplishment; and Sanders 1994 who focuses on veterinarian-patient exchanges to outline the tactics that veterinarians use to categorize and control “problematic” patients.
analysis can be usefully employed in future research to lend insight into the types of relationships that humans set up with nature itself, specifically with companion animals. Most important, for the purpose of this research, a focus on the encounters that occur within this institution might lend insight into how human-'other' animal encounters are shaped by the social conditions surrounding them.

This research presents an examination of human-feline encounters in a veterinary hospital. To best understand these encounters, I also provide a detailed analysis and description of the ideological frameworks of official veterinary medical practices and the consensus or conflict that these medical frameworks enjoy by human participants. Specifically, I looked at the conditions within the hospital that are associated with types of encounters. The primary data for this exploratory, inductive analysis came from field notes that I collected by employing the ethnographic method. In other words, I participated in and observed human-feline encounters in a veterinary hospital for a period of nine months. In particular, this research was an attempt to understand what goes on within a veterinary institution, what the official practices were and what they meant to the human participants, how humans and felines encountered one another within the veterinary institution, and in what way these encounters were influenced by the social context. What I hope to show is that social encounters between humans and felines in the veterinary hospital are influenced by interpenetrating social and social psychological factors.

Having identified the primary goals, questions and thesis of this research, I now turn to address other questions that might occur to the reader at this point. First, I
explain in more detail, why I chose to include ‘other’ animals, and specifically felines, as research participants. Second, I address the nature of academic anthropocentrism in sociology. Third, I point the readers’ focus to the defensive methods that some researchers have employed to challenge anthropocentrism in sociology. Fourth, I expand on this present study’s focus and indicate my own tactic for the incorporation of felines in sociological research. Finally, I outline the remaining chapters so that the reader will have a general guideline of the research presentation.

The Problem of Giving Voice to the Less Powerful

Many feminists point out that mainstream sociologists have “given voice” to women in the construction of sociology. In their theories, male sociologists have reconstructed the everyday experiences of women. In other words, they gave the less powerful group “a voice.” Likewise, black feminists such as Patricia Hill-Collins (1990) and bell hooks (2000) point out that in traditional feminist theory white women have “spoken for” them, rather than hearing them from their own perspective. The voices that were “given to” women and other less powerful groups in other words, were inaccurate. Fortunately, “giving voices” to others has been challenged
and more “objective” (in the Hardian sense) representations of the everyday lives in society are being sought.

Understanding the experience of women from their own point of view corrects a major bias of nonfeminist participant observation that trivializes female’s activities and thoughts, or interprets them from the standpoint of men in the society or the male researcher. Georg Simmel (1858-1918) was one of the few early social scientists to recognize this problem. As he put it ‘almost all discussions of women deal only with what they are in relation to men in terms of real, ideal or value criteria. Nobody asks what they are for themselves.’ This problem is endemic in Western civilization and in the social sciences. The misogyny and gynopia of a culture are mirrored in its social science. (Reinharz 1992:52)

I am inspired by more recent feminist discourse and research that argue that simply “adding women (or people of color or people of poverty) will never result in a body of knowledge that reflects diversity of human experience” (Zalk & Gordon-Kelter 1992:8-9). Likewise, I argue that the add nature and stir approach can result only in one-sided versions of these relations and encounters that stand within them. With other animals for instance, we are left with the perception that animals are passive receptacles of human social constructions –nothing more than human manipulated objects within human society. The fates of these animated objects then are left to individual or group attitudes toward animals or culturally constructed categories that these animated objects are placed within.

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22 Sandra Harding suggests that social science should not reject “objectivity” but to redefine it to include the multiple standpoints of those that have been marginalized. She argues that “malestream” sociology that claims to be “objective” is actually less objective because their subjective position is not made explicit. Moreover, she argues that those groups that have been marginalized can be more objective because they have to have an understanding of the perspective of the dominant group in order to function. The powerful group, on the other hand, does not need to see “reality” through the perspective of the ‘other’ and often defines reality—putting their perspective as the ‘norm.’

23 For just a handful of example, see hooks 2000; Mason 1997; Held 1993; Reinharz 1992; Mies & Shiva 1993; Lorde 1984; Harding & Hintikka 1983.
Certainly, I am not suggesting that we can interview ‘other’ animals to open up what the meanings are behind their actions. Nor do I wish to delve into the philosophical debate about animal consciousness – I feel that this is a job better suited for cognitive Ethology and philosophy. Nor am I suggesting that I can “speak for” the experience of any actors in this setting. However, I am suggesting that it may be possible to attain a less anthropocentric understanding of the experience of other animals through the techniques of empathy and intent observation. A big part of my research project is to describe the experience of the actors involved (human, other animal, myself) in the setting. This is important to sociology because it offers a more holistic and “objective” account of our social reality, challenges the view of animals as automata and affords them more respect.

When I first read the passage on the first page of this introduction from Martin Buber’s (1970) book *I and Thou*, I thought that it most eloquently captures the thesis of his book regarding how humans and ‘other’ natural entities encounter one another. From Buber’s perspective, these encounters are based on the ways that human and ‘other’ nature can ‘know’ each other ranging from subject (being-ness) to object (thing-ness). It appears to me that Buber contrasts two ways of relating, subject to object (“I-It”), and subject to subject (“I-Thou”). Some social theorists, largely feminists, explore this contrast and suggest that the “I-It” relationship and the process of creating this relationship (objectification) can have devastating and

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24 I use this word in the Hardian sense again.
objects. Moreover, individual men can encounter women as subjects (agents) in this structure, even as their group status positions them/us as objects.

In this paper, I extend the aforementioned idea (that ‘others’ are agents) to include ‘other’ nature as individual agents (as participants in social encounters) in an attempt to better understand the nature of such encounters. Martin Buber refers to a tree symbolically to illustrate human-‘other’ encounters. I choose another agent of nature, one that is frequently encountered by a large segment of the U.S. human population and one that I am intimately familiar with: the feline animal.²⁷ As Buber suggests, “the tree is no impression, no play of my imagination, no aspect of a mood; it confronts me bodily and has to deal with me as I must deal with it—only differently” (58). Likewise, for the purpose of this paper, I assume that the feline agent is not a passive construction of the human, although this subject is often encountered through human social constructions – including the constructions of subject-ness and object-ness. What this means is that while I assume that felines are agents and thereby include them as participants in these encounters, I do not assume that human participants encounter them as subjects.

This brings me to the reason that I chose to explore human-feline encounters in the first place. I believe that the promise of sociological research is that it can be used to challenge the dominant ideological and material structures that help to perpetuate “I-It” relationships. Sociology has a long history of research whose larger goal is to

²⁷ According to the 2002 U.S. Pet Ownership and Demographic Sourcebook there are 70 million cats living within U.S. households. Likewise, A national survey presented by the Humane Society of the United States and conducted by the American Pet Products Manufacturers Association between 2001-2002, three in 10 households (34.7 million) house at least one feline (2.1 on average).
understand and break down the socially constructed barriers of race, class, and sex in order to promote less distorted versions of social reality. Humans and ‘other’ animals have encountered one another throughout history in any number of manners. For humans, animals have been sources of protection, food, clothing, and intimate companions. For ‘other’ animals, humans have served the roles of colonizer, protector, and curious entities. Cross-culturally and historically, we have been afraid of each other, killed each other, depended on each other, and have loved each other. Yet, these encounters have been neglected in traditional sociological endeavors to understand social reality because ‘other’ animals are not considered the subject matter of sociology.

Academic Anthropocentrism

‘Other’ animals are not the subject matter of sociology. I agree with this. Sociology, as a discipline is concerned with human social life. Indeed, this is what separates the field from other academic disciplines. A focus on humans and social experience is what separates sociology from biology, ecology, anatomy, physics, and a whole host of other academic disciplines. However, it is important to recall that humans are natural entities—biological, natural creatures. Moreover, humans, as social and natural creatures, socially encounter those whom they are connected to. In part, this is one reason that I chose to refer generally to animals outside of human animals as ‘other’ animals. I recognize that this generalizing term can be
problematic. As Birke (1995) argues "To counterpose ourselves to 'other animals' is to universalize on both counts: which humans are we talking about? And which animals?" (38) Universalizing is not my intention by the use of the term; rather I intend to blur some of the distinctions to create a place for animals in sociology while simultaneously recognizing that animals are also different — are for many humans distinctive 'others.' Othering is not an inherently problematic phenomenon. Humans and 'other' animals are 'others' in relation to one another and as Buber (1970) suggests, this 'othering' defines relationships. It only becomes problematic when one group uses this othering to justify exclusion or dominance of another group. Focusing on the differences between groups and using one group to define what is valuable has social consequences that privileges one group and harms both.

Traditional sociology has relied on this hierarchical type of othering to exclude 'other' animals and their contributions to social existence from the discipline. In other words, sociology has been driven by anthropocentric assumptions about humans and nature. Anthropocentrism can be understood in one of two ways: 1) Humans are the most important entity in the universe and are "separate from and above the rest of nature" (Dunlap & Catton 1983:116) and 2) Understanding or interpreting reality through human values and experiences (Nichols 1997). I do not argue with the value of the second part of this definition. I do not argue that sociologists as humans can divorce ourselves from the human standpoint but rather, in the study of society, humans must be recognized as socially connected and thereby influenced by 'other' animals and nature itself.
The hierarchical othering to which I earlier referred is often defined by human-animal interactionists and Ecofeminists as the disciplinary reliance on oppressive dualism. Evidence of this reliance can be found through specific oppressive tactics that were first outlined by Plumwood (1993) and best summarized by Hawkins (1998):

1. Backgrounding denial, whereby contributions of the other on which the master depends are denied or minimized;
2. Radical exclusion or hyperseparation, whereby an absolute discontinuity, a difference not of degree but of kind, is postulated between the master and the other;
3. Incorporation or relational definition, whereby the other is defined only in terms of the lack of some quality possessed by the master or, conversely, only in terms of qualities that can be incorporated into the master's needs and desires;
4. Instrumentalism or objectification, whereby the other is recognized only as an object, resource or means for the master's ends rather than as a subject with ends of its own; and
5. Homogenization or stereotyping, whereby all members of the oppressed class are seen as uniform and stereotypic, stripped of all individuality or within-class difference.

Sociologists have tended to ignore or minimize 'other' animal's contributions to social reality. Evidence of this can be found in a majority of introductory textbooks where 'other' animals' contributions to social reality are largely invisible. The main texts that socialize sociology students to the core of the discipline ignore or reject Darwin's (1859/1873) suggestion that the differences between the species are one of degree rather than one of kind. What this means is that no clear demarcation exists between humans and 'other' animals but rather, there is a blurry continuum of qualities and characteristics. Indeed, White (1949/1982) not only ignores this theory he rejects it outright:

There is a fundamental difference between the mind of man and the mind of non-man. This difference is one of kind, not of degree. Man uses symbols; no other creature does. An organism has the ability to symbolize or it does not; there are no intermediate stages.
Of course, White does not limit his distinction simply by virtue of being born human: "deaf mutes who grow up without the use of symbols are not human beings...The symbol is the universe of humanity" (31). This ability, according to White and others, stems from the distinctively human use of words.

The line used to separate humanity from ‘other’ animals is mainly drawn upon the ability to use human language and have human consciousness. Some theorists, such as Hawkins (1998), Kheel (1985), and Benton (1993) rightfully note that our dependence on oppressive dualistic constructions have fostered a neglect of sociological interest in relations with other species. However, these oppressive dualistic constructions, such as human/animal and culture/nature are rooted in a variety of interconnected assumptions about humans, the rest of nature, and academe.

One assumption that I mentioned earlier is that there is a clear distinction between humans and the rest of nature – or what Raymond Murphy calls a “radical discontinuity between humans and non-human animals” (1997:4). Humans are thought to possess certain qualities that other animals lack. The assumption that only humans have the ability of self-reflection and consciousness or rational thought (exemplified through symbolic language) is just one (albeit the major one in sociology) yardstick by which many sociologists measure inclusion into the study of this field.

This “radical discontinuity” is an assumption or “premise” that guide other assumptions about humans and the rest of nature. As Murphy (1997) points out, Berger and Luckmann (1968) contend that “man” can produce “his” reality (can
break free of natural constraints) but “animals” are “biologically fixed” and their “structures are predetermined by the biological equipment of the several animal species” (Berger and Luckmann 1967:47). “Man” somehow can escape nature – can break free of nature’s constraints. Consider the following statement made during an introduction to the sociological concept of culture in an edited theory book by Coser & Rosenberg (1982): “By reason of his peculiar endowment, man, unlike any other species, is able to recreate the natural environment. Man makes tools and rules and patterns his life accordingly” (17).

Humans may have power to manipulate and control natural constraints more than other animals. However, it seems odd that Berger & Luckmann (1967), Bell (1977) (who claim that human potential is limited only in the social sphere), and many others fail to recognize that humans still remain subject to illness, natural disasters, gravity and ultimately death. As Daniel Quinn points out in his novel Ishmael, humans may fly in an airplane and appear to defy gravity – but the airplane is constructed with the theory of gravity in mind. Humans have to obey the theory of gravity in order to fly, just as a bird has to obey it. While “man” is often believed to break free of natural constraints, other animals remain caged within their biological and environmental limitations. They are mere machines – objects to be acted upon – rather than cultural or social creatures (agents of their own degree).

These assumptions based upon hierarchical othering that humans are flexible conscious beings not limited by ecological constraints and animals are biological
instinct driven objects, are intertwined with an assumption of human superiority. No
doubt, there are differences (as there are similarities) among the various species that
exist in this world. Moreover, no doubt, these differences can have a significant
impact on social relations. Nevertheless, when it is humanity’s “special”
characteristics\textsuperscript{29} that count as what is social (and one looks for evidence of these
characteristics in others to determine inclusion) one is claiming that humanity is what
should be aspired to.

Nowhere is this human superiority assumption more evident then in George
Herbert Mead’s (1934/1962) theories that lay the groundwork for a major perspective
in sociology. In the 1930’s, George Herbert Mead theorized that humans have a
distinct style of social interaction. While he makes a great deal of distinctions
between humans and ‘other’ animals’ types of interaction, the pivotal one for
Symbolic Interactionists, is the ability to communicate using significant symbols.
Significant symbols, and human language is the primary one, is a type of gesture that
signifies the meaning of an experience or object to another person and the second
person responds in recognition of that meaning. Significant symbols make shared
meaning (communication) possible among human beings. If I use the word “cat” you
may have a similar mental image of a furry creature with four legs, whiskers, and soft
fur who purrs and meows or hisses and scratches.

\textsuperscript{28} Raymond Murphy, in \textit{Sociology and Nature}, does a very good job of analyzing theoretical work
within sociology and revealing these assumptions – pointing to specific theorists and their ideas.
\textsuperscript{29} Please note, I am not suggesting that I am assuming that other animals do not possess similar
characteristics.
These significant symbols are also an elemental ingredient to human thinking. Mead theorized that these symbols make human thought possible. Moreover, these symbols can stimulate similar actions among individuals and allow people to adjust behaviors to others. Only humans, he asserts, have this ability – this ability to symbolically interact. Moreover, this ability, he argues is what enables humans to create complex social organizations that can not exist in a similar way in ‘other’ animals. The chains of instinct, immediate reactions and conditioning bind ‘other’ animals to simple gestures of the here and now.

The act of each dog becomes the stimulus to the other dog for his response...The very fact that the dog is ready to attack another becomes a stimulus to the other dog to change his own position or his own attitude. He has no sooner done this than the change of attitude in the second dog in turn causes the first dog to change his attitude. (Mead 1934/1962: 42-43)

This situation, he explains is a “conversation of gestures.” It is a stimulus-response, an action/reaction type of interaction and because of the ‘other’ animals presumed lack of ability to think, to “take the role of the other” and to have a “shared definition of reality” with humans; social interaction between humans and ‘other’ animals can not exist. As Sanders (1993) explains, from this perspective

...dog owners’ babbling endearments to their canine companions are simply taking the role of the animals and projecting humanlike attributes on them...Interpreting the behavior of dogs as authentic social responsiveness is the same form of anthropomorphic projection in which people engage when they “interact” with a computer (Turkle 1984), automobile, or other inanimate object (Cohen 1989). (206)

According to Mead (1934), humans are the only species with the ability to use language and communicate symbolically. This ability, it is assumed, is the pre-
requisite for consciousness and social agency. Because animals are assumed to lack this ability, they are insignificant to sociological attention: they are mere objects that we use to accomplish the social construction of our reality.30 Because many social scientists retain the underlying assumption, that symbolic interaction is language dependent, the tendency is to minimize ‘other’ animal consciousness and demarcate incompliant boundaries between humans and other species.

Following Arluke & Sanders (1996), I argue that because humans are animals and a vast part of the social world(s) entail interactions with other species, this assumption can have the effect of locking the field into the “same human categories of communicating and knowing, denying the possible discovery of animal-based or animal-sensitized categories” (50). It disallows interspecies understanding of our social worlds. Here I have to point out that Mead’s (1962) assumption that humans are sole possessors of self-reflection and Berger and Luckmann’s (1967) and Bell’s (1977) assumption that humans are somehow exempt from natural constraints are just that -- assumptions! These assumptions may very well have limited the ability to examine social behavior holistically and effectively. As Arluke & Sanders (1996) further argue, the major “effect of human centered (anthropocentric) ideology is just as distorting as male-centered (androcentric) ideology” (50). It detracts from knowledge informed by perspectives and actions of all possible social actors. Catton and Dunlap (1978, 1980) call for sociology to begin a move away from the “Human Exceptionalist Paradigm.” They urge a push toward a less anthropocentric paradigm

30 See Kruse 1999; Alger and Alger 1997,1999; Sanders 1993 for this analysis of Mead.
which recognizes, among other things, that “human beings are but one species among
the many that are interdependently involved in the biotic communities that shape our
social life” (45). The larger purpose of this research is inline with that agenda.

In Defense of Animal Agency

Some sociologists have recently taken up the quest to show that humans and
‘other’ animals do have “authentic social exchanges” and that ‘other’ animals can
symbolically interact with humans. In other words, ‘other’ animals have the ability to
take the role of the other, are minded social actors, and possess the ability to share
definitions of reality with humans; even altering the definition of the situation to their
desired ends. They argue that this “common” human and animal ability is “proof” to
animal subjectivity and is the basis for their argument that ‘other’ animals are worthy
of sociological study.

Janet and Steven Alger, for instance, conducted an ethnographic study of a cat
shelter (1999) and in-depth interviews of 20 “cat-owners” (1997) to counter Mead’s
(1934) assertion that other animals do not possess the ability to symbolically
communicate. They argue that “humans and animals do achieve an operative
understanding that not only makes routine interactions possible but also provide
insights into the animal mind” (Alger & Alger 1999:201). These authors observed
(1999) and asked participants (1997, 1999) about things that their cat(s) did to

provide evidence for minded activity. Many of the stories told by participants and the
observations by Alger and Alger (1999) offer evidence that cats anticipate events and
have control over the meaning and action of gestures; two of Mead's (1934)
qualifications for self-awareness and symbolic interaction. For example, cats are
often described by participants and researchers as anticipating a trip to the
veterinarian even before the cat carrier comes out (the cats would hide). In addition,
many people noted that cats anticipate the arrival of the person whom he or she is
believed to be most bonded to (cat will run to the window or door before the person
even leaves the car).

Other research verified that many people believe (almost half 48% of all surveyed)
that companion animals anticipate the arrival of a human companion.\textsuperscript{32} Moreover,
experimental evidence suggests that these participants are right; 'other' animals do
anticipate the return.\textsuperscript{33} This anticipation is even noted before people walk out of their
work environment and at random times.\textsuperscript{34} What this suggests is that an empathic
bond can exist between the species.\textsuperscript{35}

Alger and Alger (1999) not only found that other animals could anticipate events,
but also have control over the meaning and action of a gesture. One cat learned how
to ring the doorbell when he wanted to come inside and many cats figured out on their
own how to open cabinets and doors to get where they wanted to go or to inform

\textsuperscript{33} Sheldrake 1999; Sheldrake and Smart 1997; 1999.
\textsuperscript{34} Sheldrake and Smart 1999.
\textsuperscript{35} For empirical and theoretical discussions on empathy between species, see Jensen 2000; Sheldrake
and Smart 1999; Hogan, Metzger & Peterson 1998 (eds.); Tobias & Solisti-Mattelon 1998 (eds.) and
people that they wanted food. The authors provide further evidence of the ability to have control over the meaning of a gesture using an action controlled by their own cat, Casey:

In good weather we took this elderly cat for a walk, always putting a collar on her. Generally, we took the collar off as soon as we returned, but on this day we forgot to do so. About an hour later, we were standing in the kitchen talking when Casey came in and placed her front paw on Steve's foot. Every time Steve tried to move back she followed and kept her paw on his foot. We laughed and dropped to the floor to ask what she was doing and only then saw her collar was stuck in her mouth. We had to cut it off to free her. Casey had realized that we would be able to help and communicated her need to us. (74)

Another part of symbolic interaction according to Mead (1934) is the ability to have an internal conversation – to weigh the possibilities between actions. In other words, to make choices. Alger & Alger (1999) found this in the actions of cats as well. Many human companions recalled times when their cat would wait for a preferred food or wait until no one was supposedly looking to do something considered against the house rules. According to these researchers, “though these animals did not have a conversation with themselves in human language, they seemed to their owners to be making mental calculations based on memory, taking the role of the other, and assessing further consequences” (74).

Clinton Sanders (1993) takes a slightly different approach to counter Mead’s assertion that humans and ‘other’ animals can not engage in social interaction. He approached the study of “canine-human relationships” using three different sources: autoethnography of his relations with his dogs over a four-year period; a nine-month participant observation at a veterinary hospital where he talked to clients and
observed relations between “owners and their dogs” in the exam room; and semi-structured interviews with 24 “dog owners.” His major goal was to provide evidence that “caretakers” believe, through experience, that humans and dogs engage in “authentic social exchanges.” Authentic social exchanges, according to Sanders (1993) basically consists of four elements all revolving around the recognition of the other (dog) as having a distinct “humanlike” identity. This identity construction is similar to the construction of identities of human “disabled” family members (Bogdan & Taylor 1989).

The “dog-owners” first “attribute thinking” to the dog. The “owners” believed that the dogs were “minded social actors.” That is they had at least an elemental ability to make cognitive choices between behaviors, “acted in ways that were thoughtfully intended to shape the owners’ definitions of the situations and to manipulate their subsequent behavior to desirable ends” (214). Second, the “owners” regarded their dogs as distinct individuals. For example, each dog was reported as having specific likes and dislikes—preferences for specific food and toys. Third, the “owners” recognized the dogs as emotional and reciprocating beings. Dogs were described as feeling lonely, angry, sad, and even vengeful. Moreover, they seemed to have a “conscience” in that they understood the house rules and felt guilty when they broke them. A simple example that many of us can relate to is when a dog pees in the house. This is a breach of house rules in many American households. Typically, the dog will put his/her tail between his/her legs and cower when the person discovers it—even before a word is exchanged. Sometimes, the dog is hiding before the person
even notices the breach – indicating a knowledge of the rules and an emotion that “I did something wrong.” In addition, caretakers came to believe that the dog reciprocated feelings of love and affection: “He loves me and I love him.” Finally, because the caretakers defined the dogs as minded individual, emotional and reciprocating beings the dogs were regularly incorporated into “the rituals and routines that symbolize and constitute owners’ daily lives and intimate social networks.” As such, humans and dogs are routinely engaged in authentic social exchanges. I believe that Sanders sums it up quite nicely using an example, early in his research:

As I write these words, for example, one of my dogs comes to my study and stares at me. She then walks back down the hall to the door opening onto the porch and rings the bell she uses to signal her desire to go outside. Because I am not immediately responsive, she returns to my study, pokes me with her nose, and returns to the door. Grumbling about the intrusion, I get up, open the door, and she goes out to lie down in her usual spot.

I maintain, and the dog owners presented below would maintain, that the most reasonable interpretation of this mundane sequence of events is to see it as an authentic social exchange. My dog has encountered a problem, realized on the basis of remembered past events that my actions hold the potential for solving her problem, purposefully behaved in a manner that effectively communicated her “request,” and, in so doing, shaped my behavior to her defined ends. (211-212)

According to the above researchers, these findings are not surprising to people who live with and interact with cats or dogs on a daily basis.

**The Present Study: Encountering Context**

While the above sociologists worked to defend the inclusion of ‘other’ animals through the common human ability of symbolic communication or social exchange, I
argue that this tactic is a defensive sociological maneuver. This tactic for inclusion is akin to the liberal feminist position that women, like men, are rational and therefore deserve equal rights. Defending ‘other’ animal subjectivity from the sociological standpoint might present a distorted version of social reality from both the ‘other’ animal standpoint as well as the human member’s standpoints. ‘Other’ animals are indeed similar, but they are also different. Therefore, we should expect that interactions between humans and ‘other’ animals will be significantly different (not only in nature, but in social power) than human-human symbolic interaction.

Although, I extend the above research by showing that many human participants in the veterinary institution do utilize the above definition of animal subjectivity and act on this, they also draw from another definition of animal subjectivity framed in part through the ideological frameworks within the institution. This subject is defined as having the ability to suffer, and that suffering will be more rampant outside of human control. So, while the felines are, as the above researchers claim, minded, emotional and reciprocating beings--like adult humans--like human children they are not able to defend or even define their own best interest. Unlike most human children, these subjects remain dependent ones. In addition, unlike human children these subjects are legally regarded as objects. This ambivalence itself is structured within some of the institutional ideological frameworks and presents considerable emotional conflict in many human-feline encounters.

The above researchers aim to incorporate other animals into sociological investigation through common human and animal abilities, which defends them as
subjects. I aim to incorporate ‘other’ animals into sociological investigation by
drawing out their observable social experiences that are in part structured by an
ideological framework whose underlying assumptions privileges human control over
them by legitimizing this control in their best interest. Often, when people think
about control over another, the assumption is that the encounters will be riddled with
conflict and tension. In contrast, some people believe that affectionate and mutually
rewarding encounters are derived from an attitude that recognizes the ‘other’ as a
subject with interests that ought to be respected. From my perspective, this is just the
position that Arluke & Sanders (1996) make in the excerpt below:

the behaviorist perspective allows humans to maintain the psychological distance
necessary to exploit animals ruthlessly, untroubled by feelings of guilt while still
retaining a view of humans as a qualitatively unique category of being.

On the other hand, the natural attitude in which companion animals and other
nonhuman actors are regarded as minded, emotional and intentional—and whose
orientations and interests can be spoken for with some degree of validity—has the
practical utility of allowing the construction of effective mutually rewarding patterns
of social interaction.

Nevertheless, I found that “mutually rewarding” encounters could occur within
relationships centering on human privilege and control over nature. I also found that
people can explicitly define and act toward a feline as a “minded, emotional and
intentional” being and the social encounters can be mutually unrewarding. In other
words, I depart from the research described above in the sense that I examine not only
how the subject is defined and created, but also how the feline subject’s and the
human subject’s social encounter is shaped by other social factors.

While how humans come to “know,” nature, including ‘other’ animals, is no doubt
an important element in the structuring of social encounters with others, this
'knowing' is not the only structuring element, as we do not encounter each other in a vacuum. In other words, this interaction occurs in a social context that must not be ignored when examining the encounters themselves. As I pointed out earlier, the human cultural construction of 'other' animal identity, as family member versus tool for example, was shown by other researchers to influence the social practices, perception of these practices, and ideas of humans about 'other' animals. For example, drawing from both archival and experimental data, Rajecki, Rasumussen, & Craft (1993) found that people are more likely to accept some practices toward animals if that animal is labeled "companion" than if the animal is labeled "farm animal." In 1983, for instance, people protested, and temporarily halted, the use of "companion" animals as targets for military weapons training. This training, however, was reinstated without protest when the targets were changed to "farm animals." More significantly, using the same species, their experimental data showed that people evaluate the cruelty and suffering, and altered their willingness to participate in animal practices by the labels applied to the animals. Likewise, Arluke & Sanders' (1996) report that the same laboratory technician can dissect a "lab" dog and simultaneously indicate that they would never do such thing to a "companion" dog.

In the present research, I argue that these categories do have an impact on human action toward felines (as the research implies), and thereby influences the encounter themselves. However, these cultural categories alone are not enough to either explain human action toward felines or describe the complexity of human-feline encounters.
Rather, these cultural categories are embedded within ideological cultural frameworks, the underlying assumptions of these frameworks and the consensus and conflict that accompany them, interacts with these categories in different ways to produce differing social encounters between humans and felines. Finally, while cultural categories and the ideological frameworks help to structure the encounters, the role that the doctor plays, the age of the patient, and the presence of the client can also influence both humans' and felines' social experiences within the veterinary hospital. In other words, I argue that human-feline encounters within the hospital are a product of multiple interacting social and social psychological factors. The major social factors explored in this study include ideological consensus/conflict, role of the veterinarian, client presence, feline age, and cat status. The social psychological factors most significant in this study and important elements of human-feline encounters in a veterinary hospital include the social construction of feline identity and the tension management strategies employed by staff members.

Research Presentation

This research comprises eight chapters. Chapter two presents the basic conceptual framework that this research stands upon. Because human-feline encounters are an under-explored social phenomenon, I draw upon a variety of theoretical positions to underlie the concepts that I utilize throughout this research. In chapter three, I orient the reader to the place where I conducted most of my research. I point the reader to
important key social and material features of this specific veterinary hospital, including the kind of hospital and the participants involved in the various types of human-feline encounters. In this chapter, I also outline the methods that I employ to better understand the nature of human-feline encounters and how the social conditions shape them. Specifically, I present an overview of how I gained entry into the field, what roles that I played in the field to maximize observations and comprehension of member meanings, how I maintain the confidentiality of the participants, and how I recorded and analyzed my observations from the field. Because my research is complemented by a qualitative content analysis of the *Journal of American Veterinary Medicine*, I also describe why and how I utilized this analysis to better understand the role that ideological frameworks have on everyday encounters.

After I laid out my conceptual framework in chapter two and described the setting and method in chapter three, I move on to present my findings in chapters four through seven. To evidence my claim that human-feline encounters are a product of multiple interacting social and social psychological factors, each of the findings chapters, four through seven, presents a different medical practice. I organize the findings chapters in this way because this is how the participants primarily organize their social encounters in the veterinary hospital.

Chapter four presents the medical practice of preventative health. In this chapter, I outline the ideological framework for this practice instituted by the larger veterinary institution paying close attention to the underlying assumptions that, similar to those
found in sociological practice, draw a strict divide between culture and nature. Given this strict divide, I show how the feline subject, that the clients are expected to be responsible for, are socially created by rescuing them from nature and drawing them into the domestic and civic realm of human culture. I also show that most human participants in the veterinary hospital agree with this institutional framework that preventative health is in the patient’s best interest and how this consensus is maintained in the local setting. Finally, I present the most significant human-feline encounters that I found to be largely structured by the ideological framework and the social consensus. While the ideological consensus appears to be the primary structuring force within these encounters, the feline experience is more immediately dependent on the presence of the client than on the human constructed frameworks in which these encounters occur.

Chapter five introduces the medical practice of neutering. The ideological framework of the practice of neutering involves a solution to a social problem—feline overpopulation. As such, I present how human participants following the larger veterinary institution come to define and understand this practice as in the best interest of feline populations. Similar to the practice of preventative health, both staff members and clients are in agreement that this practice serves the best interest of the patient. This consensus seems to draw the human participants into a moral crusade that enables them to ignore the patient’s own definition of the situation. Given that observable feline experience is more immediately dependent on the presence of the client, and neutering is a surgical procedure that separates patient from client, felines
are more likely to experience a significant degree of tension during neutering than during preventative health. However, the degree of tension experienced by patients is not solely dependent on client presence. Indeed, I show that this tension and reciprocated affection by staff members is often also associated with the social status of the patient. In this chapter, I explore the various reasons why this association appears to occur and how the medical ideology, social status, and the age of the patient are actually interrelated. To complicate matters further, the doctor’s role has an indirect influence on the social encounters, but this influence too is interwoven with the ideology of neutering. I also present how patients challenge the definition of the situation that neutering relieves suffering and how staff members work to maintain that definition both for themselves and for the client.

In chapter six, I acquaint the reader with the medical practice of declawing. While the larger veterinary institution in the United States, as well as the owner of the hospital, supports and engages in this practice as in the patient’s best interest given the structural inequality between the species, there is little consensus among other staff members and clients that it does. As such, staff members created a local framework better enabling them to deal with the situation of participating in this practice while simultaneously protecting their self-identities as people who care for rather than engage in harm to felines. Similar to neutering, declawing is a surgical procedure. As with neutering, felines are notably upset and frightened in this context. However, unlike with neutering, because of the ideological conflict between whether this practice is in the patient’s interest, staff members have greater difficulty ignoring
the feline definition that this procedure is not in their best interest. In this way then, the ideological conflict between humans enables patients to have a greater influence on the staff members’ social experiences and definitions. However, because of staff member’s reliance on tension management strategies (that I outline in this chapter), the patient’s influence stops at the immediate social encounter – their definition does little to influence the outcome of the encounter itself. Finally, I found that the role that the doctor plays tends to produce significantly different social encounters in the context of ideological ambiguity as it does in the context of ideological consensus. It seems that the less certain staff members and clients are about a cultural practice, the more they look to the doctor to model their behavior toward the patients.

In chapter seven, I introduce the medical practice of euthanasia. In this chapter, I present the institutional framework that blends differing definitions of feline identity. On one hand, euthanasia is used to reduce the suffering of a subject. On the other hand, the institution leaves it up to the property owners of the feline (client) and the hospital (Owner-veterinarian) to make case by case determinations of life and death of this property-subject. Unlike declawing, the owner of the hospital does not choose to employ the blanket institutional framework (it is up to the owner), but leans heavily on a locally constructed ideological framework that better equips him and his staff members to deal with some of the emotional consequences of this practice. While this local framework helps to structure the encounters, there is little consensus among humans about where the line should be drawn.
In chapter seven, I also present the various types of social encounters associated with euthanasia. I show how it is not the end result of the practice (death) that presents emotional conflict among humans, but rather the uncertainty that what they are doing to the patient is best for them. While staff members are often uncertain about this practice, they do not resist (decline to participate) even when they define the patient as "completely healthy." This lack of resistance attests to the powerful social-psychological impact that tension management strategies can have on human action towards 'other' animals. Again, as with other medical contexts, the feline experiences with death, are more immediately dependent upon on their physical illness, human reciprocity, and physical contact. However, I show that while humans are more directly involved with their ideological and cultural constructions, and felines are more directly involved with the material sensations, these material and ideological forces reciprocally interact with each other to produce significantly differing social experiences for both humans and felines. In other words, while human social constructions are created and maintained by humans, they are experienced, challenged, and reconstructed by felines. While feline life and death are dependent on human action and the cultural constructions, together, humans and felines, create the encounters.

All in all, the picture that should emerge is that when certain social conditions are combined there is a tendency for certain types of human-feline encounters in the veterinary hospital. In chapter eight, I discuss how these social conditions are combined to form a greater relationship that perpetuates human privilege over nature.
I also discuss the implications that human social consensus has on the human-feline relationship. In addition, I point to future avenues of research as I explore the limitations and implications of separate social factors. Finally, I present my concluding remarks about human-feline encounters in the veterinary hospital.

What I found, and I hope that the reader will come to appreciate, is that human members care for the feline members as individual subjects deserving respect. This attitude toward the felines can result in mutually affectionate social encounters. However, while the social structure can enable these mutually rewarding encounters, it can also constrain them. In the current U.S. structure, the feline is simultaneously an object and a subject. While human members defend feline subject identity, they are sometimes constrained by the structure to act toward the feline subject as an object. This constraint often presents mutually unrewarding encounters. People care about animals and define them as subjects but the context of the situation often constrains them to action that they might not have taken given another social context. Felines have voices and are often heard by the humans who care for them, but sometimes their voices are muted by the neutralization techniques that human participants employ to deal with the social conditions that constrain human caring action. I leave this chapter with a quote from Martin Buber (1970:69).

~ The It is the chrysalis, the You the butterfly. Only it is not always as if these states took turns so neatly; often it is an intricately entangled series of events that is tortuously dual.
CHAPTER 2

CONCEPTUAL FRAMEWORK

Encounters in Context

The specific focus of this research is human-feline encounters that occur within the context of a veterinary hospital. By encounters, I refer to a "co-presence"36 of two or more actors (always including at least one patient) socially implicated and engaged in purposeful social action. Both Giddens (1984) and Goffman (1972) describe "co-presence" as involving the physical presence of actors.37 With felines in the veterinary hospital, however, the presence of a client can also be socially implicated. Cats do not bring themselves to the hospital. Even if only one staff member and one patient are physically present there is always another socially implicated human actor (be it either a paying customer or someone who just dropped the patient off on the doorstep) involved in any given human-feline encounter at the veterinary hospital.

These encounters encompass, but are not limited to a single face-to-face interaction, which I define as Goffman (1959/1978) does, as the “reciprocal influence of individuals upon one another’s action” (177-178). An example of an interaction would include a patient leaning up against a client and in noting the patient’s behavior

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and interpreting that behavior as a request for attention, the client bends down to pet the patient. An encounter, on the other hand, will include many such types of interactions revolving around a larger social purpose. The social purpose, for example, could include checking in a patient, drawing blood, or conducting an annual checkup.

The Nature of Human-Feline Encounters

In studying human-feline encounters, I wish to point out that, like Thoits (1989) and Hochschild (1990), I take the perspective that humans are not simply rational social actors, but “what we feel is fully as important to the outcome of social affairs as what we think or do” (Hochschild 1990:117). Moreover, as Martin (1999) indicates,

> Emotions are feelings that people experience, interpret, reflect on, express, and manage (Thoits 1989; Mills and Kleinman 1988). They arise through social interaction; are influenced by social, cultural, interpersonal, and situational conditions; and are managed (112)

by people in everyday life both in public and private. Because of this perspective, the dimensions of the encounters that I became particularly interested in during the process of this research include the interactional dynamics and the tension involved in the encounter. By interactional dynamics, I include the reciprocity and displays of affection between human and feline participants. Reciprocity refers to the degree to

37 See also Lofland & Lofland 1995:105.
which actors are mutually engaged throughout the encounter. If, for instance, a client and a doctor discuss a patient’s medical condition without indication of noting the cries or the movements of the patient (i.e. do not look at or touch the patient in response to the patient’s behavior), then reciprocity was noted to be absent. Likewise, a human participant might attempt social contact, such as speaking to the patient and the patient may fail to respond repeatedly to these efforts. Finally, reciprocity is absent when human participants and feline participants do not attempt, during the process of the encounter, to engage each other.

The dynamic of reciprocity was brought to my attention as I began to note its regular absence under certain contexts. The interactional dynamic of reciprocity is an indication that the ‘other’ is valued enough to respond to. I conceptualize the significance of reciprocity in a similar fashion as Carl Couch (1989) describes the importance of social responsiveness between humans.

Whenever people are mutually responsive, there is at least a minimal merger of self and other. Each indicates that he is implicated with the other and or is willing to become implicated with the other. Each indicates the other is worthy of a response, and a degree of autonomy is surrendered. When people are mutually responsive, they indicate to each other that they are willing to associate with the other.

Whenever people are socially responsive, they indicate the other is of some significance. Even when two people snub one another, each indicates the other person has been noted and is of some significance, even though only negatively so. (52-53)

Granted, we cannot know with any certainty that the patient’s failure to respond regularly throughout an encounter is an indication that he/she thinks that the humans involved in that particular encounter is worthy of attention. However, a lack of reciprocity from the patient toward a client or a staff member could indicate an
increase in stress, a lack of social bond with the client, or distrust toward the staff member.

As Couch (1989) mentions, reciprocity can exist without displays of affection. Displays of affection are one significant interactional dynamic that I attended to during the process of this research. Affection is generally understood to be a feeling state that indicates a positive regard of the other and includes nurturing or attentive social contact such as speaking warmly to, hugging or kissing. The motives behind displays of affection are typically in-line with Max Weber’s (1968) description of affectual social action as “consciously or unconsciously” motivated by “emotions or feelings” (24-25). The intention of such action is to connect to the other for a pleasurable feeling. However, I would like to point out that affection can also be motivated toward an “instrumentally or value-rational” (Weber 1968) end or purpose. For instance, sometimes I am affectionate toward my son or my cat simply to calm them down or to comfort them. In this sense, affectionate social action would be a “mixed” type of social action (Weber 1968).

The importance of affection within human encounters has been explored by early social psychologists. Couch (1989) noted that affection is an important element of sociability as well as early childhood physical, emotional and social development. Affection between humans and other animals has been similarly recognized as an important element in human-‘other’ animal encounters. Indeed, displays of affection are one indication of the bond that humans have with ‘other’ animals (Luke

38 Spitz 1946; Bowlby 1973; Harlow 1959.
1992/1996). According to some human-animal Interactionists,\textsuperscript{39} one such display indicating the attachments that humans have with ‘other’ animals is the common referent to companion animals as members of the family. Stephens & Hill (1996) suggest that references to a companion animal as “baby, child or kid” or references to human self as “mommy or daddy” are affectionate displays that indicate a strong social bond. While this kinship “metaphor” is not utilized cross-culturally (Sabloff 2001) where humans are also found to report attachment to ‘other’ animals, and may therefore call this relationship into question, it is a particularly salient “metaphor” in the United States and Canada (Sabloff 2001). Survey statistics indicate that anywhere between 70 (Beck & Katcher 1983) and 93 percent (Katcher & Rosenberg 1979) of respondents claim that their “pet” is a “member of the family.” Moreover, in her ethnographic research (conducted in different settings in Toronto, Canada at varying times over ten years), Sabloff (2001) contends that “every interview I conducted with people who kept pets yielded a reference, implied or explicit, to the pet as a member of the family” (58-59).

Social contact such as petting and holding is another such display of affection that indicates attachment to ‘other’ animals. For instance, in an effort to understand the connection between the degree and type of social contact and human-‘other’ animal attachment, Smith (1983) observed more than 20 hours of human-dog interactions within ten different households. He found that participants reporting less attachment also failed to spend much time engaging in affective social contact with the dog.

\textsuperscript{39} Alger & Alger 1997; Arluke & Sanders 1996; Sanders 1993.
Moreover, the dog reciprocated this lack of social contact. In other words, the lack of affectionate displays was often mutual; the dog spent relatively little time initiating contact with that person. A good indication of the popularity of this thesis is that one of the most notable research tool to measure the “human-animal bond” developed by Poresky et. al (1987) referred to as the Companion Animal Bonding Scale (CABS) includes, in an eight item scale, the degree to which a person has physical contact (stroked, pet, held) with a companion.

Generally, researchers assume that this bond or attachment that is partially evidenced through displays of affection will increase the positive experience of an encounter for both humans and ‘other’ animals (Corson & Corson 1981). In fact, a significant amount of research has been devoted to exploring the possible positive correlation that this bond has in a variety of human developmental, psychological and physical health. To a much lesser extent, researchers have considered the possibility that this attachment and the displays of affection that indicate such bonds might also have a positive effect on the animal other as well. As Corson & Corson (1981) remark, it is a common understanding that “many domestic animals like to be petted and that such petting is apparently pleasurable both to the animal and to the human” (152).

To my knowledge, only two empirical studies have undertaken the task of empirically verifying that a bond exists from the side of the ‘other’ animal and that this bond is mutually beneficial to both human and ‘other’ animal. From her
observations of human-'other' animal interactions in her veterinary hospital and
interviews with clients, Voith (1981) observes that

pets indicate that they are also attached to owners. An animal may follow an
owner within a house, always staying in the same room as the owner. When
separated from an owner, it may howl or engage in escape behaviors. Some pets
become very quiet, stop eating, and look despondent when there is prolonged
separation from an owner. (273)

In his experimental study of the interactions between patients with high blood
pressure and "their pets," Katcher (1981) provides evidence for the mutual effect of
affection, specifically social contact such as petting and stroking on both the ‘other’
animals and the person’s blood pressure and heart rate. His study indicates that
affectionate human-'other' animal encounters can have the effect of comfort and
pleasure. In other words, this affectionate exchange is mutually beneficial and is a
positive experience.

Three studies can be extended to support the contention that humans and ‘other’
animals can and do have affectionate exchanges, are mutually attached, and these
exchanges are pleasurable for both humans and ‘other’ animals although it was not
the main purpose of the research.40 This lack of reciprocal evidence is
understandable, given that the focus of social scientific research centers on human
social behavior and not ‘other’ animal social behavior. However, given that humans
and ‘other’ animals encounter one another, I would suggest cross-disciplinary
research (social scientific and ethological) to balance out the bond research. In any
case, it is important to note that displays of affection combined with reciprocity, are
an indication of respect for the patient by the staff member and the client, and a stronger social bond between the client and the patient.41

Does attachment or a social bond necessarily lead to a positive encounter? I would suggest that while affection can indicate attachment to a social other, attachment does not necessarily lead to a positive experience of an encounter. Research on domestic violence and animal abuse certainly provides evidence to support this contention. Some batterers claim to be attached to the children that they abuse (Silverman 1996). Likewise, some batterers claim to regard their abused “companion animal” as a “member of the family” (Flynn 2000). In other words, humans sometimes hurt the ones that are reported to be “members of the family,” and “companion” animals are vulnerable to domestic violence.42 The point that I am trying to make is that attachment does not necessarily lead to what I refer to as an affectionate encounter. Affection (including being regarded as a member of the family) that is not reciprocated does not necessarily lead to a positive experience of that encounter.

Tension in Human-Feline Encounters and Tension Management

On the reverse side of affectionate encounters are those riddled with tension. Tension can arise in any social encounter, particularly in a public setting where conflicting ideologies and expectations are present. Tension is defined here as a state of physical and/or emotional and cognitive unrest arising between participants but

41 Poresky et. al 1987; Siegal 1993.
experienced by the individuals. In other words, for an individual, tension has both a cognitive and an affective element including both an “appraisal of a situational stimulus or context” (Thoits 1989: 318) and uncomfortable feelings such as guilt, fear, anger, sadness, and anxiety. Of course, as Thoits (1989) points out in her discussion of emotions, one can “be afraid and not know why” (318). Also, particularly with young children and ‘other’ animals who can not communicate their cognition to researchers, one can not always retrieve the cognitive element to the tension. However, lack of retrieval by the researcher does not mean that there is no cognitive element. If a cat is shaking and hissing, generally that cat has appraised the situation as dangerous. Maybe the cat’s appraisal is mistaken in that the intentions of those around him or her are mundane, but that does not mean that no appraisal has taken place.

Between humans, sociological research has made significant advances toward understanding the nature, sources, and management of tense or “problematic” encounters. However, little is known about the nature, sources, and management of problematic encounters between humans and ‘other’ animals. To explore what I refer to as tense encounters, between humans and felines in a cat hospital, I draw from three empirical trajectories: the problematic situation, the emotion management perspective and tension management within human-animal interaction research. From my perspective, a substantial amount of researchers have implicitly analyzed tensions between human participants in social encounters. One trajectory of such

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research has taken the form of research on everyday “problematic situations” and the strategies or tactics used by participants to manage those encounters. From this research, we learn, for example, how physicians (Charmaz 1975) and coroners (Roth 1972) handle the tension arising from the death or announcement of a death of a patient. We also learn how the police handle the tense encounter involved with “bearing bad news” (McClenahan & Lofland 1976). In addition, we learn that providing emotional support and information to mothers of hospitalized children reduces the tensions involved in hospital encounters (Skipper, Leonard & Rhymes 1968). Moreover, clinical staff members that are ineffectively provided with adequate coping mechanisms such as social support (Mechanic 1974) are subject to “burnout.” Burnout is a product of sustained tension within the field. In other words, what we learn from these studies is how specific social conditions can produce or reduce tension within an encounter. Also significant is how things we do or experience within specific occupations, which can feasibly be generalized to ‘problematic encounters” in everyday life, like dealing with bad news or death, can impact the encounter and what strategies are engaged in to ‘deal with’ with certain social situations.

Another trajectory of social research that engages the analysis of tense encounters between humans is generally referred to as the emotion management perspective. This perspective was inspired in part by Erving Goffman’s (1959, 1974)

43 Here Peggy Thoits (1989) is describing one of the four components of emotions generally used by social researchers.
44 See Lofland (1979) for an excellent collection of empirical work on a wide variety of generic situations, including how tension is managed in some of these situations.
“situationism” which recognizes that individuals are constantly and actively negotiating social action (Hochschild 1979). This work also had a significant impress on the empirical and theoretical discourse relating to the “problematic situation.” Another Goffmonian (1959) insight taken from this perspective is the recognition that people work to manage their impressions of others; including emotional displays. Although Goffman has since recognized the limits of his dramaturgical metaphor, he argued early on that people, like actors on the stage could render even their emotional expressions appropriate to the situation. These two sociological insights laid a great portion of the foundation of Hochschild’s (1979) theory of “emotion work.”

According to Hochschild (1979), Goffman’s actor failed to look inward and therefore her theory also draws partially from Freud’s “theory of self” in that humans have a defense system that enables them to recognize ‘inappropriate’ and unpleasant feelings. Freud theorized that this ‘defense system’ was an unconscious entity and that inappropriate feelings were measured against some abstract ideal. In contrast, Hochschild theorized that humans recognized ‘feeling rules’ that were socially constructed as ‘appropriate to the situation’ and consciously worked to change them according to the social norm of the situation. As Hochschild explains,

...the emotion management perspective fosters attention to how people try to feel, not as for Goffman, how people try to appear to feel. It leads us to attend to how people consciously feel and not, as for Freud, how people feel unconsciously. (560)

Her theory of emotion work, labor, and feeling rules takes on a broader perspective within sociology, a perspective recognizing that emotions are not necessarily

uncontrollable unconscious entities, but are socially constructed, constrained, and managed behaviors.

This “emotional labor” which is gendered, seldom recognized as an explicit part of the position, and materially compensated for is used not only to alter the feelings and/or emotional displays of the employee, but also to manage the feelings of the client, customer, or patient. From this perspective, we also learn that emotions can be commodified on the job and sold to clients as wait staff, airline attendants, cashiers, and Disney personnel are expected to “put on a smiling face.” In addition, doctors and nurses are expected to perform a different type of emotional labor than those occupations regarded as “service work.” Doctors are expected to be more serious and display a certain “affective neutrality” (Smith & Kleinman 1989), and nurses are expected to display caring and empathy for the patient. The significance of examining emotion management strategies across occupational settings is that the social strategies used to change feelings of self or others is shaped, in part, by the context of the encounter. However, I would guess that the occupational atmosphere – the institutional feeling rules – are not the only significant context.

From this perspective, it is also theorized that these specific occupational demands cause tension in the lives of the individual participants (Hochschild 1983). Erving

46 Steinberg & Figart 1999.
47 Jacobs & Steinberg 1990.
48 Hochschild 1983; Steinberg & Figart 1999.
49 Hall 1993; Paules 1996; Steinberg & Figart 1999.
50 Hochschild 1983.
51 Rafaeli 1989.
Goffman (1959) argues that people in organizations as in everyday life don a role or play scripts in order to convey a specific image of reality to the audience. Arlie Hochschild (1983) points out that having to play a role or perform a script, to create and maintain a particular image can be emotionally demanding. Because of the roles and scripts, a flight attendant for instance, must "work to suppress her feelings that such behavior [passengers flirting with them] is intrusive or demeaning" (94). In other words, the roles and subsequent scripts not only work to convey a specific image, playing it causes tension that is subject to emotion management.

One such consequence of this emotional labor includes "emotive dissonance"\textsuperscript{53} or as Wharton (1999) describes a "disjunction between different aspects of the person" (163). In other words, an employee may "experience certain emotions during their interactions with customers and clients but feel compelled to display other emotions" (163). While this may happen, Hochschild (1983) claiming to depart from Goffman, also suggests that the emotion management perspective may also be applied to employees who attempt to alter genuine feelings. Possibly, this perspective is only intended to apply to changes in feelings to conform to feeling norms.

A related consequence of emotional labor is referred to as 'burnout.' According to Amy Wharton (1999), "Burnout has been defined as the numbing of the inner signals of emotional feelings, reflected in the inability to create or feel any emotion (Maslach 1976; Maslach and Pines 1977; Maslach and Jackson 1982)" (162). Mattley (1998) suggests that 'burnout' is aided by roles and scripts which demand additional

\textsuperscript{52} Van Maanen & Kunda 1989.
“emotional labor of employees” (147). However, Martha Copp (1998) argues that ‘burnout’ would decrease if employees had social support. From this connection, we could ask the question: couldn’t roles and scripts provided by the employer then be a form a social support? Could this “professional capital” (Cahill 1999) be used as a resource for tension management, thereby actually reducing the amount of emotional labor that is needed throughout the day?

Before I became a sociologist, I was an actress. When I played a role, my focus was on the presentation of that role and not on the tensions that arose all around me. Backstage there were lighting, costume and prop problems, and emotional tensions between personalities in the field. On stage, people sometimes forgot their cues or forgot their lines. When I was playing a role, I harnessed myself through that role to only display the appropriate feelings. The role did not cause the tensions; they allowed me to manage them. This experience leads me to question the assumption that roles and scripts inevitably produce tension. Possibly, they could also be used as resources of social support that help staff members manage the uncomfortable feelings.

Implicitly drawing from the above two perspectives, Arluke & Sanders (1996) empirically analyzed data derived from an ethnographic study of a humane shelter to better understand the tension management strategies utilized by shelter employees who were expected to “put down” a large number of shelter animals. The larger goal

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54 With the exception of sourcing an idea about emotion management strategies reproducing institutional practice by Smith & Kleinman 1989, Arluke & Sanders (1996) use some of the words
of this specific study was to examine the assumptions made by Schleifer (1985) and Serpell (1986) that emotion management “tactics” are used by farmers and laboratory scientists to lessen the guilt involved in killing animals under their care. One such tactic is distancing self from other – objectifying the animal other before the killing takes place to armor oneself from the emotional experience of killing another being. This tactic then is supposed to “prevent any attachment to and empathy for animals...and to make killing ‘a reflex...’” (Serpell 1986, 152)” (Arluke & Sanders 1996: 83). There is some evidence indicating that this objectifying tactic has been used throughout human history to control, use, and kill ‘other’ humans55 and ‘other’ animals.56

This brings up a couple of questions: 1) Do humans necessarily ‘objectify’ other animals to deal with tension that arise in these encounters or are there other strategies used to deal with tense encounters? In addition, 2) Is the source of tension actually the practice such as euthanasia? In other words, are some practices inherently problematic or do tensions arise from some other source?

Arluke & Sanders (1996) suggest humans do not necessarily objectify ‘other’ animals to deal with the tension that arises from ‘problematic practices.’

Learning to cope with the uncomfortable feelings provoked by euthanasia in shelters is a complex social process. Feelings such as attachment, empathy, and loss were not eliminated but instead came to serve as coping devices that enabled workers to maintain a sense of themselves as people who liked and cared for animals...[F]ar

relating to the emotion management perspective (e.g. emotion management and feeling rules) but do not explicitly refer to their theoretical or empirical studies.
from being completely detached from their charges, all workers became uneasy at
times, although for different reasons, when their everyday noninstitutional identities
emerged at work. (83)

The source of tension for these employees was euthanasia itself, because the practice
conflicted with an individual’s self-identity as a person who cares for and about
‘other’ animals. However, that does not necessarily imply the practice itself was
problematic, though it was to by participants who regarded themselves as “caring
about animals.” Moreover, these employees did not distance themselves from the
‘other’ animals by objectification, but rather used a variety of other individual
emotion management strategies. Among these strategies, employees redirected their
focus from the consequences of the practice and their uncomfortable feelings to other
things. Among tactics include: blaming the clients, focusing on the adoptions rather
than the death, focusing on technical skills, focusing on the welfare of the ‘other’
animals, and trying to make the death the most comfortable for the patient by
empathizing with the patient.

Using empathy as well as blaming the client as a distracting technique was also
noted by Smith & Kleinman (1989) in their study of medical students’ emotion
management strategies for dealing with tense encounters. I must note, however, that
Smith & Kleinman (1989) found that many students and doctors sometimes
dehumanized/objectified their patients as an emotion management strategy depending
upon the situation. Therefore, sometimes staff members in their case do distance
themselves from patients as they manage uncomfortable feelings arising in tense
encounters. Distancing is one strategy, but not necessarily, the primary tension
management strategy used in an unequal power relationship. In any regard, I draw from the above theoretical frameworks to support the importance of tension as a defining element of human-feline encounters. I also use these frameworks to explore how staff participants manage their own tensions as well as those of the clients and the patients in order to maintain certain definitions of the situation that both support the practice ideologies and maintain the practices themselves.

Types of Encounters

Having previously discussed the ideas of affection, tension, and reciprocity as they apply to human-feline encounters, I will now discuss the types of encounters that are defined by the presence and absence of these social experiences. Focusing my analysis on dyadic encounters between the two most prominent social actors (client-patient and staff-patient) at any given time, each actor can feasibly have four different experiences. For example, a patient can express affection only, can experience both tension and express affection, experience only tension, or experience neither tension nor express affection. When I speak of affection expressed by the client or the staff member, I refer to those displays that are directed toward the patient only (not between the human members). However, the patient can express affection toward either the client or the staff. Feasibly, the total types of encounters experienced by these dyads then is 16.
Eventually, I hope that other researchers can employ this typology by collapsing these encounters into four types classified along a continuum from mutually affectionate (all expressing affection) to ambiguous (all experiencing both tension and expressing affection) to tense (all experiencing tension) to distant (none experiencing either tension or affection). However, for the purposes of this specific exploratory study, I wanted to preserve all three members’ experiences in order to understand if differing social factors influence the experiences of differing social actors. As such, I could not justifiably collapse them into this continuum. I provide examples from my field notes below, to describe the endpoints of the continuum as I see them as well as the blurred types between. When I describe these encounters in my finding chapters, I use the labels only when they appear as ideal types.

Mutually Affectionate Encounters

In the encounter below, the client-patient, and the doctor-patient each experience a mutually affectionate encounter.

Dr. Curtis is examining a stray that was brought in by a female client to have her mammary glands checked out because they appeared swollen. The woman is leaning against the exam counter and stroking the patient. She explains why she brought in what she refers to as a “warehouse cat” but the doctor refers to as a stray. “I just love animals so much that I thought since I work there someone should take responsibility of getting them checked out...and she should probably be vaccinated while we are here. I think that she is missing her kittens.” Doctor Curtis gently feels the patient’s glands and the patient begins to purr. He smiles down at her “you are so sweet aren’t you? Are you missing your kittens hmmm?” While the client and Doctor talk about stray cats they both stroke the patient and she looks back and forth between them and continues to purr.
Affectionate encounters have a distinctly relaxed atmosphere. One would expect this type of encounter to be associated with specific medical situations (such as when a patient is relatively healthy) or in the context of a close or “bonded” social relationship between clients and companions. However, as the example above reveals, these encounters can also exist outside of these social parameters.

**Ambiguous Encounters**

Ambiguous encounters are characterized by a display of affection (reciprocal or not) between a human and feline and the presence of observed tension. Below is an example in which both the client’s and the patient’s experience of the encounter is ambiguous.

In the context of an exam of a female patient who has not defecated in three days, the female client holds the patient in her arms, rocking her back and forth while speaking to Dr. X. The patient is trembling and looking between client and Doctor while they speak. When the client and the doctor determine that he should examine the lumps that the client had found near the patient’s anus, the client gently puts the patient down in between herself and the doctor. The patient freezes as he examines her and then lets out a long drawn out meow as she looks into the client’s face. The doctor lets the patient go and she quickly moves into the crook of the client’s arm. The client looks down with a smile and smooths out the patient's fur. The patient leans into the client’s hand. The doctor determines that her anal sacs had to be "expressed" meaning that he had to make a small incision and push really hard on the sacs to remove the blocked feces. The client’s face went white, “will that hurt her?” The doctor explained that it is “uncomfortable” but that it was “necessary.” While the doctor is in the middle of pushing on the sacs, the client stands facing the patient. I can tell that the doctor is pushing rather hard as he exclaims that it was the “hardest he had ever seen.” The client is rocking back and forth and she cringes each time the patient lets out a howl.

**Tense encounters**

Tense encounters are marked by a lack of affection (reciprocal or not) between human and feline participants and the presence of discernible tension. By tension, I
refer to clear bodily, expressive, or communicative indications from patient, client, or staff member that at least one participant is recognizably uncomfortable, or in Goffman’s words “uneasy,” through most or all of the encounter.

A male and female client walks briskly into the hospital and toward the reception desk. The man carrying a wriggling dusty white cat is frowning and struggling to keep the patient in his arms when finally he looks at me and sighs. The woman laughs nervously and asks the receptionist how late they are. As they spoke, the man, still struggling to maintain control over the patient, grabs her by the scruff of the neck, hands her over the counter and pushes her into my arms. “Here you hold her – do you want her?” The patient’s body is stiff and quivering, but she stops struggling once in my arms. The woman looks over and at me and says, “at least she stopped struggling now.” The man snorted and said “that’s cuz a woman has her...here give her back.” I reluctantly handed the patient back to him and the patient immediately began to struggle to get away. The man looked down at her “you made us late you know...you are still mad aren’t you? I guess I whooped you good huh?”

Distant Encounters

Distant encounters are distinguished by a lack of affection (reciprocal or not) between a human and feline and the absence of discernible tension.

In the back room where the patients await surgical procedures, I noted that a patient named Taisho who was brought in by a client for surgery sat far back in the cage throughout the morning. She appeared to watch me as I peeked in her cage but other than her eyes, she did not move. The veterinary technician came in soon after I had peeked into Taisho’s cage with an anesthesia shot. She quickly opened Taisho’s cage poked her with the anesthesia without complaint by the patient, closed the cage door and swiftly left the room.

Distant encounters can also include those encounters when one participant noticeably fails to attend to (ignore) the social cues of the other but no participant is notably tense.

A young couple waits in the waiting room while the receptionist checks them in. As they stand at the reception desk, the male client picks up the carrier and places it on the counter. He looks in and taps the carrier door. “Hey there, you.” The patient
simply turns away. The client stops tapping, shrugs his shoulders, and begins to talk to the receptionist.

**Contextual Influences**

During the process of my fieldwork, I began to note some significant social factors that appeared to be more or less associated with some types of encounters. As such, I narrowed my analytic focus on how these social factors influenced human-feline encounters. The most salient contextual condition I found was ideological consensus (or lack of) regarding medical procedures. The specific medical procedures referred to in this research include: preventative health management practices including vaccinations, parasite control, and weight management; neutering; onychectomy (declawing); and euthanasia. I now turn to brief definitions of these practices and then the operational definition of ideology and ideological consensus.

*Preventative Health Management*

Preventative health management includes a number of practices intended to protect the body from disease. In veterinary medicine, like human medicine "protection from disease" has largely centered on controlling the immune system through a process called vaccinations or commonly referred to as one type of ‘shot.’ The discovery of vaccinations is largely credited to Dr. Edward Jenner and Louis Pasteur. In 1796, Jenner “found” that after he injected a person with the material collected from a pustule of a small pox infected milkmaid that person became
immune to the disease (Richards 1996). Of course, this English physician was not the originator of this practice or the discoverer of the small pox vaccination – only the colonizer of it. In 1717, Lady Montague witnessed the “local practice” of “inoculation” practiced by local women in Turkey during her travels and wrote about it in her letters.57

According to James Richards (1996) the history of feline vaccinations is “far shorter” but has had a “dramatic impact” on feline health.

Prior to the development of effective panleukopenia virus (PV) vaccines in the 1930’s more than 50% of cats passing through adoption shelters developed panleukopenia with very high mortality. The early tissue-origin vaccine was quite crude by modern standard, but saved countless feline lives. Thirty years later, techniques were developed that allowed production of cell-culture-origin inactivated and modified-live panleukopenia virus vaccines that remain the basis for vaccines used today. A pneumonitis vaccine was developed in the 1950’s and in the 1970’s, vaccines were developed to protect cats against disease caused by FGV-1 and FCV. The first FeLV vaccine was licensed in 1985, and an FIP vaccine followed in 1991. More recently, an inactivated M canis vaccine has become available. Rabies virus (RV) vaccines play an extremely important role, not only in protecting cats from infection, but in helping to prevent spread into the human population. Some feline vaccines are considerably more efficacious than others...but all have, to some extent, improved the health of vaccinated cats and remain a valuable armament in the battle against infectious disease. (507)

Steele (2000) asserts that Pasteur “changed science and veterinary medicine” by creating a “new concept of the origin of disease.”

No longer would myth and spontaneous origin of disease guide society, even though there were as many objections to scientific advances then as now. The 1984 centennial celebration of Pasteur’s rabies vaccine was a tribute to the man...Pasteur was a genius who gave public health the science and vaccines to combat 19th century diseases and prepare his followers for the 20th century’s emerging problems. (1814)


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In the *Journal of the American Veterinary Medical Association* (JAVMA) which is regarded by veterinarians as the “official” journal of the *American Veterinary Medical Association* (AVMA) as well as the “legitimate voice” of the veterinary institution (Rollin 1999), annual vaccinations are considered an *essential ingredient* in the care of ‘other’ animals. They are constructed as a part of “responsible pet-ownership” and an important part of animal welfare.

According to the *American Veterinary Medical Association*, another “proper” way to care for companion animals, “to protect animal health,” is to keep the felines clean and free of internal and external parasites. External parasites that are frequently treated on felines include fleas and ear mites. These external parasites are commonly related to medical problems such as hearing loss, dermatitis, and devastating disease. Internal parasites include a large variety of what is lumped into one category and referred to by the lay person as ‘worms.’ Cleanliness is related to animal health in much the same way that it is related to human health. Germs are expected to prosper in an environment that is dirty and parasite ridden (Jerving 1999).

Finally, another growing part of preventative health in the veterinary institution includes the management of a feline’s nutrition and diet. This means feeding felines only food that is scientifically balanced, as well as making certain not to feed a feline too much. An author and veterinarian, Jerving (1999) indicates that this aspect of care is new to the institution.

58 The AVMA was established in 1863 to provide a “cohesive” and “legitimate” voice in veterinary medicine in government decision making, media, “pet owners,” and industry.
It is only relatively recently that there has been serious interest from the veterinary profession in the nutrition of companion animals. Finally, dietary management is the lifelong, daily control of nutrient intake to meet the changing needs of a pet both in sickness and in health (67).

**Neutering**

Neutering is the sex neutral term for the “surgical removal of an animal’s sexual organs” (Jevring 1999: 115). A female is “spayed” when her ovaries are removed and a male is “castrated” when his inner testicles are squeezed out of a small opening and removed. The practice is generally employed when a client wishes that the patient no longer reproduce and/or to reduce “sex-hormone related behaviors.” Some of these behaviors include spraying (territorial marking of urine), wandering (moving long distance to find mates), fighting (males will be aggressive to other males to protect their sexual territory) or calling (making sounds to attract mates) (Jevring 1999: 116-117).

**Onychectomy/Declawing**

If one looks to the medical texts on the practice of declawing the picture one would get would be a sterilized medical procedure devoid of context and agency. Onychectomy in veterinary medical terminology is the “disarticulation” or more frequently, the “bony amputation of the distal phalanx”59. This “elective surgery” is clinically described in Slater’s second edition of The Textbook of Small Animal Surgery on page 352:

The claw is extended by pushing up under the footpad or by grasping it with Allis tissue forceps. A scalpel blade is used to sharply dissect between the second and third phalanx over the top of the ungual crest. The distal interphalangeal joint is disarticulated, and the deep digital flexor tendon is incised. The digital footpad, is not incised. If a nail trimmer is used, the ring of the instrument is placed in the groove between the second phalanx and the ungual crest. The blade is positioned just in front of the footpad. The blade is pushed through the soft tissues over the flexor process. With the ring of the nail trimmer in position behind the ungual crest, the blade is released just slightly so that traction applied to the claw causes the flexor process to slip out and above the blade. At this point, the flexor tendon can be incised and disarticulation of the joint completed. Both techniques effectively remove the entire third phalanx.

Declawing is what the procedure is called on the local level. If you put your hands up to your face and look at your first knuckle – where your nails are – think of them chopped off. It is the amputation of that first knuckle.

**Euthanasia**

When a client and veterinarian agree that a feline is suffering physically and little can be done (either medically or financially) to provide relief, the veterinary institution advocates the practice of euthanasia to control that suffering. Euthanasia means “good death.” It means taking the life of someone with the least possible amount of pain and distress for that someone to put them out of misery. “Death should be induced as painlessly and quickly as possible” (McMillan 2001: 1204) with the “intent of the best interest” of that someone. Ideally, according to McMillan (2001), the term euthanasia was meant to incorporate two things: an intention of mercy from one, and severe suffering of another. Therefore, if someone is in horrible pain and can “no longer bear it” or has no “quality of life” (such that they can not live without suffering) then the release from that suffering is euthanasia with the
“unintended outcome” of death. In other words, the intent is to relieve severe suffering, not to end a life.

Ideological Consensus

The above practices within the veterinary hospital have a greater or lesser degree of ideological consensus. Ideological consensus refers to a general adherence to the larger institutional ideology relating to a particular practice. Ideological consensus also means the degree to which members agree within the local setting about the utility of a practice. By ideology, I employ a somewhat loose definition in the sense that I simply refer to a system of interconnected ideas or beliefs relating, in this case, to a specific practice. This definition is somewhat similar to that used by other social theorists. However, unlike the aforementioned theorists, I did not originally assume that this system of beliefs necessitates some domination of one class over another. In other words, in terms of human-'other' animal encounters, a practice ideology does not necessarily reinforce or perpetuate the interest of the more powerful class—humans. This was something to be explored rather than assumed. I agreed with Bloch (1986) that ideology is complex and could contain dominating as well as utopian ideals. In other words, the practice ideology could contain within it beliefs about the obligations and rights of both humans and 'other' animals, and it may be intended to serve both human and animal interest. What I found during my analysis,

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60 See for examples, Waitzkin 1989; Gramsci 1971; Lukacs 1971; Althusser 1971; and Habermas 1971.
however, was that the assumptions behind these frameworks, did indeed serve to privilege human control over felines.

Burkart Holzner (1968) argues that common frames and constructs unify different communities, including occupational communities. These common frameworks enable members to share a construction of reality from which general agreement about constructs make it easier to cooperate in a given institutional culture. One could extend his notion of common frames to include ideology regarding practice and infer that if in any occupational community there is a consensus regarding a practice, little tension would erupt and the encounter would tend more toward either affectionate or distant. Actually, this extension is in-line with other social theorists. As Hochschild (1979) explains:

"Drawing on Durkheim (1961), Geertz (1964), and in part on Goffman (1974), we can think of ideology as an interpretive framework that can be described in terms of framing rules and feeling rules. By "framing rules" I refer to the rules according to which we ascribe definitions or meanings to situations...By 'feeling rules' I refer to guidelines for the assessment of fits and misfits between feeling and situation (566)."

Moreover, these interpretive frames are not just cognitive; they influence the encounter in affective ways.

Rules for managing feeling are implicit in any ideological stance; they are the 'bottom side' of ideology. Ideology has often been construed as a flatly cognitive framework, lacking systematic implications for how we manage feelings, or, indeed, for how we feel. (566)

In this sense, I draw from Hochschild's (1979) extension of ideology to explore how ideological consensus in the first-degree (consensus with larger institution) shapes the
nature of those encounters – including the degree of tension that might occur – as well as how these tensions are managed.

Arluke and Sanders (1996) point out however, that “although the community may try to put a protective membrane around its knowledge, it is not impervious to the wide diversity of meanings in the larger society that its members can draw upon and express” (108). In other words, at the local level one might find shared practice ideologies with the larger institution. At the same time, it is possible to find ideological disparities within the local setting because participants may enter the field with their own ideas about the utility of a practice and whether or not that practice serves the interest of the patients. In each chapter, I explore what practices enjoy ideological consensus (and what the assumptions behind this framework entails) relating to the larger institutional framework and how this social context impacts the nature of human-feline encounters. I also explore what happens to practice ideology when the institution fails to provide a common framework for human participants to lean upon, and how this has an effect on the nature of encounters in a veterinary hospital.

While ideological consensus has an impact on the nature of human-feline encounters, I argue that ideology alone is not the only influencing condition on human-feline encounters. In order to provide evidence of such, I also explore four other social conditions that often interpenetrate with the ideological frameworks to shape the nature of human-feline encounters: the type of veterinarian, client presence, the age of the patient, and the social status of the patient.
Type of Medical Doctor

Bernard Rollin (1999), a philosopher and sociologist that works closely with veterinary medicine, explains that in veterinary school two distinct “models” or roles are provided for the students of veterinary medicine to use when they become veterinarians. He argues that, in his opinion, 90% of veterinarians today employ the “pediatrician” model. In other words, a significant number of veterinarians approach the encounter similar to that of a child’s doctor. In this sense, patients are generally treated as “members of the family” and clients are sometimes subject to lectures regarding patient health. Similar to human parents, who bring their children in to see the pediatrician, clients are lectured about proper nutrition, weight, and their role in behavioral problems. Humorously, Rollin (1999) points out that parents are not only subject to long lectures about child development, but also pay for these lectures. He suggests that, from his ethical standpoint regarding ‘other’ animals, veterinary doctors “ought” to use their Aesculpian authority to educate and influence client behavior toward ‘proper treatment’ of their “pets.”

The other 10% of veterinary doctors, Rollin (1999) argues, adopt a mechanical model of care. In other words, during their medical encounters they play the role of the mechanic. This “type” of veterinarian is concerned about the business of medicine and recognizes that the patient is the property of clients. The mechanic does not challenge the client’s unwillingness to pay or seldom questions the client’s type of care. The focus for this type of veterinary doctor is on ‘fixing’ and ‘maintaining’ optimum body health. Interestingly, as I was observing the two
veterinarians, I realized that each took a very specific role when they were in consultations with clients and patients - and these roles conformed quite substantially to Rollin’s roles of the pediatrician and the mechanic.

Dr. Curtis, the owner of the hospital, plays the role of the pediatrician. As the reader shall see in chapter four, he does use his Aesculapian authority to lecture clients about a patient’s health - particularly their weight. However, there are also other indications that he plays this role. For instance, he frequently interacts with patients as a pediatrician would interact with a child, speaking to them in a soothing voice. He employs short scripts in gentle tones to comfort the patient’s as he examines them; “oh what a brave kitty” is the most common. He also uses familial names as he speaks to the clients and the patients. I provide an example from my field notes below.

Billy and Bunny are brought back to have Bunny’s stitch removed. Dr. Curtis and I are in exam room one, with what he refers to as the “whole family.” The children and the female client take turns holding the kittens. Watching them with a smile, Dr. Curtis states, “what good little kittens you have there don’t you? They are getting big and strong huh?” When Billy is placed on the table, he [Billy] looks over at the woman and meows. The woman says, “awwww, it’s ok baby.” Dr. Curtis smiles and says to the patient “it will only take a minute...there now...it won’t hurt a bit...that’s a good kitty...what a brave kitty you are.”

Another way that this role is apparent is his references to a pediatrician and comparisons between child patients and feline patients.

When we enter exam room two, the female client is sitting down at the bench. She stands as we enter smiles, picks up the carrier at her feet, and places it on the counter. She opens the door and waits. After about thirty seconds, she looks in. “Come on out Boxer.” We can hear him growling from inside his carrier. Dr. Curtis laughs and says, “just like kids...they hate visiting the doctor.” The client laughs, shakes her head and reaches into the carrier, “that is enough you are going to come out now” she says sternly as she pulls him out and plops him in the middle of the
exam table. Dr. Curtis looks at Boxer, a rather large orange male cat, and states with a grin, "oh, boy. Your momma is not going to put up with much is she?"

Another encounter, when a client laments that it is "really difficult to give [her cat] medications...he just doesn't like to take them and just spits it right back out." Dr. Curtis replies, "yep, just like kids." In the context of giving a patient a vaccination, a female client visibly cringes as Dr. Curtis brings out the needle. He looks at her and says with a smile, "like a pediatrician, sometimes I have to calm down the parents as much as the patient."

Dr. X, the mechanic, approaches caring for felines with a distinctly different medical model than Dr. Curtis. In a way, this makes sense because his expressed motivation for entering the profession was out of interest in medicine while Dr. Curtis' motivation was out of interest in animals. Dr. X is concerned with the optimum health of the patient – not in their emotional needs. He works on the medical problem, engaging in a bare minimum of social interaction (with client or patient) as he constructs his medical solutions. While he is civil to the clients and respectful of the patients, his approach is a mechanical approach. Interestingly, Dr. X. actually compares himself to a mechanic on a couple of occasions. For instance, when I asked him what goes through his mind when a client is unwilling or unable to pay for a recommended procedure he makes this comparison explicit.

Well, I am thinking that it is their pet and it is their decision what to do. I tell them what they need to do to help their pet and if they don't want to follow my directions then it is up to them to decide. I don't believe in laying a guilt trip on clients for making whichever decision, they need to. I mean...if you go to the mechanic do you think that he gets upset when he tells you what your car needs to run efficiently? That would be crazy, [ise – expression revealing that my question was a bit "silly" to him], I mean it is my car why should the mechanic tell me what I should do with it?
Like a mechanic, I feel that the cat is the client's and not mine. I only practice medicine and tell them what I think that the cat needs, in order to improve its health. I am not here to judge them.

As he points out, his job is not to "judge" the clients on their decision. He is only practicing medicine. Caring for felines, to him means the improvement of the health of client property. I wish to point out however, that he does not believe that felines are objects. Rather he tends to take a more explicit moral stance that felines are less valuable subjects than humans are. A large part of why he may have a construction that is slightly different from the other participants in the local setting is simply because he does "not practice here on a regular basis." However, the approach is also derived from his moral stance (also in line with the institution) that animals are just that—animals, "cats die everyday" and humans "ought" to be accorded more value and respect.

The following field note excerpt outlines his moral stance toward animals. I was watching him spay a patient while I interviewed him. I must point out that during this interview Ezra and Nell are within earshot and are teasing him. This may have influenced his answers. I had just asked him if he describes the practice of declawing to clients who request it.

"Yes, but only if I am asked specifically." He shakes his head and sets down his tools. He looks at me and says "you know...those people who think that animals should be the same as humans have something wrong with them...I mean they must be mentally unstable." After a few minutes of teasing [this encounter will be described in more detail in chapter seven] he states with an exasperated expression at myself and then the two staff members present, "Well, that is how I feel. I just don't believe that animals should have the same rights as humans...come on...they are just animals."
Rollin (1999) argues that from an ethical standpoint, this role fails to challenge the subject/object relationship between clients and their patients, and will do little to challenge unethical behavior by the human toward the patient. Indeed, the mechanical model does fail to challenge the subject/object model, as it is defined by many sociologists (such as those described in the introduction), including myself. However, as I hope to show throughout the findings chapter subjects and objects often hold differing meaning in the everyday life of the veterinary hospital. To Dr. X, “just animals” does not mean that he is necessarily objectifying them. As I will make clear in chapter six, he does try to empathize with the patient’s perspectives. For example, he argues that declawing is better than the alternative of “cowering behind furniture afraid of getting yelled at.” He also added, “you must look at it from the cat’s point of view.” Although these patients are “just animals,” they also have feelings, a perspective, and some type of conscious.61 They are feeling subjects, who deserve to be treated with an element of respect and care. He is an animal welfare investigator, and it “makes [him] feel good that [he] is working at a job that protects their needs.” While his translation of their needs might be different than many of the other staff participants, it does not mean that, from his perspective, he thinks of them or acts toward them as objects.

Client Presence/Absence

I recognize that this social factor could have the effect of complicating the

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61 They are “afraid” and it is not just, because they are being yelled at, but “afraid of getting” yelled at.
definition of the encounter itself. However, by presence/absence of the client, I refer to the effect that having them there or having them absent has on the other two member's social experiences. This is because although, I present encounters involving various human-feline participants, I prioritize patient-staff encounters in my analysis. For example, is there a notable pattern to staff-patient dyads in the presence or absence of the client? In other words, are staff members more attentive to a patient's needs in front of the client or in their absence? Are staff-patient dyads more often tense as a result of the client’s absence? Are patients themselves more often notably tense during staff-patient dyads when they are away from the person who brought them to the hospital?

**Patient Age**

By patient age, I make a distinction between kitten and adult. I chose to examine this specific factor for two reasons. The first reason is that I began to note a qualitative difference between the way that some staff members and clients spoke to and acted toward kittens and adults (the way that affection is expressed). This difference is presented most explicitly in chapter five. The second reason comes from two empirical studies. In an analysis of how humans “talk about and interact with their pets,” Belk (1996) observes that several of his participants suggested that they lost interest in their pets as they grew out of kittenhood. In a historical analysis of dominance and affection toward less powerful others including pets, Tuan suggests
that the older the pet becomes, the greater the “temptation to destroy them” (88). I extended these observations to explore both the qualitative features of kitten-human encounters and to find out if kittens are more often associated with affectionate encounters.

**Social Status of Patient**

The last social condition explored in this specific analysis of human-feline encounters in a veterinary hospital is the social status of the patient. Particularly in sociology, investigations of how social status affects humans are expansive. Social status generally refers to “an individual’s standing in the hierarchy of a group based on the prestige, honor, and deference accorded to him or her by other members (Lovaglia & Houser 1996:868). Generally “high-status members” are accorded more opportunities and influences (“low-status members” are accorded less) upon the structure and within interaction and this impacts their own experiences as well as others’ evaluations and expectations. Therefore, differing status groups experience differing treatment in everyday life. So, for instance, women in a patriarchal society earn less than men, occupy less prestigious positions, and have differing expectations attached to the status that they occupy (such as the expectation to perform more caring labor than men) (Hochschild 1983).

Like all status groups, the status of ‘other’ animals carries with it particular expectations and rights. In modern Western societies such as the United States, ‘other’ animals occupy the lower-status position in relation to humans. This is clearly
evidenced in the ways that ‘other’ animals are used and treated within the larger social system. ‘Other’ animals are used as tools within the laboratory, as material to be used for human consumption, and are ‘disposed of’ when human companions deem them no longer suitable ‘family members.’ As a matter of fact, in the United States, ‘other’ animals are legally recognized as a special form of private property.

The legal status of animals as property is not surprising when the very language that a large segment of American population uses – the grammar that many of the children are socialized to believe is the “proper way to speak” objectifies animals (not to mention that it is also culturally insensitive). Simply go to a grammar book and look up to determine if the following sentences are constructed in a “grammatically correct” way:

\[
\begin{align*}
I & \text{ ran to the cat who cried for help.} \\
I & \text{ ran to the boy who cried for help.} \\
I & \text{ ran to the radio who cried for help.}
\end{align*}
\]

Depending upon the quality of the grammar check on your computer, you may also be able to plug these sentences into your computer and the grammar check will underline the word who in the first and third sentences. Why? Because after an “object” the “grammatically correct” word to use is “that.” A boy can be a “who” but a cat and a radio – as objects in the English language – can only be a “that.” Anyway, the legal status of patients as private property is important, given that in the United States medical services for both humans and ‘other’ animals are largely accorded to
those who can afford it, and those who can afford it are generally those individuals
who occupy higher status positions.

In the United States, human medical services are largely practiced under economic
conditions, which often constrain health care professionals to charge money in
exchange for their knowledge of health. This “fee-for-service” type of medical care
in human health has produced significant health care inequalities. Largely treated as
a commodity in the United States, adequate medicine is provided to those who can
afford it. While public pressure generates attempts at reformation of the health-care
system grounded in the social ethic that all humans have a fundamental right to
adequate health-care (seen in the forms of HMO’s, managed care, and public health
insurance), the reformations largely fail to provide equal access to this health care.
Moreover, many people “fall between the cracks” – are medically indigent – in other
words, they make too much money to receive public health insurance and not enough
to buy private insurance in United States health care system and frequently “go
without” (Weiss and Lonnquist 1997).

Much like human medicine, which exists within a corporate-capital complex, the
economic structure is such that private veterinary hospitals must generate income to
provide for their patients. Unlike human medicine, where there is at least a dialogue
(though inadequate) regarding equal access to health care, ‘other’ animals do not
even have the guise of rights to medical care. This is due to their social position in
the dominant culture as the private property of the clients. According to Gary
Francione:
The ownership of animal property is, for all intents and purposes, no different from the ownership of other sorts of personal property....Our current system of animal protection, legal welfarism, requires that animal interests be balanced against human interests. The problem is that the law has not developed any doctrines that require that animal property be treated differently than because an animal is different from inanimate property, such as a tool. Rather, the law only requires that animal property not be “wasted” or that animals not be killed or made to suffer when there is no legitimate economic purpose.62 (290)

Given their legal status as the property of the client, the ultimate responsibility of patient care rests with the client (Rollins 1999). The income for the hospital then is generated through clients who use their “discretionary” income to pay for health service for their companion animals. Because of the dependency on the clients’ income, veterinarians must serve the interests of ‘other’ animals under the economic position of having to please their customers. They must service the clients to care for their patients in order to generate an income to buy the medicine and technology to serve their patients and provide economic stability for themselves and their families.

In veterinary medicine people decide what counts as healthy and sick for their animals, and this decision is made not by reference to biological facts but to such things as economic considerations, the role the animals plays in a client’s values, and the subculture the client comes from...[often a veterinarian] is forced to practice his or her art in keeping with the client’s conception of health and illness, a view shaped not to any significant extent by scientific considerations but, rather, by economic and cultural attitudes toward animals. The concept of animal health derives not from a scientifically based ideal of proper function, but instead from the client’s idea of what state the animal needs to be in to function properly in the client’s life. (Rollins 1999: 66-67)

Having to please their customers to provide medical care for patients places the veterinarian in the position of balancing obligations to clients, themselves, and patients. In this way then, I explored both how the social status of the patient as the

62 See also Tannenbaum 1995.
property of the client influenced the outcome of the encounters, as well as the
experiences of the encounters within the veterinary hospital for both humans and
felines.

Social Status between Patients

While 'other' animals occupy a lower status position in relation to human beings in
the United States and this, I will show has an impact on both the ideological
frameworks and the encounters themselves—'other' animals are further ranked
between themselves. Some 'other' animals then enjoy differential treatment
depending upon their social status in relation to each other. This ranking has been
theorized by Arluke & Sanders (1996) to run along a "sociozoologic" scale depending
upon how 'other' animals are regarded to "fit into and play the roles they are
expected to play in society. How well animals seem to know their place and stay in it
determine worth and position on the social ladder" (169). According to Arluke &
Sanders (1996), "good animals" will be accorded better treatment and enjoy
encounters that are more affectionate than "bad animals." For instance, insects are
often regarded as vermin because they fail to stay outside the human domain, and are
therefore subject to extermination. On the other hand, dogs and cats or 'companion
animals' more often enjoy the comfort of human homes and affection.

Even individuals of the same species may be accorded a differing social status
depending upon their perceived use (Arluke & Sanders 1996) or their ability or
"willingness" to stay within the human boundaries (Herzog 1988). For example,
Herzog (1988) found that mice that live within the cages of a laboratory (lab animals) are encountered as tools of scientific medicine and are thereby offered some protection from inhumane treatment. However, if that mouse escaped into the building it was recognized as a “pest” and the encounter turned toward one of extreme abuse as these mice were chased down and often brutally killed. In the United States, ranking also occurs within the feline species. Some felines are ascribed the social status of ‘lab animals’ and this status limits the conditions of the encounters. Affectionate encounters are less frequent as the laboratory technicians and scientists attempt to distance themselves from their charges to handle the emotional difficulty of seeing the feline, suffer. Other felines are ascribed the social status of “companion” and these encounters have been shown to be significantly different (Arluke & Sanders 1996).

I wish to point out that felines are ranked even further. Those that are recognized as “strays” (felines who are not-owned by humans) are regarded by many people as ‘nuisance’ and subject to being trapped and killed by animal control agencies. Felines that are brought under the protection of humans are regarded as “owned” and are treated with more protection and respect than the “strays.” Because of the larger societal ranking of felines, one would expect a similar status ranking within the veterinary hospital; encounters with ‘strays’ should be significantly different than encounters with “client owned” felines.

There are three types of patients in the veterinary hospital: companions, rescues

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63 Birke 1994; Arluke & Sanders 1996.
and strays. Participants categorize these types by the relationship that they have with the client. However, I hope to show that these types also stand in relation to how much the feline fits into the domestic sphere. As such, there are differing human obligations toward them and differing social expectations of them. Outside of drawing out what these obligations and expectations are, part of the aim of this paper is to explore how encounters are influenced by the social status of the patient within the veterinary hospital as well as to examine the differential treatment of animal participants along status lines.

Summary of Conceptual Framework

In sum, this research is intended to present various types of human-feline encounters in the Loving Care Cat Hospital and to explore the relationships between the social factors and the encounters. Given that this is an inductive study and that, to my knowledge, no sociologist has yet engaged in an empirical analysis of feline-human social experiences, I had to create my own typology drawn from my observations in the field. To conceptualize the social factors involved in this study, I drew from a variety of macro-micro sociological theoretical fields. I now turn the reader's focus toward the setting itself and the manner in which I collected and analyzed my data to better understand these social encounters.
CHAPTER 3

SETTING AND METHOD

*Ethnographic Encounters in the Loving Care Cat Hospital*

To best understand the nature of human-feline encounters in a veterinary hospital and how the social context shapes them, I employed the ethnographic method. This method is a form of participant-observation to which the researcher, in various degrees, immerses themselves in the everyday lives of the participants.\(^4\) This method maximizes the researcher’s ability to understand, analyze and to translate the ongoing social processes within a place, as well as the perspectives of participants. This is done through a “reflexive process of appreciation and experiential learning rather than through the collection of facts or the controlled observation of objective events” (Arluke & Sanders 1996:33).\(^5\)

Since my ultimate research goal was to incorporate ‘other’ animals into the sociological analysis of society, the ethnographic method was the most useful tool. Wishing to explore influences of ‘other’ animals on the nature of human-‘other’ encounters and to explicate their experiences within those encounters, and not being able to rely on a shared language for feline participants to communicate this

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experience, it became necessary to observe behaviors and participate in the encounters. Indeed, researchers have indicated that this method is a useful tool to explore relations between any actors who rely heavily on nonverbal communication (Alger & Alger 1999). Nonverbal communication is a particularly salient feature of human-feline encounters.66

I also chose to employ this specific method because, like most social encounters, human-feline encounters involve a great deal of emotional experiences. Carolyn Ellis (1991) suggests that sociologists can and ought to use their own feelings in the participation of a field to better comprehend how participants construct meanings and relate from those constructions. A researcher can

examine emotions emotionally, feeling for the people [and ‘other’ animals] we study. We can view our own emotional experience as a legitimate sociological object of study, using our feelings as a way of understanding and coping with what is going on emotionally in our research. Finally, we can concentrate on studying how emotions feel in the context, and by the narrative terms, of people’s everyday lives (125).

Christine Mattley (1998) adds that “in the same way that we cannot ignore participants’ feelings and expect to understand their social groups, then, we cannot omit our feelings as participant field researchers” (149). In this way then, I thought it necessary to not only observe encounters, but also to participate in the emotional lives of the participants.67 To draw from feelings experienced with participants, to observe various encounters between participants (some of whom I can not directly speak to)

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66 Of course, it is also a salient feature of communication between humans as well (Hammersley 1990; Bogdan & Taylor 1989). Strict adherence to symbolic language can limit understanding of the social world.

and to most adequately understand how these encounters are shaped by the social context, I decided that the ethnographic method would be the most useful empirical tool.

Immersion into a field where human-'other' animal encounters are prominent was particularly important. While there are many places where such encounters are central, I chose a veterinary hospital specifically because I felt that I would find the greatest range of encounters in one location. The hospital that I chose is a feline-specific veterinary hospital. I choose this specific setting for a variety of reasons. First, I have personal experience with this place. Both Robert Emerson (2001) and Dorothy Smith (2000) suggest that in any research endeavor we start close to home—from where we are. As a client of this specific hospital, I had the advantage of gaining easier access to this site and I was already familiar with the participants and social organization of the field. Entrance into this field simply required approaching the owner of the hospital to receive permission to participate in and to observe both clinical and non-clinical encounters. Finally, I chose this specific setting because it services only feline patients. This species limitation offered the advantage of limiting the 'other' animal participants to one specific species, one with I am intimately familiar (five members of my family are felines). Limitation to one specific species of 'other' animals made it easier to focus on individuals as opposed to species groups. I wanted the felines to be participants.
Describing the Setting

Types of Veterinary Care

My ethnographic fieldwork was carried out at what I shall call, for purpose of confidentiality, the Loving Care Cat Hospital. This hospital is a dual-owned private feline-specific veterinary hospital in an average sized city in the Midwest United States. A dual owned private practice is one that is owned and operated by two veterinarians. This can be distinguished from either single-owned or multi-owned private hospitals where more than two veterinarians invest their time and money into the organizational features of a single veterinary practice. A private practice stands in contrast to publicly owned or corporate-owned practices including government agencies, universities, industrial corporations, or military organizations.

Veterinary hospitals can also be categorized by the types of species that the hospital services. The primary classifications according to species include small animal exclusive, small animal predominant, large animal exclusive, large animal predominant, mixed and equine. Small animals are most often recognized as “companion” animals, including, but not limited to, cats and dogs; large animals are most often recognized as “farm animals,” including, but not limited to, cows and

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68 According to the Veterinary Market Statistics survey conducted by the American Veterinary Medical Association, a total of 21,705 private practices existed throughout the United States in 1999. On average, private practices generally consisted of three or fewer veterinarians who worked in or owned (mean number 2.08) the practice (http://www.avma.org/cim/vstat1.htm).

69 In 1999, 60,487 individual veterinarians worked in public or corporate owned practices (http://www.avma.org/cim/vstat1.htm).

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hogs. Feline specific means that the hospital services only the needs of the feline species.

Finally, there is a range of facility types that veterinarians can manage. Full service hospitals are the most frequent among those practices that service "small animals." For instance, in 1998 86.8% of small animal exclusive and 61.4% of small animal predominant provided full-service hospital facilities as opposed to only 6.8% of "large animal exclusive" and 13.3% of equine practices provided hospital facilities (Wise 1999). Other types of facilities that one might find in veterinary practices include emergency or critical care, mobile units or office only facilities. Because of the greater need for on-site care for "farm animals," mobile units are most frequently used by large animal practices. In 1997, for instance over 90% of the "large animal exclusive" practitioners utilized a mobile unit (Wise 1999).

The physical layout of the entrance and waiting room presents a clear image of the type of hospital and the nature of service that one will expect upon immediate entry. Below I describe the entrance to the hospital for the first time as a "legitimate researcher" taken from my fieldnotes:

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I pull the large door open and step in the entryway noting the sign reminding clients that patients must be on a leash or in a carrier upon entry. The sign is a clear indication that clients are responsible for control over the patient when they are present. Another lighter and smaller door closes off the entrance to the waiting room.

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70 A significant percent of the 21,705 private practices in 1999, serviced "small animals" exclusively or serviced "small animals" exclusively or
I stand for a minute in the entry between the two doors. On the walls are pictures of various cats who need to be placed for whatever reason in new homes. These pictures indicate that staff members care about cats even when they are not patients.

I enter the waiting room through the inner door. The waiting room is very clean, fresh smelling and well organized. Although I have entered this building many times before, I am struck by the similarity that this clinic has with the pediatric clinic that I take my son to. Might this suggest that staff members consider patients to be part of the family? In front of me is a row of eight hardback (the client is not expected to wait too long) chairs lined back to back: five facing the receptionist desk and five facing the entrance. The receptionist counter is directly in front of the entrance across the ten waiting chairs. It clearly divides the front stage from the back stage. It runs almost from one wall to the next. On the counter, there are various things for sale. Catnip mats, little catnip pillows, laser lights, and toy mice made of real mouse fur that “cats go crazy over.”

On my right are two doors: exam rooms one and two. Both exam rooms have the same layout. Against the left room is a counter that runs along half of the left wall and then extends out about four feet into the middle of the room. On the counter against the wall are a small hazardous waste box, three jars with swabs and gauze, and a sink. At the end of the exam table near the wall is a scale, a three ring binder which is labeled “Welcome to the Loving Care Cat Hospital,” a small display with cat licenses hanging from it, and a display with brochures about Science Diet cat food

predominantly: 13,315 (61.3%) exclusive and 2,688 (12.4%) predominant
and Heartgaard heart worm medication. The walls have various pictures: picturing breeds, heartworm danger, and funny quotes about cats. It is clear where the client is expected to stand. The doors are distinct markers and there is a short bench attached to the wall between the exam table and the front exam room entrance.

Back in the waiting room, there is a little alcove to the right of the exam rooms; it holds a plastic crate with toys and a Fischer Price kitchen set. In between exam room two and the alcove, are two additional waiting chairs. On the left side of the reception counter is a short swinging door, which designates entry into the back stage of the practice. To the left of the swinging door in the corner of the room is a vending machine that looks exactly like the kind one might find in the entrance of a store or a pediatrician’s office. Instead of holding gum and M&M’s, this one is marked “for cats only” and holds IAMS and Pounce brand kitty treats.

On the adjoining wall is a short bench covered with a variety of magazines – donated from clients – relating to cat health and care and a white binder marked in black ink “lost and found.” On the left side of the waiting room is a small restroom that is open to the public and further left is a plastic shelf lined with an assortment of products from flea control to cat toys. In the far-left corner, stacked against the wall are cardboard cat carriers – these are the carriers that a client may be required to purchase if that client consistently fails to bring in a patient that is not under constraint (e.g. leash, carrier, box). On the walls are various types of pictures of cats. The left wall has a large tree with a Siamese cat in one of the branches painted across

(http://www.avma.org/cim/vstat1.htm).
of it. Very soon after an individual enters, it becomes obvious that the medical care is focused around cats, is very well organized and expects to service not only the physical needs of the patients, but also needs of affection and compassion.

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The Loving Care Cat Hospital was established by a young (middle thirties) married couple -- both licensed veterinarians. They began to work for the former owner "in hopes" that they could purchase his two practices (the other a small animal exclusive hospital) when he retired. After a couple of years, their "hopes" became a reality. Soon after both practices were purchased, the female veterinarian chose to work in and manage the other clinic, while the male chose the feline-specific hospital. As the couple are the "owners" of the hospital where I conducted my fieldwork, this organization could be categorized as a "family owned" business. Like many "family owned" businesses, the decision making processes are less formal and bureaucratic than other types of veterinary hospitals. This, combined with the warm and open personalities of the owners, translates into a pleasant and cooperative social atmosphere. Indeed, all of the staff members as well as a great number of the clients regard the owners with great respect and are very loyal to the hospital.71

71 I learned this from various comments by clients "this place takes such good care of Sunshine that I would never think of going anywhere else...not to mention how much they go out of their way to care for 'other' cats," and "Dr. Curtis is amazing...and he really cares about cats." Also, in the context of personal chats and more formal interviews, many staff members commented on their high regard for the hospital and the owners.
Types of Patients and Clients

A part of this respect comes from the hospital owners’ willingness to expand their services to patients and clients that are not regularly serviced by all veterinary hospitals. The expressed purpose of the Loving Care Cat Hospital is to service the medical needs of feline patients. However, due to the institutional, legal and economic arrangements in which the hospital is contextually situated, these medical needs are met through the discretionary income of the clients. Because this income comes mainly through client dollars, not all veterinary practitioners are willing to service patients who are unaccompanied by an “owner.” The Loving Care Cat Hospital, however, has expanded their patient care to include not only “owned” felines, but also “unowned” felines: namely “strays” and “rescues.” Strays are patients who are dropped off on the doorstep of the hospital – usually in a cat carrier. Rather than transporting the abandoned felines to animal control (which many veterinary hospitals do), these strays are brought inside and cared for at the expense of the owners themselves. Strays are most often held at the hospital until they are “adopted” into a permanent home or accepted into “foster care” by the local animal rescue organization.

The representatives of this organization which I call the County Animal Transfer (CAT) to maintain confidentiality of all participants, are the other “type” of client that this particular hospital services. County Animal Transfer is a loosely structured not-
for-profit volunteer organization that rescues “stray” (dogs and cats that are found living “on their own” and subsequently trapped) and “unwanted” (discarded from human homes) dogs and cats. This organization places the animals in “foster homes” and “adopts them out” to families who go through “adoption procedures” (visitations, applications, background checks) and pay a neuter/vaccination fee to get a “pet.” The medical services needed by “rescues” are provided at cost (cost of equipment and pharmaceuticals) by the hospital. In sum, the **Loving Care Cat Hospital** services two types of clients, “owners,” and “CAT representatives,” as well as three types of patients, “companions,” “rescues,” and “strays.” This expanded service is part of what clients and staff members find so appealing about this hospital.

It was quite easy for me to establish “who was who” regarding clients and patients in the field. When a client and a patient enters the hospital, the first question asked by the receptionist is “Who do you have with you?” This question functions in a couple of ways. First, it informs the clients that the patient is regarded by staff members as a subject through the referent “who.” This question also helps the staff member establish the type of relationship that the client and patient have. Usually, the client will offer relational information without further prompting. “Oh, this is Sammy...I found him in a store parking lot...and now we are rarely separated...he even sleeps on my head at night...he is my baby now...and I was told to check him in before 9:00 to be neutered.” From this information, the receptionist can look up the client’s name in the computer appointment book and fill in the identity card that will be placed on the front of Sammy’s cage. That card will have Sammy’s name,
client's last name, the sex of the patient, and the procedure requested by the client. Likewise, if a CAT representative brings in a "rescue," the identity card will show this. Strays are most often kept in the isolation cage and do not have a name of a client on their identity card.

On average, the practice services 125 clients and 150 patients each week. During my nine months in the field (May 15, 2001—January 15, 2002), I varied the times that I spent there to maximize observations of encounters between different selections of clients and patients. For the first six weeks, I spent on average 25 hours per week during varying office hours. After that, I spent about 10 hours per week in the field. A majority of the clients were Caucasian, middle to middle-upper class, females between the estimated ages of 26-50. The CAT clients also largely represented Caucasian, middle-aged females. Patients were also included as participants in this study. Both sexes, all ages and breeds were represented, although a majority of the patients were domestic shorthaired.

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72 Estimated by their presentation of self through dress and demeanor, type of car (many SUV, sports cars, and well-kept Sedans) and method of payment (mainly credit cards and checks).

73 Although, this statistic should be taken cautiously because I did not systematically sit and count the number of clients that entered the hospital at various times throughout the day; I did enter the gender and educated guess regarding race and age, of each client observed for an extended time period (ie. observed a consultation or observed a conversation with a receptionist). Out of the 124 clients that recorded in my field notes, 92 (74%) were female and 32 (26%) were male. Although I could not ask clients about their racial origin, my best guesses from appearance, which is admittedly problematic, is that a majority of the clients appeared to be of Caucasian origin (117). Of the remaining 7 clients observed two were African American, three were Hispanic, one was Japanese, and one client was Chinese. Most of the female clients appeared to have ages ranging between 19-70, middle ages (26-50) being over represented. The male clients had a similar age range, but no over representation in that the ages appeared to be evenly distributed.
Staff Members

As I described in depth in the conceptual framework, my focus was on human-feline encounters including at least one patient, at least one staff member, and at least one client (even if the client was socially implicated and therefore not actually materially present). In this regard, staff members (including the male owner and veterinarian) are included as participants in this research. Eleven staff members participated in this research: One owner-veterinarian, a part-time veterinarian who works full time as an animal welfare investigator, the office manager, three receptionists, two veterinary technicians, two veterinary technical assistants, and one cleaner. All of the staff participants are Caucasian—a limitation of this study. Another limitation of this study is that both veterinarians are male and therefore I was unable to examine differences in veterinary-patient encounters across gender. I was unable to provide written consent by the female-co-owner/veterinarian. While I had her verbal consent and spent time speaking with her, I could not ethically include her in this research. While the two veterinarians that did participate in this research were male in their middle thirties, the remaining staff participants are female (ages ranging between 18 and 44).

It is important to note that all the staff members had some early childhood exposure to caring for ‘other’ animals. In the context of an interview, for instance, Dr. Curtis explains that

“there were always dogs and cats....um hamsters, guinea pigs, a boa constrictor, a python, tarantulas, plenty of fish, we had rabbits and turtles...oh and a skunk once.
There were probably others that I can’t think of off the top of my head, but we always had pets of various kinds in our house.” Three of the staff members point to their grandmothers as being important socializing agents in this regard and that this exposure probably helped them to respect and eventually choose a career working with ‘other’ animals:

“My grandmother…My dad’s mom…took in anything and everything. They had many cats and my grandfather had chickens but it was not a farm…[her grandmother] took in many birds that the cats had got or squirrels…she would care for them…but many baby kittens…she spent a lot of time caring for other animals and I got to experience that when I was as a kid and that probably helped with that [choosing to work in a veterinary clinic]…that exposure.” (Lisa)

“…and us kids moved in with my Grandma who saved anything she found and fixed ‘em up…monkeys…alligators…birds…everything. She turned me into a real animal lover. My Grandma took me on nature hikes…she took animals to fix ‘em up and teach us…she always had cats all over the place…My grandma taught us to love nature and I am pretty grateful for that. I am pretty good at putting myself in others’ shoes…you know…being able to see from their perspective. I just would never harm a hair on other animals…they are defenseless from people you know what I mean? I would think about what if that was happening to me…you know…would I like it? I guess that this probably helped me to decide to work here…” (Laura).

The staff members also express great satisfaction working at the hospital. In part, this is because many of them “love working with animals” as well as “with people.” The satisfaction also arises from the pleasant and cooperative atmosphere of the hospital. As Angie, one of the receptionists, describes:

“everyone here is so easy to talk to and if you have a problem with anything, you know that you can talk to anyone here about it or ask for help. Everyone here is so easy to work with, including the doctors. There is hardly any fighting here everyone helps everyone out, it’s great.”

Some of the staff members also point to the doctors as being a large reason for their satisfaction. Marcie, a veterinary technician, explains that she loves the people and
the work itself and has felt extremely fortunate to get her hands-on training with Dr. Curtis, "he is a brilliant man and he is a really good teacher."

*Occupational Organization*

While the staff members are highly cooperative in the sense that they share occupational responsibilities to maintain a smooth and pleasant atmosphere for themselves, clients, and the patients; they do have specific occupational statuses that they occupy, and with them, certain obligations. The office manager's role in this clinic I would describe as an overall organizer. Lisa, is the office manager and she carries herself with an air of confidence and direction. She knows what is going on and why, both in the clinic and even sometimes in the home lives of "her" employees. From early observations, I noted by the way that other staff members and Dr. Curtis (the co-owner of the hospital) speaks to her, she is highly respected and needed in this office.

As the office manager, Lisa is responsible for hiring, organizing staff schedules and responsibilities, organizing patient files and other paperwork, billing, purchasing, and making certain that "everything runs ok." She also answers phones, greets clients and checks in-patients for surgery and exams--the same duties as a receptionist. Another part of her role is to present a public image to the clients. Receptionists are also the public faces of the hospital. All three receptionists, (Angie, Anna, and Laura) present a warm, friendly caring image.
While the office manager and the receptionists work more intimately with clients, the cleaner Pam is directly responsible for maintaining the clean, comfortable and sterile environment for all participants. A “cleaner” in this hospital does a great deal more than clean the cages and the hospital. Her job not only involves the janitorial work in the hospital (washing cages, floors, windows, and surgical toweling and pacs) but also keeping the patients comfortable. The textual description of keeping them “comfortable” means to make certain that the patients have fresh litter pans, food, water, and bedding. A large part of the job, which is not in the textual job description, is to take care of the emotional needs of the patients and help other staff members when needed.

Marcie and Ezra, are the veterinary technicians. Like the cleaner, Marcie and Ezra mainly work with the patients in the back. Unlike the educational requirements of the cleaner, each of them has a bachelor’s degree and intends to become a veterinarian. Marcie is in the middle of her veterinary medical training while Ezra is just entering. Their primary task is to “prep” patients for surgery. What this means is that they take blood-work to determine if patient can be anesthetized, administer the anesthesia and analgesia, keep all the patient “travel sheets” in order (know who had which shot and what had to be done), administer vaccinations for surgical patients, shave the surgical area, and to have the correct surgical pac (package of surgical tools) and patient ready when the doctor is prepared to do a surgery. Other tasks include: sometimes assisting the doctors during surgery, helping with minor surgical procedures such as removing
abscesses, removing bandages, and monitoring the patients for physical problems relating to surgery.

The veterinary technical assistants, Victoria and Nell, are the aides to both the doctors and veterinary technicians and so this keeps them fairly busy running back and forth between them. Veterinary technical assistant's primary tasks involve: making certain that all the medicines and drugs are logged, running virus tests, checking stool (“run fecals” and “spin poop”\(^\text{74}\)) and urine samples for worms and pH-levels, scruffing (restrain by the scruff of the neck) patients while the veterinary technician draws blood, preparing vaccinations for the doctor, and to helping check in clients and patients into the exam rooms. The veterinary technical assistants are also primarily responsible for taking care of the “surgical pacs.” A surgical pac is a packet of surgical tools that have been sterilized after surgery. Each surgery gets a new package of tools. The veterinary technician’s assistant will sterilize the tools after the surgery, wrap it tightly in linen, and then store them in the surgery room. Because they also work directly with the clients, these assistants, like the receptionists present an image of competence and caring.\(^\text{75}\)

Generally, when the doctors enter the hospital, the first thing that they do is check in on the patients and note which surgical procedures are waiting. While both doctors check in on the patients, Doctor X’s (the part-time veterinarian) style is significantly

\(^{74}\) A simplified description of this is that the feces are placed into a test tube and a solution is added. Then the test tube and its contents are spun by a machine to mix and allow foreign material to float to the top – thus called “poop spinning.”

\(^{75}\) I wish to note here, that this role may be played to the audience, but it is a sincere one.
different. He does not speak to or address the patients as Dr. Curtis does. I discussed these differing styles of veterinary medicine in the conceptual framework.

After the doctors check on the patients, their normal routine is to alternate between surgical procedures and exams. Surgical procedures can run anywhere from setting a broken bone, having a tooth extracted, placing a “protracted uterus” back into a patient, to removing gunshot shell from a patient who wandered onto the neighbors property. However, these practices generally involve some type of anesthesia. There are three differing types of surgical procedures in this hospital: elective, emergency, and routine. Emergency surgeries are those that are unexpected, intended to medically alter the result of an accident, sudden illness, or bodily dysfunction. Routine surgical procedures include those that are understood by staff members to be regularly needed but not a matter of life or death. “A dental,” when a patient is having their teeth cleaned or pulled, is an example of a routine surgical procedure. Elective means that it is not necessary for patient health and is practiced solely on client demand. The elective surgical procedures performed at this clinic include both neutering and onychectomy or commonly referred to as declawing. While emergency and routine surgical procedures are an obvious element to veterinary hospitals, I focus on elective surgical procedures in this research because these are the most common.

There are many purposes for medical exams or consultations. Clients schedule exams for patients for a variety of reasons, but the two most frequent are for preventative health or to examine a patient whom has suddenly changed behaviors or has fell ill. The preventative health check-up includes a client-patient-doctor
consultation, which focuses on checking the patient’s general physical health and often results in vaccinations. When a patient changes behaviors (such as peeing outside of the litter pan or becomes lethargic) or has a sudden illness (these are not mutually exclusive categories—peeing outside of the litter pan could indicate an illness) there are varying end-consequences. In this research, I focus on the preventative health exams and those exams that have a terminal result (euthanasia) or client and doctor discuss this “treatment.”

**Physical Ecology of the Hospital**

To orient the reader to the place, I now turn to a brief description of the layout of the back-stage of the hospital. As I stated earlier, the reception desk separates the front-stage from the back-stage. Generally, there are two or three people at the reception desk: the office manager and one or two receptionists. They sit in front of the two computers behind the reception desk which sits lower than the counter. On that desk, there are also multi-line phones, a fax machine, a printer, and a great deal of paperwork. The consultation and surgical appointments are all logged into the computer. The computer enables the staff quick reference to available appointment times and logs and computes the procedures and medications given to the patient. In this hospital there are both paper and computer files detailing patient records. Behind the reception desk is a rather large shelving system that is filled with files. It almost
covers the whole wall. The files are alphabetized by the client’s name. Many clients have more than one cat\textsuperscript{76} and those files are kept together in one binder.

Also behind the reception counter is a door that leads into the “prep” room. In the middle of the prep room is a counter that extends out in an L shape from the wall. This is the place where veterinary technicians, with the aid of veterinary technical assistants, draw blood for testing, prepare the anesthetic syringes, and ready patients for surgery. Sometimes they do “minor” or “routine” surgical procedures in the prep room, like cleaning out abscesses or dental surgery. The prep room is also where euthanasia is practiced when the client chooses not to be present or remain for the body. On the wall closest to the reception area is a large double tiered metal cage. This cage is completely barred with a flat plastic tray on the bottom. One can look in from all sides if need be – but it is up against the wall next to the door. Towels are placed on the bottom of each cage and a litter pan is in the back and food and water dish in the front. Most often, these cages are used to house the patients who need close monitoring or IV’s. In the far-left corner of the prep room is a closet with a glass door. This is what the staff members refer to as the “isolation room.” When I first asked about this closet, I assumed that it was storage for extra cages. Marcie explained, however, that this is where “we keep patients who may be contagious. The glass door is so that we can monitor them.”

At the end of the counter against the wall, past cupboards that hold anesthesia, is another sink. Adjoined to the end of the prep room is another smaller room with a

\textsuperscript{76} According to the National Pet Survey (2001), on average most people who have cats have at least
glass window and door: the surgery room. This room is rather simple. A short counter extends from the far wall. A stool sits on the left of the counter and a small, but tall, metal table with a surgical pac laid out on it, stands to the right. The doctor stands with his back to the wall to do the surgical procedures on the patient who is lying unconscious on the table. Across the “surgery table” (the counter) from where the doctor stands, is a smaller counter with surgical pads and pacs. Above the counter are two cupboards that hold extra-sterilized surgical pacs. And finally, in the corner stands a machine that holds gas anesthesia that is used when a patient is getting “light” (waking up from the shot of anesthesia) or needing longer surgical procedures.

On the other side of the prep room, another door leads into the “back room.” The back room actually has two doors, one adjoining the prep room and the other leading to the reception area (next to the swinging door on the left side of the counter). Entering from the reception area one immediately notices, that this is where the majority of patients either awaits or recovers from surgery. On the immediate left is a block of cages against a wall: three across and three high. These cages are most often used for the patients awaiting surgery. The staff members refer to these cages as the “front cages.” The 2 x 2 x 2 square cages are all durable cream color linoleum – like a kitchen counter except for the front. The front of the cage is a barred door with a hanging metal slot that can hold a 5 x 7-index card. Lisa explains the function and nature of this card:

two.
These are kinda like charts. They have the name of the client, in this case [she points to the upper left corner of one of the cards] the client is CAT...you know...Country Animal Transfer. On the upper right corner is the patient's name or names if there are more than one together. In the lower left hand corner is the surgical procedure...see [she points to the words “spay x2”] this tells the veterinary technician and the doctor what surgical procedure has been requested...in this case there are two female kittens in here and each one is in for a spay. If it was a male and female together in the cage it would say spay/cast. ...which is short for castration...and finally on the lower right hand corner are the medications needed and...or the tests that need to be run. So, for instance, this one is marked FELV which means that Fluffy here needs to have a feline leukemia test before she goes in for surgery....all patients in this hospital must have a feline leukemia test run before they have surgery...otherwise we run the risk...if the patient is positive...of exposing other patients when we do surgery...it is just a safety procedure...must keep the environment sterile you know...if they have already been tested and vaccinated then we don’t have to run the test again.

On the side of this wall of cages are two containers stacked on top of each other with flip up lids holding cat litter and food. Directly across the door, adjoining the reception desk is a long counter. It looks like a kitchen counter with a sink, strainer, and cupboards above and below. Lisa describes the contents of the cupboards:

In the cupboards are glasses if you need to get a drink and paperwork which we hand out to clients...like pamphlets on how to take care of a kitten or a senior cat...and extra paperwork that goes into the patient files...you know stuff like that.

Across from the front cages is a closet that houses a wash machine and a dryer stacked on top of each other. I was confused at first about the function of the machines and asked Lisa about it. “This is where we do our wash.” I look at her with a puzzled expression “you mean you wash your scrubs here?” She laughs “well, if they get really dirty sure...but we wash the linen that we use to make the surgical pacs [she walks a few steps over to a tall metal closet and pulls it open]. “See. Here they are.” She reaches down to the to the fourth shelf from the top – there are five
shelves -- and pulls one out. They look like thick blue handkerchiefs. “We do a lot of laundry here. This machine is almost worn out. See these?” She pulls out a white rectangular piece of cloth that has rubber padding on the bottom and soft material on the top, which looks like the wool on a sheep. Lisa describes the function of the surgical mats and need for a good functioning wash machine:

“These are the surgical mats. Once a patient has been put under - anesthetized - for surgery we put the patient on the mat and carry them into the prep room where they are shaved for surgery and have their nails trimmed. This way they don’t slide around. Then after the patient has had surgery we carry them back to their cage on the mat. We leave the mat in the cage until the patient has woken up and has been moved into the recovery cages which I will show you in a minute...The mats and the bath towels are what really needs to be kept up...we cover patients with the towels after surgery to keep them warm while they are waking up from anesthesia. We also line the recovery cages with a towel so that the patients are more comfortable. So you can guess, we go through a lot of towels.”

She laughs and I look at the two large shelves, which are packed with towels. “There are more in the boarding room if you run out and need one, but we try to keep up. Pam does the laundry when she is here, but she leaves before lunch, so we all really help out with the laundry.”

Lisa shows me that the other shelves have the kitty litter pans and the food bowls. I point to a cake pan. “Why do you have cake pans in here?” She laughs. “They make great kitty litter pans, especially for the kittens.” She turns to her left where there is a kitchen style refrigerator between the counter and the metal closet. “If you ever need any soft cat food, check in the refrigerator first ok?” She opens it up. “If you need to bring in a lunch you can keep that in here too. We also keep the solution for the snap test – the test that checks for Feline Leukemia – and other medical items

77 Scrubs are the employee uniforms. These are similar to uniforms used by human medical staff.
in here. In the freezer is where we keep the bodies...before they are picked up by animal control for disposal.” I swallow hard and look at the freezer, which is attached to the top of the refrigerator. Lisa laughs at my expression, “don’t worry we wrap them in black plastic bags first.”

She closes the refrigerator and walks to the other end of the counter, and stands in front of another set of cages, identical to the ones described above. “These are the back or recovery cages. As I said before, when a patient wakes up and is doing fine, we move them over here. We need to keep room open for new surgeries.” Lisa looks into one of the cages and smiles. “Hey...you want a toy huh?” A small white kitten leans her whole body against the cage door. Lisa pets the kitten through the cage, reaches up to the top of the stack of cages and picks up a small box. She pulls out a toy mouse and pokes it through the bars of the cage door. The kitten leaps at it and flips it around and we laugh. The cage is lined with a towel and has a cake pan filled with litter and a small food and water dish - both full. I wonder at how clean and organized the cage is when the kitten spills some of her water during her mouse flipping antics.

Leading out the door of the back room that adjoins the reception desk and past the file system, is a small hallway that steers off into the rest of the hospital. The doctor’s office is on the side with the file system. It is simple: desk, chair, phone, and a bookshelf with veterinary manuals. Across from the office is a door (staff entrance to exam room 1) with a file pocket on the wall next to it that holds the chart for a

They are made of lightweight linen and easy to wash and dry.
patient who is waiting for consultation. This pocket stands empty unless there is a client and patient waiting in the exam room. Although the receptionists or veterinary technical assistants will verbally indicate that the doctor has a consultation waiting, the chart serves as a visual marker and enables the doctor to quickly familiarize himself with the case before entering the room.

Farther down the hall is an X-ray room on the left and a wide hallway on the right. The hallway functions as the laboratory. On the left wall of the hallway is a long counter with various machines, microscopes, charts, test tubes, three ring binders, a sink near the far end, another phone, and a printer. Underneath the end of the counter is a small refrigerator. Above and below the rest of the counter there are more cupboards. The microscope and a rack of test tubes are at the far-left side of the counter next to that, hanging on the wall is a chart with pictures and descriptions of various parasites. Across from the counter, on the other side of the hallway is a rather large chart of urine sediments, a backlighted board to examine X-rays, a cat calendar, and another doorway (back entrance to exam room 2). Between the doorway and the calendar is another file folder that holds the chart of whomever is waiting in that exam room.

**Research Methods**

**Research Role**

As Lawrence Neuman (1997) and Adler & Adler (1987) indicate, field researchers
can play a variety of roles throughout the process of a study; these roles come with differing levels of involvement.\textsuperscript{78} As I made note of earlier, my original role in this field was that of a client. This role not only enabled easy entry into the field; it also helped me to have empathy with the perspectives of the clients. Once I gained access into the field, while this role did not disappear (I brought my cats in for health care after I had gained entry), the predominant role that I played was that of a researcher/volunteer. A part of how I played this role was to conform my clothing to the staff member's scrubs. The first couple of days in the field, I wore nice slacks, shirt, and vest. I quickly realized how obtrusive this outfit was behind the reception desk in the midst of others wearing scrubs. I stuck out like a sore thumb, and clients would look at me with furrowed brows, not knowing how to relate to me. Moreover, staff members seemed to worry about me ‘getting dirty’ and would hesitate to ask me to “do the dirty work” of cleaning up feces or urine. Scrubs then were essential to being more accepted and less obtrusive in the setting. Scrubs also gave me a stage pass into the consultation room; as it appeared to the clients that I was simply there to observe the doctor.

As I stated before, all of the staff members were aware of my role as a researcher; but I also participated in the social activities in the field, similar to that of a volunteer ‘helping out as needed.’ In order to help out, I had to ‘learn the ropes’ similar to any

active volunteer member. At varying times throughout the first couple of weeks in the hospital, differing staff members 'took me under their wing' so to speak. I would follow them around during their work day, watching them, asking them questions and assisting them in their work. For instance, I followed Lisa (the office manager) around at first and she taught me how to use the computer, how to check clients and patients in and out for exams and surgeries, and how the phones work so that I could answer them if needed. In other words, she taught me the requirements of a receptionist. Pam (the cleaner), Marcie (one of the veterinary technicians), and Victoria (one of the veterinary technical assistants) also took me under their wings and provided 'on the job' training to assist them as needed.

Once I felt comfortable with some of these tasks I was able to assist others in their work and perform many of the same tasks as a volunteer would perform (ie. cleaning, helping to hold the patients for blood work, and others as described above). In this way then, I assumed an "active membership role" as described by Adler & Adler (1987) in that I went through a similar socialization process (Holy 1984) and participated in "core activities" in the field. Active membership can be distinguished from complete membership where the researcher completely immerses herself into the field. A "complete membership" role was not something that I wished to engage in. I did not have a regular schedule (although I usually informed Lisa when I was intending to come in throughout the week); I was therefore not penciled into the schedule as a 'volunteer' might be so I assisted in activities more than I performed. Taking a slightly less immersed role enabled me to lean on my researcher identity
when I periodically needed to do so. Full immersion would mean being cut out of the consultation rooms and watching surgeries. It would mean that the duties performed while at the clinic would deter what I felt was necessary distance to observe interactions between clients and patients and staff and patients. The “active membership” role provided me with fairly high levels of trust and acceptance in that I helped participants with their work, but at the same time enabled me to periodically distance myself.

As a client in a hospital, I already had a certain element of trust and rapport with the staff participants. I tried to earn additional trust by being myself.\textsuperscript{79} I was straightforward and friendly and disclosed personal information with staff members just as I would with any other co-worker. I laughed, cried and empathized with staff members about social activities in the field as well as things that were going on at home (theirs and my own). As Neuman (1997) points out, this open self disclosure and rapport, “is a step toward obtaining an understanding of members and moving beyond understanding to empathy—that is, seeing and feeling events from another’s perspective” (355).\textsuperscript{80} This empathy, in turn, promotes the ability to earn an even greater degree of rapport. In addition, I kept staff members updated on my research progress. Often, I would ask staff members’ questions about what they thought would be important to explore in the final work. Finally, I frequently checked the


\textsuperscript{80} For further discussion relating to researcher self-disclosure as a form of gaining trust see Reinharz, Shulamit. 1992. \textit{Feminist Methods in Social Research}. New York: Oxford University Press.
accuracy of and clarified my observations relating to institutional practices, ethical stances, and beliefs about felines, categories, and terms.

Observations From the Field

While I was both participating and observing at the *Loving Care Cat Hospital*, I focused at first on three main social activities: practices, interaction, and meaning (mined activity). My main and early focus was on the practices involved in the setting. By practices, I mean the regular practical activities that are employed on a day to day basis by individuals involved within a particular setting. Sometimes these practices involved "official tasks" (such as vaccinations, surgery, and filing). Other times these practices were not expressly defined by administration but by individuals involved in the everyday ongoing construction of the institution. An "unofficial" but important practice in this field for instance is figuring out how to get a patient to eat without getting injured. Another unofficial practice includes constructing and responding to a patient's emotional needs. Staff participants often described these invisible practices as a part of "what they do"--the work that they were involved in.\(^{81}\) As I watched and engaged in practical activities in the field I paid close attention to who did what, where the practices occurred, and how they were accomplished.

After I felt more comfortable, had learned the ropes, and could recognize what staff was doing and why, I began to focus more on the nature of the interactions between participants. By interactions, I employ Erving Goffman's definition as the

\(^{81}\) Diamond 1992; DeVault and McCoy 2000.
“reciprocal influence of individuals upon one another’s actions when in one another’s immediate presence” (Goffman 1959/1978:177-178). Depending upon which tasks I was engaged in or which research role I was using at a specific time, I mainly focused on interactions between patients and staff, clients and patients, clients and staff, and between individual staff members. I also observed multiple interactions client-staff-patients when I was in the consultation or waiting room and during special events (such that a client was brought back stage). Of course, as a pseudo-staff member, I was an agent within many of those interactions and would pay close attention to my own feelings and nature of interactions. During those interactions, I would watch and employ empathy to gain an understanding of how varying participants related to each other. I noted such things for instance, as physical proximity, how they communicated, touched and looked at each other, when they interacted to get a feel for the nature of the relationship and what they said and how things were said.

To gain a better understanding of the experiences of the encounters and practices, I paid specific attention to and participated in the emotional expressions (verbal and non-verbal) of participants and how these emotions influenced their motivations to act and the actions themselves. For example, I spent time affectionately interacting with patients, watched staff members engaging in these affectionate displays, listened to how staff and clients talked about these displays, and observed how patient’s responded to and initiated them. To illustrate, I provide an example from my field notes.
Walking by a cage, I felt a paw reach out and grab me. I stopped and looked in. A large orange cat, whose identity card read “Mister,” stared at me for a second and then meowed. “Hi there Mister,” I said to him. He leaned his whole body into the bars of the door. I pet him through the bars and then turned and walked away. He began to meow. I looked at Pam who was folding towels and she smiled at me. Then I looked back at Mister. He meowed louder and reached his paws out toward me. I looked at him and said, “what do you want huh?” Pam answered for him; “he wants attention.” I looked at her and then said, “but I want to help you with the towels.” She replied, “well, it will make him feel better if you just pet him for a few minutes first.” She stopped folding towels, walked over to the cage, and opened the door. She pet him and spoke to him and he rubbed vigorously against her caress. She smiled at him and then reached for a toy and placed it in his cage before closing the door. He stopped meowing and busied himself with the toy.

From this, I learned that affectionate initiation from the patient can be interpreted by the staff member as a request for comfort. I also learned that staff members do respond to these requests through further affectionate displays. What this means is that comforting and to be comforted is one motivation for displays of affection in the veterinary hospital. Further, when I engaged in this comforting myself, I felt good about it. I was doing something and being enrolled by someone (Michael 1996) in an action that enhanced my self-identity as someone who cares about and for ‘other’ animals.

In order to grasp the ideologies that underpinned the “official” cultural practices such as neutering, vaccinations, declawing, and euthanasia and to better understand what the feline subject meant to the human participants, it was important to attend to the minded activities—the meanings that human participants attributed to these interactions and practices. Symbolic Interactionists point out that people do not always respond directly to each other’s actions but to the meanings attributed to them. To better understand the meanings behind events and relations in the field, I paid close attention to what people said about each other and the practices they engaged in.
I focused mainly on the minded activity of the human participants in this study. I agree with Barbara Noske (1989) that attending to the meanings that 'other' animals might attribute to experiences and interactions is an important and much neglected area of research, especially in the social sciences. However, from a sociological standpoint, we do not even have practical accounts of interaction or even some sort of close representation of what the other animal’s experiential perspective may be. Thus, I started from there, focusing on observations of patient behavior and social cues to begin opening up possibilities for future research. Finally, individual patients usually spent only a short amount of time in the field. This short time limited my empirical evidence for attaining confidence in my interpretation of the meaning behind their individual actions. I think that asserting what things mean to them on a regular basis throughout this research would be like ‘giving voice’ to them. For the purposes of this research, and because of limited time spent with the patients, I think that a rich description of their actions and staff member’s interpretations of them may be a good start for the patients to “speak” for themselves. Maybe after a good deal of accounts are collected, a conceptual framework for trying to understand the meaning behind the experiences can be constructed.

I also paid attention to my own feelings and experiences in the field. I paid particular attention to what I was doing during the day, how practices and interactions made me feel, and what I was thinking about while I was engaged in them and relating to other participants. In addition, I paid close attention to how my feelings, thoughts, and relations changed throughout the process. For instance, before I was in
the field, I was extremely uncomfortable with death. I would go into emotional turmoil for weeks on end when I lost a family member (human or ‘other’ animal). Probably because of this turmoil, I was ethically opposed to euthanasia.

I realized how much my ideas about euthanasia changed when our old horse lay down in her stall and could not get up. Instead of requesting that the doctor give her steroids to relieve her pain hoping that she would stand (as I had in the past); I petted her for a second and went directly into the house to inform the family member most responsible for Bess of her condition. Two hours later, before the doctor arrived, Bess had stumbled to her feet but was limping around. Rather than plead with the family member to ‘see the injustice of a forced death’ when Bess was (from my perspective) struggling to survive, I kept my mouth shut and stood in support of the decision. I watched Bess die and felt ok with it because she was old and we were unsure if she was suffering. I rubbed my family member’s back while this member cried and I spoke soothingly to both of them “it’s for the best.” After the event, this family member and I spoke about how much the time spent in the hospital had changed my ability to witness death and my ethical stance on euthanasia. Noting these changes in my own feelings I was better able to understand the feelings of the other participants (particularly staff members) as they engaged in what they sometimes referred to as “difficult practices.”

Although I had already begun to record my observations as encounters, after four months in the field, I began to focus observations more specifically to notable tension and displays of affection and to record if these encounters were associated with
certain social factors. To this end, I began to center my field observations on the presence or absence of certain social contexts, the expressions of the participants (client-patient-staff) in each encounter, the manners in which the human members spoke about the patient, and how staff members and clients spoke about the specific practices. My informal chats also became more directed to practice ideologies, how staff members dealt with tension, and to questions focusing on what staff members thought about the various social contexts, the patients, and what they were doing. I did not have a theory in mind as I began to narrow my observations in the field. Rather, my focus was on what participants indicated (through action) to be the most important elements of the encounters and the social contexts that influenced them.

Field Notes

I wrote down my observations in the form of field notes. I used a form of taking field notes similar to the one employed by Timothy Diamond (1992) during his research in nursing homes. "I would surreptitiously take notes on scraps of paper, in the bathroom or otherwise out of sight, jotting down what someone had said or done" (7). I originally wanted to carry a small notebook, however scrubs did not have large pockets. Therefore, every day, I took a new eight by eleven sheet of typing paper, folded into a small rectangle, in the pocket of my scrubs along with a pen. I would write down the date and start time in the parking lot of the hospital before I entered. After greeting everyone, I would go to the corner of the room where the patients were housed and quickly write down who was present (including the patients), what
surgeries were scheduled and anything that someone had said relating to the practice, the patient’s or the clients. Then, I would place the folded paper in my pocket and ‘get to work.’

Throughout the day, I would find times and hiding places to jot things down in shorthand. Writing in front of people seems obtrusive to me. I found that when I was caught writing (sometimes back stage a staff participant would catch me) the atmosphere became strained and uncomfortable. “Are you writing about me?” Confronted with this situation, I would tell the staff participant exactly what I was writing about and give them the option of looking at my notes. Generally, the individual would laugh and say something like ‘no that’s ok.’ However, sometimes, the staff participant would add an observation or thought and I would write that down as well.

Kath Weston (2001) suggests that researchers should practice the art of listening. She explains that if researchers really concentrate on what is going on and what is being said that remembering becomes easy. I think that this was good advice – particularly because earlier acting training taught me to be attentive to details and to remember quite accurately what I observed and heard. Combining this skill with writing down ‘verbatim’ quotes as soon as I could provided more accurate descriptions of the events and exchanges in the field. When I left the field each day, I would write down the time left, go home, and transcribe the written notes immediately into my computer. Then I would re-read these notes, reflect on what had occurred, and add more in-depth details that were reconstructed from memory. I
would also include sections relating to my own feelings throughout the day: autoethnographic notes.

AutoEthnography

Arluke & Sander's (1996) argue that these autoethnographic field notes are an invaluable part of the data. In their interpretation of Gouldner's (1970) emphasis on the importance of these notes they claim that

ethnographers can learn an invaluable lesson about the nature of social relationships between animals and people by examining feelings prompted in themselves when in the field. These confrontations with emotion help to bring home, in a very direct way, the close connection between knowing one's self and knowing the social world. (21)

Because my analytic focus turned primarily toward staff-patient encounters, these notes were particularly useful in that they provided insight into the complexity of tension, affection, and reciprocity and as defining properties of human-feline encounters. They were also invaluable toward recognizing the important role of social and social-psychological factors in shaping these encounters. I illustrate this importance from the autoethnographic field note that first prompted me to think about encounters in this way.

Shortly after surgery, while recovering in the cage, a rescue kitten woke up screaming. It was a scream that made my stomach drop: loud and shrill. I was in the prep room checking on Paco and considering feeding him again when I heard the scream. I ran into the back room to see what was up. The kitten had his leg wrapped around the cage bar and was flipping around (many patients who wake up from gas are freaked out — and twitch, meow loudly and sometimes flop around in the cage). Concerned that he might hurt himself I went to the cage (bottom of three tier) and lifted him out. While doing so, the patient (a companion kitten) directly above the kittens cage (Rascal) reached out and scratched me in the face. I was pissed off at him and noticed that his card indicated "declaw." No wonder I thought, why should

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anyone put up with that behavior. Then I felt a little guilty; it was probably the last
time he will ever scratch anyone. I am holding a kitten who is screaming (screeching
– loud piercing sounds) with blood dripping off my nose when Lisa comes running
in. “Oh my goodness (as she is grabbing a blanket) what happened?” I told her what
happened as she is wrapping the kitten up tightly in the blanket. “Oh,” she laughed.
I was embarrassed that I was scratched and worried that Lisa would think that I am
incompetent.

The hospital was very busy so I offered to hold the kitten to calm him down. We
thought that he was just scared and needed to be held. Doctor Curtis and Marcie
came in shortly after this and asked what happened (they were in surgery during the ruckus). I told them. “Hmmm,” said Doctor Curtis, “we should probably watch him
carefully.” Then they went into the prep room. Marcie came back with a needle, “we
need to sedate him some more,” she said. I was nervous about him squiggling
because I worried that his stitches might burst. He screamed louder for awhile after
the shot and he tried hard to bite me. I just kept thinking, well thank goodness he is
so little, or I would not be able to control him. I carried him around trying to get him
to stop screaming because I did not want the staff to think that I was incompetent and
I did not want the clients to think that they we are torturing cats back here. The shot
took effect and he became calmer but I could not put him down. Every time that I
tried, he would scream. After about ten minutes of holding him tight and feeling
aches in my arms, I asked Marcie if she would look to see if something else was
wrong because he was still making so much noise – awful scary screeching meows.
Was he in pain or just scared? I asked. We unwrapped him a bit, as I held him real
tight. Sure enough, he had ruptured his surgery – intestines had come out and were
just under the stitches. Marcie and I looked at each other “In pain” we said to each
other. Although I felt extremely sorry for him, I felt fortunate and proud of myself
because I was actually helping the staff and the kitten. Later that day, they thanked
me for “being such help.” Their thanks and knowing that I participated in helping
the kitten made me feel good about being a part of this institution.

We were busy, there were clients present, it was an emergency, Rascal was in for
declawing (a surgery that I was morally opposed to), the patients were both kittens (I
would not have been comfortable or possibly able to constrain an adult), one patient
was a rescue the other a companion, and the kitten was defined by both Marcie and
me as in pain and needing my care through control over his movement. The kitten
and I were both tense, I was trying to comfort him using affectionate displays and I
did not feel overly affectionate toward him. It was at this point that I realized that it
was not how I defined him (as subject versus object) that primarily shaped our
encounter. Rather it was how I defined his behavior and my actions in relation to that
identity, how and why I managed my own tensions, and the specific social context that we were involved in that shaped the nature of that encounter.

The Power of Names and Disclosure

Jeannette Winterson (1985) points out that "naming is a difficult and time-consuming process; it concerns essences, and it means power" (170). Translation of everyday lives into sociological discourse is also a use of power (Smith 1987). I firmly believe that no matter how "good" the intentions are that power in the hands of one person or a small group can be oppressive. One way that I attempted to diffuse my power while simultaneously retaining confidentiality, was to ask staff participants what name they wished me to use in the final re-presentation of their lived reality. I asked them if they wished to use their own name, to pick an alternate name, or if they would prefer that I chose one for them. Some of the staff participants chose to use their own name, some of them chose an alternate and some requested that I choose one for them. When I was requested to chose for them, I spent a considerable amount of time deliberating on a name that I believed best represented their personality, styles of interaction, and physical characteristics. After I had chosen a name, I asked those specific participants if they liked the chosen name. Most of those participants really seemed to like the chosen name and gave me the "go ahead" to use it. One participant said, "that is so funny...it is very close to the name that I always wanted and that my friends use." I then asked what that name was and if she/he would prefer
that one to the one I chose. The member replied, “Yeah, use the name that I always
wanted...that’s cool.” To further retain confidentiality of the staff participants, I do
not divulge which participant chose to use their own name and which have not.

All of the names of the clients have been changed to retain their confidentiality.
Disclosure of my role in the field was up to the owner of the hospital so that the
clients did not feel uncomfortable with my presence and thereby disrupt business as
usual. Sometimes the owner disclosed the purpose of my presence and sometimes he
did not. When he did inform the client of my purpose, I was never asked to leave and
I never noticed any discomfort. I would generally receive a nod and maybe an “oh,”
but nothing indicating discomfort.

Clients usually paid little attention to me during consultations. When they did
include me in the interaction within the encounter, it was most often because the
patient had made a physical contact with me or the doctor included me by looking at
me. The few times that I did interact with clients during consultations, I was careful
not to do or say anything outside the “norm” of the hospital activities. This helped
ensure that no physical or emotional harm came to any client because of my presence.
Generally, other than a nod of recognition of a physical presence or a smile upon
entering the room, clients paid little notice of me. Sometimes, I felt like a “fly on the
wall.” Given that I leaned up against the wall in an inconspicuous spot in the corner
during consultations, this analogy is probably pretty accurate. Because disclosure
was not consistent with clients, I most often refer to them as “client.” When I did

For a discussion on the power and oppression behind naming in science, see Birke, Lynda. 1994.
choose names for them, I used pseudonyms and changed any identifying characteristics to protect their confidentiality.

Patients' names, like Sunshine, Sammy, and Fluffy, were also changed. Their names were changed for two reasons. First, I wished to recognize them as participants in the research. Given our lack of shared symbolic language, I was unable to provide disclosure or consent from them so confidentiality was necessary. Second, considering their close relations with the clients, changing the patient's names provided further confidentiality for the clients. I chose the names for the patients.

Empirically, changing the names of the patients without being able to provide the clients with the options provided to the staff members was problematic. Names hold so much power and meaning that I really wished to use the patient's given name. While some the patient's names were "generic" to feline names in the United States (ie. Fluffy, Morris, and Whiskers), many of the real names of the patients seemed to reflect intimate relations between the client and patient, and physical characteristics and personalities of the patients. Changing those names limited my ability to adequately reflect those relations and best represent a patient's characteristics and personalities. To work past this and at the same time retain confidentiality, I tried to choose alternate names that followed a similar pattern. For instance, if the patient had a "generic" name, I used an alternate generic name. If the patient had a name that reflected a specific personality trait (ie. Spunky) I chose a distant synonym for that

personality trait. If a patient had a very original name I did my best to make the sounds of the name similar and maintain the originality while at the same time make it different enough so that patient and client confidentiality would be preserved.

Disclosure

Staff members became the most prominent human participants during the research process. The reason for this is that full disclosure of my presence as a researcher was only offered explicitly to staff members and therefore, I could only infer the meaning of encounters from patients and clients through observations of various behaviors (such as gestures and talk). In other words, I was unable to directly ask clients and patients (due to language barrier) what they thought about an encounter or why they chose to do what they did. I did often engage in “informal chats” with clients where I could sway the conversation toward specific topics. Below is an example from my field notes that illustrates my use of “informal chats” with clients.

A young white female and a small black kitten were at the reception desk waiting for an exam. The kitten was playing with a string that the client slowly pulled across the counter as she spoke with Angie (a receptionist), Lisa (the office manager) and me. He pounced on the string and almost slid off the counter. We laughed and the client looked at him and said, “he is such a good kitten.” Wanting to understand from her perspective, what makes a kitten a “good” kitten I responded, “oh, yeah...I bet he is. What makes him such a good kitten?” She smiled at him and said “well he is so playful, but also he has already learned how to use the litter box, no problem.” Lisa nodded and stated, “that is good.” The client nodded and smiled at the kitten, “yes, and he is careful not to scratch me too...he is a very good kitten isn’t he?”

From this “informal chat” I learned, at least from this client’s perspective (but agreed with by the staff members present), that “good” kittens are playful, use a designated spot to urinate and defecate, and are careful not to hurt their human companions.
Outside of these “informal chats” however, I did not directly question the clients because this would be defined as going against the staff-client interactional norm of the hospital and would disrupt hospital routine. The owner was also concerned that asking clients to sign consent forms would make his clients uncomfortable. Staff members, on the other hand, were aware of my purpose and signed written consent forms (See Appendix A) to participate in the research and I was able to verify my inferences about their definitions of the situations through “informal chats” and semi-structured interviews.

Interviews

Usually the ethnographic method does not solely involve participant-observation; some types of interviews with all or some of the participants most often accompany the participant-observation. These interviews better able the researcher to get at the meanings, clarify practices, and get an in-depth view of the participants’ perspectives (Lareau & Scultz 1996). Through “informal chats” with staff members I was better able to grasp their definitions of the situation as well as how they felt and managed emotions in tense encounters. This method of interview was similar to a conversation except that in the process of a conversation, if the moment presents itself, I asked mostly staff but sometimes (as above) client participants questions such as: “what are you doing?” “Why are you doing this now?” and “how does that make you feel?” I found these “informal chats” to be an invaluable research tool. For instance, before euthanasia of a sick kitten, I asked one of the staff members if it “bothered her.” She
replied that it did "and in some cases, really makes me mad," but that she deals with it in different ways. "With this kitten, I focus on the fact that he is really sick and he would be better off dead." This deceptively "simple" question guided me toward various tension management strategies that staff employ depending upon the context of an encounter. It also helped me to see that there is not a cohesive ideological framework centering on euthanasia (in this situation, it was ok – but it is less acceptable in ‘other cases’).

Through "informal chats," I could also check the accuracy of empirical evidence in my field notes. I checked my field notes each night before going to the field the next day and wrote down questions for the staff participants. I would come in and ask such questions as "I noted that you said this about.... Is this accurate because I do not wish to misrepresent you in any way." I also verified tactical knowledge and terms, "when you refer to the mats that are used to place patients on after surgery do you refer to it as surgical pads or something else?" I employed this "checking back" tactic with staff participants frequently both throughout and after I left the field to ensure the most accurate re-presentation of participants’ definitions, categories, and knowledge.

To gather background information on the staff members, to collect further evidence of ideological frameworks surrounding specific practices, and to check empirical consistency both across participants and across multiple methods, I constructed two semi-structured and open-ended interview scripts. I interviewed the veterinarians face-to-face while they were in surgery with a specific script relating to
their role in the profession (Appendix B). I interviewed the remaining staff participants as well as the veterinarians over the phone utilizing a different, but similar script (Appendix C). These pre-constructed interview schedules provided more in-depth background information and ethical standpoints relating to declawing, neutering, and euthanasia. They also enabled me to double-check the accuracy of my field notes. The structure of the interviews allowed me to ask consistent questions to each of the staff participants. However, because they were open-ended, staff participants could elaborate on their thoughts and ideas without being unduly constrained. Phone interviews have their drawbacks. For example, I was unable to observe non-verbal communication that is sometimes a telling indication of discomfort with questions. However, I thought that it might be more comfortable for participants to divulge personal information with me over the phone. During the phone interviews, I directly transcribed the answers, complete with verbal hesitations and styles of speaking, into the computer – I present their answers unedited in the final work.

Textual Analysis

Many researchers have talked about the value of triangulation – the use of multiple methods – to represent a more holistic and accurate picture of social life.\(^3\) Taking this to heart, I complemented the ethnographic method with a textual analysis of the *Journal of the American Veterinary Medical Association* (JAVMA). A textual

\(^3\) See for example, Mason 1997; Czaja & Blair 1996; Reinharz 1992; Jick 1979.
analysis is a form of qualitative content analysis (Reinharz 1992). As I pointed out in the last chapter, JAVMA is the "official" journal of the *American Veterinary Medical Association* (AVMA). In addition, AVMA is the legitimate "voice of" the American veterinary institution. Along with clinical studies, JAVMA discusses rules and obligations of veterinary practice, offers biographies of veterinarians, and discusses ethical positions and guidelines for various practices.

At the same time that I was engaged in fieldwork, I went to the library and skimmed through eleven years (1990-2001) of the journal to familiarize myself with the textual discourse relating to the field. After I had skimmed the journals, I photocopied AVMA guidelines and policies on feline health, special commentaries about feline health and care, welfare and ethical articles relating to feline practitioners, and specific clinical studies on pain management and specific practices (such as vaccinations, declawing, neutering, and euthanasia). Then I put these photocopies into binders in chronological order so that I could draw a picture of textual reality and look for connection and disjunction between that reality and the actual experiences of the everyday practice. My original reasons for studying this journal included: to get a better idea of what veterinary training entailed, answer more adequately the question "in whose interest do they serve," explore how more macro-structural influences affect the production of the practices, and simply to compare the textual reality with the "actuality of everyday life" (Smith 1987). In the textual analysis, these questions were answered. However, the most invaluable part of this research for the final work, was using this empirical evidence to outline ideological
frameworks surrounding medical procedures and to analyze implicit assumptions within these frameworks.

To best examine, code and analyze what DeVault & McCoy (2000:30) refer to as the “ideological character” of the various official practices I extended my earlier analysis described above to include more of the underlying assumptions that support official practices. To this end, I looked for highly consistent and highly inconsistent statements about a specific practice between the interview texts and the textual representations of practices presented in the JAVMA. Once, I recorded these statements (many of which you will find in the findings) I began to ask the text some specific questions. Among these questions included:

1. What does this text claim is the right way to care for felines?
2. What is regarded as natural/unnatural?
3. Where is the proper place of felines?
4. What are the human obligations towards felines and nature in general?
5. What are the feline obligations toward humans?
6. What is the ultimate and utopian vision of human-feline relationships toward which this practice is supposed to serve?
7. What are the interests of felines and of humans and whose interest should be prioritized?
8. Why is this practice important and when and on who is it supposed to be employed?
9. Are there times when this practice is bad?
10. What happens if the practice is not employed?

Asking questions of the data was not my own idea. Nor were the general questions themselves. Although I looked through and employed many research method's texts, I leaned heavily on Emerson's edited book *Contemporary Field Research* (2001) for guidance on both ethnographic and textual analysis of qualitative research. Howard Becker's "Tricks of the Trade" and Kathy Charmaz's "Grounded Theory" were particularly helpful in devising specific questions and focusing my attention to the "place" and the assumptions behind such practices. For example, the tenth question above is a rewrite of Becker's question "Or Else What?"

*Field Research Analysis and Significant Indicators*

Given the gap in sociological knowledge of human-'other' animal encounters, an exploratory inductive analysis seemed the most appropriate to examine the nature and conditions of such encounters. My analysis of the empirical evidence was multi-layered. What I mean by this is that it did not occur in a uni-directional fashion from the gathering of data to coding to analysis. Instead, I worked on coding, analysis, and the development of questions and a thesis throughout the research process. In other words, I moved back and forth between the data collection, coding, analysis, and combing through ethnographic methodology books for guidance on coding and analysis. This is akin to the grounded theory method first constructed by Glaser &
Strauss (1967). According to Charmaz (2001), this analytic method includes the “simultaneous involvement in data collection and analysis [and] means that the researcher’s emerging analysis shapes his or her data collection procedures.” Although I did not dramatically change my procedures, my questions, my observations, and categories often changed with time, jumping back and forth between the fieldwork and the coding. Indeed, it was not until after I had submitted an unsuccessful first draft of the dissertation that I began the focused coding and analysis that resulted in this presentation of human-feline encounters in a veterinary hospital. Without burdening the reader with the full analytic process, I now turn to the coding and analysis that resulted in the final version of this research.

I focus this section on the indications for affectionate displays, tension, and tension management strategies. Indications for reciprocity, the social context such as patient status, patient age, type of doctor, and client presence is straightforward and I described them in my conceptual framework. After briefly describing the manner in which I coded encounters in my field notes and discussed tension management, I end with a summary of how I laid out these observations to explore the social contextual pattern most associated with specific encounters.

**Indications for Affectionate Displays**

For felines, actions that I both recorded and coded as indications of affectionate displays included: purring combined with another display of affection; licking

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84 Denzin & Lincoln’s (2000) *Handbook for Qualitative Research* was also helpful during the earlier
someone; rubbing against; looking up at and leaning into; extending neck and body into a person’s hands; playing with a human; gently pawing at a person’s face; reaching out of the cage; loud meows from the cage while simultaneously reaching out; and soft questioning meows. I drew from both personal experiences with felines and research from cat ethnologists\textsuperscript{85} and veterinarians\textsuperscript{86} to code these displays. For example, noted cat ethnologist Claire Bessant (2001) describes how cats ask for affection. “When cats that are familiar and friendly to each other meet, they rub head, flank, and tail against one another, exchanging odors and greetings, just as we would shake hands or kiss an acquaintance and make light conversation” (28). She continues to explain that this behavior functions not only as a greeting and territorial scenting, but that the social expectation of this rubbing behavior is an affectionate response. “When the head is stretched forward, the cat is trying to encourage touch...”(32). Also particularly helpful was her observation that a cat’s purr can be included as both a display of affection and an indication of anxiety. Cats sometimes purr to comfort themselves. As such, I did not include purring as an indication of affection unless it was combined with other displays of affection.

For human participants, actions that I coded as indications of affectionate displays included: petting; speaking softly to; snuggling; hugging; holding; rocking a patient in their arms; offering toys; smiling at; words that express an affectionate attitude such as “I love you;” and gently pushing fingers into the carrier or cage to initiate analysis.\textsuperscript{85} Specifically see, Masson 2002; Bessant 2001; Turner & Bateson 2000; Miliani 1987; and Craighead 1985 supplies a “meow chart” that I used to code feline vocal expressions of both affection and tension on pages 124-125.
touch. I drew from personal experience, research on human-animal interaction,\textsuperscript{87} and veterinarians' observations\textsuperscript{88} to code such displays. For example, Victoria Voith (1981) describes how a human can display affection toward a pet.

The person may talk to the pet, often in the same way as to a dear friend or most likely a child. The owners may ask questions of the pet, without expecting an answer—much as one might of a small child—and might stroke, hug, or scoop up the pet into their arms. (281)

\textit{Indications for Tension}

Being an internal state, tension is more difficult to code. Most assuredly, then I failed to capture tension that had been most successfully managed. This is, no doubt, a major drawback in any examination of emotion work in general or tension management in particular. However, there are clear and observable indications of some tension experienced by felines and human participants. For felines, I coded as indications of tension by the following actions: hiding; growling; incessant meowing; wide eyes; trembling; struggling to get away; hissing; spiting; striking; ears pressed flat against the head; tail bused up; arched back; and hair standing erect. Again, I drew from personal experiences, cat ethnologists and veterinarians' observations to both record, and code these indications. Charles Darwin's (1897) observations of expressions of emotions were especially helpful in this regard.

For humans I coded tension in my field notes by the following observable actions: hand rubbing; crying or misty eyes with the absence of laughter; red face again with

\textsuperscript{86} Houpt 1991; Fogle 1983.
\textsuperscript{87} Alger & Alger 1999; Sanders 1999; Arluke & Sanders 1996; Katcher 1981.
\textsuperscript{88} Fogle 1983; Voith 1981.
the absence of laughter; incessant talking; sighing extensively; shivering; trembling; and quick movements combined with huffy breaths or incessant speaking. I also coded words expressing experiences of uncomfortable feelings as tension: I can’t stand this; this really upsets me; I am having such a hard time with this; that really makes me mad; I am so upset right now; I am sad; and I don’t know if I can get through this.

Tension Management

By tension management, I refer to the efforts or strategies employed by staff members to manage tense feelings or behaviors either for themselves or for others (clients and patients). Tension management strategies as I described in the conceptual framework are a type of self and other psychological defense mechanism which can include various techniques for changing or displacing an emotion (in this case tension) through actions such as apologizing, joking and directing blame onto someone or something else. I realized that staff members were doing this as I began to note regular patterned responses under certain contexts while observing/working at the hospital. I also found myself using some of these strategies to “make me feel better.” After noting this, I explored the research on emotional labor and the problematic situation in order to clarify my conceptual understanding and to see if these techniques are common. Indeed, I found some similar techniques employed in a study by Arluke & Sanders (1996) of shelter workers. People in various occupations also employed many of these techniques (discussed in the conceptual
framework) in human-human encounters. As such, I compared and contrasted the shelter worker techniques with the techniques that I recorded from observations in my field notes. I had to extend my analysis, however, to code techniques employed by staff members to manage client and patient tension.

In summary, in order to evidence the claims of my thesis that human-feline encounters are a product of multiple interacting social and social-psychological factors, I arranged my field notes by the coding above. First, I had a total of 300 human-feline encounters. My observations are categorized by the purpose of visit. I categorized the purposes of visit in five ways: preventative health; neutering; declawing; euthanasia; and disaster control. I set aside the encounters recorded for the purpose of disaster control (emergency surgical procedures and check-ups for the purpose of questionable health without discussion of euthanasia). Among these encounters, I had coded observations that allowed me to describe them as particular types of encounters (affectionate, distant, tense, and ambiguous). For purposes of analysis, these encounters were further divided by staff-patient and client-patient dyadic encounters. I often present the encounters in total (all present members) in my finding chapters. I also describe tension, reciprocity, and affection displayed by patients, clients, and staff. However, my observations and method limitations (no informed consent, limited time, and lack of interviews) leant themselves to a specific analytic focus on how social conditions are associated with types of dyadic patient-staff encounters. As such, I also had observations of the social and social psychological contextual variables that were most significantly associated with
specific patient-staff dyadic encounters. Finally, I had observations that speak to the tension management strategies and definitions of the feline subject by staff participants.

The picture that emerged, as I carefully arranged the notes on my floor, is that certain types of encounters tended to be associated with certain types of social and social psychological factors. Originally, I assumed that types of practices would be the major social factor. However, as the reader shall see, while the types of practices which organized my findings chapters tended toward certain encounters, the more significant pattern involved ideological frameworks of the practices and the consensus that they had among humans. I now turn the reader's attention to the affectionate encounters that I found most associated with the ideological framework and consensus of preventative health.
CHAPTER 4

PREVENTATIVE HEALTH

Controlling Nature

"Check-up or Check-out!" This was the title of the American Veterinary Medical Association's 1990 "Cat Health Month" public education campaign. This campaign was largely financed by 9-Lives (an extension of the Heinz corporation) to promote public awareness of the importance of preventative healthcare for companion felines. Using a variety of media resources such as national magazines (ie. Seventeen, Women's world, and Veterinary Economics), major newspapers (ie. Chicago Tribune and New York Times), radio spots, cable and local television broadcasts the "estimated audience impressions" for that one campaign totaled 2.2 billion. This is only one example of the frequent campaigns intended to promote "awareness among pet owners about the importance of regular check-ups and inoculations for cats" (AVMA 1991:25) and to make public the ideological consensus within the veterinary institution that preventative health is in the patient's best interest.

Ideological Framework of Preventative Health

As I pointed out in the conceptual framework, feline preventative health is explicitly
about providing regular checkups; the focus of which includes vaccinations, cleanliness, and dietary management. The goal of preventative checkups is the optimal maintenance of a patient’s physical health to ensure a proper quality of life for the patient. From the institutional standpoint, patients suffer when they are subject to disease. Lack of inoculations increases the risk that patients will suffer under debilitating disease and painful deaths. Dirt and parasites not only spread disease but can also cause other health problems that can further increase the risk of feline suffering. According to veterinary medicine, obesity is correlated with an increase in medical conditions that harms the proper functioning of healthy individuals (Jerving 1999). Combined, preventative health is intended to diminish feline suffering through the “protection of animal health;” this is understood by the veterinary institution to be paramount to animal welfare.

There are some interesting underlying assumptions that ride along with preventative health ideology. Consider the following statements:

“Vaccines have played a significant role in enabling people and animals to live longer and healthier lives in this world filled with microbial pathogens”.90

“[Clients] are often ignorant of the animal’s basic needs, such as feeding, exercise, preventative medicine, and play...”91

“Few [clients], as Plato says, do evil knowingly; most of them are simply ignorant.”92

92 IBID except quote on page 1155.
"National Pet Week is an opportunity not only to celebrate with your clients but also a time to educate the public about responsible pet ownership and the important role veterinarians fill throughout the life in animal and human health."93

"Nutritionally induced problems are particularly relevant in many parts of the world in which pets are commonly fed food scraps and other materials rather than commercially produced complete and balanced products or other carefully prepared foods. Veterinarians should be prepared to use information from carefully obtained dietary histories and other instructional tools to discuss important nutritional considerations and potential consequences of improper feeding with their clients."94

"The actual service the veterinarian sells is protection from contagious, potentially fatal diseases."95

"If you "adopt" the animal, you become the owner and therefore are responsible for the animal's care."96

"The extent of care given to any animal is determined ultimately by its owner. If you place a low value on the worth of a pet yourself, then you should probably not accept the responsibility for keeping a pet. Every pet owner has different ideas as to what is acceptable pet care. Veterinarians can only make their clients aware of products and services that are available to owners. Then, we guide them in their choices regarding the most important health options for their pet. It is up to [the clients] to make the choice. Veterinarians are willing and do go the extra mile for pet owners, but expenses need to be covered. This includes salaries for assistants and technicians, costly equipment such as x-ray machines, and, of course, the expense of years of professional training."97

"Animal welfare is a human responsibility that encompasses all aspects of animal well-being, including proper housing, management, nutrition, disease prevention and treatment, responsible care, humane handling, and when necessary, humane euthanasia."98

From the institutional perspective, the natural world is parasitic, unclean, and disease ridden. In other words, the natural world is dangerous. Veterinarians and their staff members must educate the “ignorant” populous of the dangers faced by

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93 Statement made by the Auxiliary to AVMA president Kimberly Topper who was interviewed by Sharon K. Granskog, assistant director, AVMA Public Information Division in 2001, *The Journal of the American Veterinary Medical Association* 218(1):8-9 quote on page 8.


96 These are excerpts from a brochure titled “The Cost of Compassion” which was published by the Hillsborough Corporation intended for doctors to use as tools for client education. The brochure excerpts were found in *The Journal of the American Veterinary Medical Association* 1995, 206(2):142.

97 IBID

98 This is a portion of the “official” policy statement crafted by AVMA in 1990 regarding animal welfare.

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their companions when they come into contact with the “germ infested” natural world. Interestingly, companion animals, like humans are separated from this natural world. Felines need to be “rescued” from the “wild” and brought under the compassionate control of civil society. They need this because they have the ability to suffer, and outside of human control, they suffer. The public must also realize the necessity of the armor that the institution provides them. This armor comes in the form of the medical knowledge and services of management. The public must be made aware of these dangers and the offered protection for their loved one, because each individual, not the community, is responsible for the animal under their care. If the individual client values the life and the companionship of the animal under their care, then he or she will provide preventative health. Finally, humans not only have the right and the ability to control ‘other’ animals as well as the natural environment; they have the responsibility to do so.

_Ideological Consensus_

_Staff Member Ideological Consensus_

From my observations of encounters and discussions with staff members, I found that they generally agree with the larger institution about the importance of preventative medicine in ensuring the well being of the patient. Moreover, their actions provide evidence that they are in-line with the underlying assumptions of the institutional ideology about preventative health. It is assumed for instance, that the
public needs to become “more aware” of the importance of such a practice. When I ask staff members if there is anything about veterinary institutions that, they would like the public to learn two participants discuss the importance of vaccinations and one discusses the problem of flea control.

“People need to be better educated about the importance of vaccinations. People just don’t realize how important it is.”

“Indoor cats need vaccinations. Indoor cats are so much more susceptible to upper respiratory diseases because they are not outdoors and raising their immune systems to the diseases. People also don’t realize that an indoor cat can get FeLV and rabies too”

“People need to know about fleas...they don’t realize that an indoor cat can get fleas...they can come through the walls or on rodents...they can be carried in on your shoes. We get these patients...and people don’t even realize that they are infested with fleas...yuck...and they say ‘but they were always inside, we don’t have fleas’ yeah right!”

In other words, from the staff’s perspective, people in general are uneducated about how to properly care for felines. They fail to realize that natural dangers can invade the home and affect their companions if they are not protected by veterinary medicine.

From the staff’s perspective, leaving cats to care for themselves is cruel and leads to suffering. Below is a typical reaction by staff participants when a patient is brought in that is “full of dirt and bugs.”

A female cream and brown colored patient was brought in by the CAT to be “cleaned up.” Some people in a trailer park had abandoned her. The people moved and left the cat sitting on the cement slab waiting for them to return.\footnote{People who live in trailer parks have a reputation of abandonment. This fosters the “trailer trash” stereotype. Moreover, it fosters a particular idea among many staff members that people with lower income do not care about or for their cat because they are irresponsible. However, this stereotype is challenged by Dr. Curtis’ assumption that clients are oppressed by the economic structure - not that they do not care. This assumption will be discussed later in the paper.} The patient was very quiet and reserved in her cage and somewhat timid, but she would allow staff members to touch her. She was anesthetized for the “clean up.” The patient
was full of ear mites, fleas and had a tick. Marcie and I spent a great deal of time washing her and taking care of her “bug problem.” According to Marcie, the patient “was a wreck.” When Marcie was swabbing her ears to pull out most of the ear mites it took a rather long time – she was full of them. Marcie kept shaking her body in disgust. She was really grossed out by all the bugs. “This part is really yucky.” She lamented over people’s neglect of care for their cats. “I don’t know why people do that – just leave them like that – it is cruel.” After we bathed the patient, dirt flowing into the sink, she turned out to be white and black.

The dirt and the bugs on the patient disgust Marcie. However, she is even more disgusted by the human irresponsibility that enables cats to get so “nasty” by “leaving them” outside, alone, unattended and without human care.

Because the larger institution and staff members assume that clients do not understand how to properly care for felines, they believe that it is their responsibility to educate clients about the importance of this care. This is why the waiting room has posters on the wall that paint pictures of the dangers felines face when they are not armored by vaccinations and why kitten care packages are handed out to new clients extolling the necessity of vaccination schedules and proper nutrition.

Given that dietary management is new to the veterinary institution, Dr. Curtis takes a more active role in this educational process. On a number of occasions, I observe him lecturing the clients about their failure to maintain a proper weight for the patient. He employs his Aesculapian authority, authority derived from the “ability to heal” (Rollin 1999), similar to what a pediatrician uses. When it comes to weight management, Dr. Curtis employs his authority to sanction clients about their failure to serve the best interest of the feline.

We were in exam room two. Dr. Curtis was speaking with two clients, a woman, and a man. They had brought in “their babies,” Tom and Tim who were “brothers” from the same litter for their annual exam. Both of the patients were very curious, walking around and sniffing everything. They were five years old and about 15 pounds. After the examination, the doctor pronounces that they are “pretty much” in good health. “However,” he continues, “I am concerned about their weight...you know next time if they come in heavier I will have to yell at you.” He smiles to soften the sanction. The woman quickly looks at the other client and he redirects the blame toward her, “hey they are your kids not mine!” Then Doctor Curtis talks about how important it is for them to keep their teeth clean as well. “Brushing their teeth will not hurt either...Well...it might hurt you.” They laugh. In the meantime, the woman has picked Tom up and squeezes him close. Tom lies still in her arms, but looks around curiously. The doctor looks at them for a second and smiles. “You know, some cats just look at food gain weight...” The male client snorts and interrupts him, “Hey, just like grandma huh?” Dr. Curtis continues smiles at him but then continues, “well, the point is that they need to be healthy and you will have to watch their calories for them...ok?”

In exam room one, Dr. Curtis discusses the rampant problem of obesity with a client. “Obesity is a problem for 80% of my patients.” He then explains to her what the leading cause of obesity is - human indulgence. “I know that the cats are not opening the can so it is not their fault. Often people just can’t say no to their cats like they can their children. They tend to just give in to their wishes.” After a lengthier discussion about feline health and weight, he reiterates his theory about the cause of feline obesity; “people really can’t say no to their cats when it comes to food. People are the reason that their cats are overweight, it is not the cat’s fault....Please refrain from giving them any more treats or table scraps.”

From the veterinary medical perspective, providing treats and table scraps is not the right way to care for felines. Controlling the patient’s diet and refraining from “giving in to their wishes” because “they don’t know what is good for them” is a socially expected behavior in this institution. Educating (changing the definitions of care to conform to the medical definition) clients about the proper way to care for a patient is intended to bring clients in-line with the institutional consensus on proper care. It is important to note that “giving in to their wishes” illustrates another important aspect of how human-feline encounters are structured in the veterinary hospital. Felines are defined as having wishes. According to the Webster’s (1997) dictionary, a wish is “a longing or desire” (254). The feline subject that is acted
toward by humans, like humans, has desires. However, these specific wishes are far from appropriate to their welfare, felines of any age, like human children, do not "know what is good for them;" people do.

Client Consensus

While staff members appear to accept the assumption that the larger public is somewhat ignorant about preventative health, clients predominantly agree that preventative health is in the patient’s best interest. Evidence that clients generally adhere to the ideology surrounding preventative health practices is the expression of guilt or embarrassment when they fail to protect a patient from fleas, "allow the patient to get too fat," and reorganize their finances to pay for "needed" vaccinations.

During nine-months in the field, I overheard a number of clients explaining to Lisa that they simply "could not afford" the health care for their patients, but that they "did not want the patient to catch anything either." Occasionally, Lisa offered a promissory agreement to the client so that the client could provide this care for the patient while waiting for their next paycheck.

As I was organizing the waiting room, I observed a middle-aged white female get up and ask for her balance. Lisa explained that it was presently at forty dollars, but with this visit, it will be an additional sixty-two. "Oh, my goodness. I really don't have one-hundred and two dollars right now...Muffy really needed her shots though...and Sammy just was not feeling too well.....Can I pay part of it now and some of it later when I get my next check? I will just pay my phone bill a few weeks late." Lisa nodded and handed her a promissory agreement for the remaining balance. The client signed the agreement, wrote out the check and as she handed the paperwork over the counter she asked, "could you please not cash this until tomorrow though? I am hoping that my parents will reimburse me for their cat." Lisa looked slightly confused and the client explained. "Dad's cat died and he wanted to cremate her. He said he wanted a proper burial [she illustrates with her fingers quotation marks as she says the word "proper"]; We had to pay twenty-five dollars here, thirty five on
top of that for the cremation, and forty five for the burial [she shakes her head and
laughs] I don’t know why he couldn’t have just buried her in the back yard...now I
can’t even afford my own two cat’s health expenses.”

For this client, vaccinations for Muffy and the check-up for Sammy could not be
delayed until her financial situation could be cleared up. Nor could she simply refuse
her father’s need for a “proper” burial for his cat. While she did not understand it,
she helped him to say good-bye to his loved one in the civil or proper way. By this
gesture, she generally accepted, although not wholeheartedly agreed with the
assumption that patients are part of civil society and must be accorded the same type
of burial that humans generally receive. She did completely agree, though, that
without vaccinations and check-ups her companions were in danger. “Muffy really
needed her shots.” These vaccinations could not wait.

Another indication that clients tended to comply with the institutional ideology of
preventative health is the display of guilt when they “fail” to “provide proper care” by
“allowing” the patient to gain too much weight or become “infested” with fleas, tics
or ear mites. Typically when a client is informed that a patient has some type of
parasite, they turn red, look down, or defend the cleanliness of their homes.

“It can’t be fleas! I don’t even let her outside. This is really embarrassing.”

“How can she have worms? It is not like my house is that dirty.”

“We keep our house really clean, there is no way that she can have ear mites?!”

On one occasion, a patient was brought in because she had a “protracted uterus”
from the delivery of kittens. Marcie and Lisa were washing off the uterus with saline
solution to ready her for emergency surgery while I was observing close by. This
patient was so infested with fleas that we could actually feel them jumping on us. After some discussion about “how dirty this poor cat is,” Marcie asked if I would “please ask the clients if we can give her a flea treatment?”

As I walked into the waiting room, the clients stood up. I asked them, “do you mind if we give the momma a flea treatment?” Both women’s faces turned red they looked at each other and then back and me and just stared for a minute before they nodded. I became embarrassed as well realizing that I had slightly offended them by bringing attention to their lack of proper care.

Not only were these clients embarrassed about the fleas on the patient but also they had to assume the financial responsibility for her care through their permission. The patient was not automatically given the treatment although it was in hers and our best interest to do so. In other words, the patient’s welfare is contingent on the responsibility of her owners.

Finally, clients express guilt when a staff member brings weight gain to their attention.

A young female client was checking in with Lisa. Lisa asked her a routine question about Callie’s [the patient] previous weight. “She was ten pounds last time that you came in right?” The client nodded as she blushed. “I think that she has actually gained a bit more weight.” Then she said in a defensive tone of voice “I can’t help it! They need to invent some sort of ball with wheels like they have for gerbils for cats.”

While the expression of guilt is an indication that clients conform to the larger institutional ideology relating to obesity; the failure of many clients to “protect their cats from ill health” by maintaining a proper weight does indicate that there is some
disagreement between clients and staff members about the definition of feline interest. On the one hand, clients recognize and accept that a patient is healthier when they are not overweight. On the other hand, clients sometimes see feeding a feline as an extension of love by attending to their individual preferences. Evidence of attending to a patient's preferences comes from such statements as: "she really only likes the food with many flavors in it," or "he hates dry food...he'll just spit it out." People feel guilty about keeping food from their companions because they love them and wish them to be happy.

"She just looks at the empty food bowl and meows at me...I just feel so mean."

"They look at you and the only thing that they have is the pleasure of their food when they get older. I just can't keep it from him when he asks for it I feel so bad."

For the veterinary institution, caring for (relating to feeding) means to keep a patient in optimal health and part of this includes controlling a patient’s diet. For clients on the other hand, caring for (relating to feeding) also means to provide pleasure. Because of these conflicting definitions, veterinarians work to convince clients that their definition is the right one. For the most part, clients recognize the conflicting definitions of care and because the institution is backed by science – has legitimate authority behind it – feel guilty about their failure to comply. Their failure to comply affirms the staff members’ position that clients are simply uneducated about “proper” care. However, from my perspective, it is not that clients are uneducated or disagree with the general institutional consensus about dietary

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management, but rather they are struggling with varying definitions about what a patient’s needs are.

**Maintenance of Ideological Consensus**

Staff members recognize that clients sometimes struggle with varying definitions and to maintain ideological consensus regarding preventative health they use both positive and negative social sanctions. These sanctions also provide further evidence for the ideological consensus and underlying assumptions of preventative health in the veterinary hospital. Clients that fail to conform or even express guilt are constructed as bad. In other words, this practice is non-negotiable. Either the client takes care of their pet or they don’t. While participants generally don’t use the words “bad” in the local setting; it is inferred that these clients are irresponsible or ignorant or both. “I can’t believe that she didn’t immunize her cat” exclaims one veterinary technician when faced with the impending death of a patient, “don’t people care about their cats?!” When discussing billing with the doctor after a client walked out without paying, Lisa assertively stated “payment is due at the time of service. It is their responsibility to provide care for the patient...some clients just don’t understand that...we really should make clients like this prepay!”

Likewise, clients that properly care for their “companions” are regarded as good clients. During the process of my research, I frequently helped by filing patient charts. These charts are filed alphabetically by the clients’ last name. I noticed that some of the charts had gold stars on them. I asked Lisa what the stars indicated. “Oh
the gold star clients. Those are the really good clients.” I asked what “really good” means. “Those are the clients that come to the clinic on a regular basis...they pay on time and they take really good care of their cats. We also know from those stars that they will not be a problem to bill...we can extend their credit if they need it.” I asked her what “good care” means and she replied slowly, “oh...you know...they bring them in when they are sick...and they are up to date [on their shots].” Unlike the client who walked out without assuming financial responsibility for patient care, clients who regularly pay on time and who keep the patient up to date on their vaccinations are “gold star clients” and are offered “extensions on their credit.”

Clients who “go out of their way” to take care of strays by providing shelter and protection from disease are frequently offered discount prices for these services. Doctor Curtis recognizes that it can be costly to provide preventative health care to a large number of patients, and while sometimes he will offer the “litter rate” to clients who have multiple companions as he did for me when my cat had a litter of kittens, he does so on a regular basis for those that bring in patients who are rescues or recent strays.

In the context of checking in for an exam to provide vaccinations for a kitten, a client is standing at the reception desk patiently waiting for me to bring up the patient’s chart. The kitten is leaning against the client on the counter.

The client looks at me and then at Lisa with a smile. Then the client looks down at the kitten and says (while stroking the kitten) “she wants to be with the other kittens...she is so scared by herself. She can’t wait to git home.” She explains to us how she found this kitten along with four others under her porch last week. She laughs and says that now she has 13 cats at home. Lisa laughs with her, pats the kittens’ head, and then gets up grabs the patient’s chart and walks over to exam room.
one. She enters from the back and opens the exam room door that adjoins the waiting room. "Ok, you may bring her in now."

When the client comes out of the exam room into the wait room to pay her bill, Dr. Curtis walks over to Lisa and tells her in front of the client to give her a "discount price." I look over at him questioningly. He looks at me and smiles. After the client pays her bill and leaves, Dr. Curtis steps over to me and says: "I want to give her the litter rate and charge her less. I take pity on her because she is taking such good care of those kittens that she found."

"Good care" means that this client is making certain that the kittens are protected from disease, kept clean, and are free of parasites. She is positively sanctioned for this good care through lower costs. Like gold star clients, CAT members are also given litter rates and, unlike other clients, fees for medical services are not expected immediately after the office visit. They have a running tab. I once asked what their "tab" was and Lisa told me that it totaled over 5,000 dollars. In both cases, the client is taking responsibility for patients that are not companions.

Another positive social sanction that staff members use to reinforce the ideological consensus surrounding preventative health, is a greater degree of intimacy through self-disclosure and backstage access. Clients are generally not invited into the "back room." Staff members check in the patients and place them in the surgical cages themselves. When patients are picked up, a staff member will go get the patient from the back and bring him/her out to the client who remains in the waiting room. If a patient needs blood-work during the process of an exam, the client is expected to wait in the exam or waiting room. There are exceptions. If a patient is extremely scared and the staff member feels or the client expresses that their presence will "calm the patient down," then, sometimes a client will be invited back-stage. However, this invitation is infrequent. Some clients, however, have regular back-stage passes. I
frequently observed CAT volunteers backstage “checking on the kittens,” and “picking up” or “settling in” a patient.

Staff members are also more apt to disclose personal information to CAT volunteers and exceptionally “good clients.” On one occasion for example, I observed Doctor Curtis talking and laughing with a CAT client about his daughter and “how cute she is.” On another day, I overheard Lisa telling a CAT client about her daughter’s horse riding lessons. On another occasion, I had originally assumed that because Angie was on the phone discussing her impending graduation plans that she was not speaking with a client. Before she hung up, however, she brought up the computer screen and confirmed an appointment for four rescue kittens. Finally, Anna discusses her weekend plans with a couple that is, in her words, “so sweet...so caring and they come here often.” She continues to explain that they “always take such good care of their cats.” I asked her what “takes good care of” means. “Their cats are always loved, are never fat...they make sure to keep up with vaccinations and they make sure that their cats’ health is checked out regularly.”

In addition to greater intimate social disclosure by some staff members, this couple, along with other “nice clients” are offered “red carpet” service by the same staff members in the sense that they are met at the door and sometimes walked to their cars. After some time in the field, I found that I too was engaging in these positive social sanctions, albeit with an expanded definition of “good client.” I began to offer “red carpet” service to clients that appeared to display a significant amount of affection toward a patient. I began to recognize the cars of regular clients and met
them at the door. I not only helped open the door for one client that had saved a patient from euthanasia at another clinic; I walked him to his car. I distinctly recall walking back into the hospital and wondering why I chose to do this as it was not a regular practice for the hospital or myself. Later, I realized that I was communicating to him that his behavior of assuming responsibility for another client went beyond my own social expectations.\(^{101}\)

**Types of Human-Feline Encounters Associated with Preventative Health**

Human-Feline encounters associated with preventative health are notably affectionate and relatively free of tension. Typically, clients enter the hospital with a patient in a carrier. The receptionist or office manager will look up upon entry and ask “so who do you have with you?”\(^{102}\) Soon after entry however, many clients bring the patient out of the carrier and hold them or place them on the reception desk as they check in.

After Lisa asks the general greeting, an older female client who had just entered the clinic lifts the carrier slightly, “This is Sunshine.” Lisa, the office manager, smiles at her and puts the name in the computer. Mrs. Flannigan [a gold star client] puts the carrier down and smiles as she sees an orange paw reaching between the front of the carrier. “Oh, honey, come on out now ok?” She pushes Sunshine’s paw back in between the bars and opens the door. Sunshine is an attractive domestic shorthaired feline kitten that looks exactly like her name, bright expectant eyes and an orange coat the color of the morning Sunrise. She slowly comes out of the carrier on her own, intermittently looking around and looking up at the woman. “Come on out” said the woman. As soon as her body was completely out of the carrier, the woman

\(^{101}\) It was at that point that I also realized that I was originally under the assumption that clients would not often treat patients with such affection. I was pleasantly mistaken.

\(^{102}\) This greeting is significant because it is evidence that staff members regard the patient as a subject. It also indicates that clients are expected to accept this definition.
reaches down and scoops her up in her arms. She holds Sunshine like a baby on her back. I could hear Sunshine purring from where I stood a few feet away behind the reception desk. I smile at the client and she returns the gesture. Lisa stands and moves closer to the client and patient and exclaims while she strokes the patient, “well, aren’t you pretty?”

Each member of the encounter is relatively free of tension and reciprocally express affection. The atmosphere is pleasant for all participants. It is important to note that Mrs. Flannigan is a “gold star” client because she has “always taken such good care of her cats” and “never fails to pay when services are rendered.” In the context of checking in, staff members, particularly the office manager and receptionists tend to accord more affectionate displays toward patients who accompany “gold star” clients and kittens receive the greatest amount of affectionate displays in this context.

A CAT client brought in a tiny kitten, not even old enough for his first vaccination. She wanted to find out how much he weighed and have the doctor check him over quickly to determine that he was the “right weight” and “looked healthy.” Angie, Anna, Lisa, Pam and I were behind the reception desk discussing our weekend plans. When she walked in Lisa said “awww...who is this now?” Each of us took turns holding, snuggling, and speaking to him. “What a cutie you are.” He purred and snuggled into our hair. Most of us, I noted spoke in tones similar to that used to talk to human babies. When the kitten started to suck on Pam’s shirt she laughed. “I don’t have anything for you cutie, but you are in the right place.” Immediately a bottle was produced from the CAT client and handed to Pam. The kitten took the bottle right away and sucked greedily, his ears flapping each time he drew some milk. We watched him as he drank from the bottle. “He usually uses his paws to hold the bottle just like a baby” (CAT client).

In each of the above cases, the social context includes “gold star” clients, kittens and checking in for preventative health. It is important to point out that Sunshine is a “companion” and the kitten is a “rescue” whereby the social status of the patient in this context has little impact on the degree of tension or affection displayed by staff or clients. Moreover, while staff members tend to display a greater amount of affection
to patients who accompany "gold star" clients, this is not always the case, as the below example will show.

A young female walks into the clinic holding a black kitten with white paws in her arms. After the general greeting and establishing that this woman is a new client coming in to have the patient vaccinated, Angie and Lisa speak to her for a bit. The client rocks the patient back and forth in her arms and he begins to purr. Angie walks around the counter and gently strokes the patient [who responds by pushing his head into her hands] while she discusses the patient's behavior.

In this case, as in the above two cases, each member is mutually affectionate. No tension is observed in any of the members. The patient is also a kitten, which suggests that in the physical context of the waiting room, during preventative check-ups, with staff members, kittens are accorded more affection more than any other aged patient. In fact, during my analysis, I noted that no adult patient was treated with as much affection during check-in as kittens. This, of course, could have been the result of recording error. However, I did record many encounters, under different contexts where adult patients were petted and snuggled by staff members.

Another typical human-feline encounter is associated with clients and patients waiting to be admitted into the exam room. In this encounter, no tension is observed and the client and patient are mutually affectionate but the staff members are busy with general everyday paperwork or answering phone calls. The staff, while physically present, is paying little attention to the rest of the encounter members. Their job of "check-in" is accomplished and there is little left to do for the new arrivals, so they turn their focused attention elsewhere as they wait for the doctor to inform them that he is ready for the next patient.
While two clients (a female and male couple) wait for their appointment they sit side by side. The female client is holding a large orange tiger patient who is calmly sitting with outstretched legs. The woman is rubbing his stomach and he is looking up into her face. The male client holds a carrier in his lap as his fingers are wrapped around the bars of the door. The patient inside the carrier is gently rubbing against his fingers with her chin. Meanwhile Lisa is watching them and smiling as she speaks to another client on the phone.

In this encounter, clients speak to, pet, snuggle, or hold the patient. Patients are typically relaxed and reciprocating the affection by purring, pawing at, or rubbing against the client’s hands. While the receptionist or office manager is present, they are displaying little affection toward the patient, simply by virtue of being occupied with other clients and tasks. However, the staff member is not ignoring the clients, they are attentive to the amount of time that the rest of the group members are waiting. Waiting time in this hospital is generally short, however, when more than ten minutes elapses, the staff member will get up, check on the status of the doctor, and keep the client informed of the expected amount of waiting time remaining. “The doctor will be with you in a couple of minutes...he is just finishing up in surgery.”

After the doctor informs the receptionist or veterinary technical assistant that he is ready, the staff member will enter from the backside of the exam room and open the front door of the waiting room. “The doctor is ready for you now,” she will say to the next client as she stands back against the door to nonverbally inform them that they are expected to enter the exam room. Once all members (client(s), patient(s), and veterinary technical assistant) are inside the exam room she closes the front door. “Let me just get a weight,” indicates that the clients are expected to help the patient out of the carrier if the patient is still inside the carrier or hand the patient over to the
staff member. After the patient is weighed the staff member exits through the back door with the statement “the doctor will be right with you.”

Most often, this part of a preventative health practice is pleasant, smooth and tension free. Sometimes the patient will balk at being taken out of their carrier or slightly resist being placed on the scale, but otherwise the significant number of encounters, similar to when they are being checked in, are affectionate and without a significant degree of tension by participants. While the client and patient wait in the exam room, behind the back door to the exam room, the doctor is examining the patient chart that has been placed in a slot next to the door. He looks over the patient’s past history, recorded weight, name, sex,\textsuperscript{103} age, and purpose of visit. In this case, the purpose of visit is preventative check-up. He enters the exam room.

\textit{Significant Social Factors}

\textbf{The Pediatrician}

If the doctor entering is Doctor Curtis [pediatrician], he smiles as he enters and greets both the client and the patient. “Hello there,” he will say with a gentle smile, as he looks whoever is in the room directly in the eyes. He will then confirm the name, sex, and purpose of visit as he approaches the patient. He looks directly at the patient as he addresses him. “Well, young man I see that you are in for your second

\textsuperscript{103}I once asked Doctor Curtis exactly what he looks at when he is standing there looking over the chart. When he was explaining the list, he got to sex and said “as a sociologist I think that you will appreciate this side-note. Clients get really upset if you call a he a she or vica versa....they will correct me right away if I make that mistake.”

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booster.” The client will usually confirm the appointment purpose “yes we are” or sometimes they have an added purpose “he has also been a bit tired lately.” In other words, the client will answer for the patient. This action is clearly an important aspect of social interaction in the veterinary hospital. It demonstrates that clients empathize with the feline enough to attempt to understand their feelings.

While Doctor Curtis and the client discuss the purpose of visit and the patient’s behavioral history, Doctor Curtis will often intermittently address the patient and move toward him to determine if the patient will be receptive to his approach. If the patient appears content and relaxed, which is the case in more than half of the exams under preventative health with Doctor Curtis, the Doctor will feel his lymph nodes, while he speaks with the client. Once, however, the Doctor moves on to look inside the patient’s mouth, ears and eyes he will temporarily discontinue speaking with the client and turn all his attention to the patient. The Doctor will talk directly to the patient “that is a brave kitty....what a good kitty you are.”

With Doctor Curtis, a significant number of the encounters in the exam room are either mutually affectionate or the client and Doctor display affection while the patient either investigates the room or sits contently on the counter neither reciprocating affection nor displaying a great deal of tension. Even his commonly offered lecture about weight gain brings little tension to the encounter. The encounters in this context [pediatrician, physical exam, ideological consensus] are light, warm, and often filled with laughter as clients and Doctor share funny antics or quirks that the patient has or stories about human-feline relationships. In the context
of an exam for instance, a client shares with Doctor Curtis her brother-in-law’s “allergy” to cats while the patient lays quietly on the counter looking from client to doctor.

“Do you know of any allergy free cats?” asks the client. Doctor Curtis laughs and explains that the Abysian (which is a breed with no hair) combined with frequent house cleaning is sometimes associated with a diminishment in allergic reactions. “However, sometimes the allergic reactions can actually be worse because it is the dander not the hair that people are allergic to...[he laughs again and looks at her curiously] why do you ask?” She smiles and shakes her head “well, my sister wants a cat and her husband says that he is allergic to them...but I am not so sure...” Doctor Curtis laughs and says jokingly “he is probably pulling her leg.” Then he looks at me as well “From my experience, many men are the ones in the couple who don’t initially want a cat, then once the cat becomes theirs, they fall in love with them and it is his cat.” The client laughs and looks down at the patient gently stroking her “Yep that’s what happened with my husband.” Doctor Curtis pats the patient on the head, leans over and looks her in the eyes “yes, you are a good, smart kitten aren’t you?” We all laugh.

After the physical examination, Doctor Curtis will excuse himself and leave the room to pick up the syringes from the veterinary technical assistant. If he has another patient waiting in exam room two, he will take that opportunity to review that chart, greet them, determine the nature of visit, and physically examine that patient. If there are no patients or clients waiting, he simply returns with the vaccinations. It is at this time that the patient, if slightly tense to begin with, will become afraid. Doctor Curtis, aware of this, speaks for a bit with the client before affectionately reacquainting himself with the patient. Sometimes this calms the patient down, and the encounter remains relatively low in tension. However, on slightly fewer occasions, the patient’s tension does not diminish.

While encounters for the purpose of preventative health with the Pediatrician rarely present tension in clients or staff members, patients do get tense. This brings
me to the third most frequent type of encounter experienced by participants when the purpose of visit is a regular checkup. In this type of encounter, the Doctor and the client are experiencing very little tension and expressing affection toward the patient. The patient, however, is noticeably tense but does reciprocate the affectionate displays.

After returning with the vaccinations, the small orange kitten named wriggles freezes for a second and then scoots behind a cardboard stand on which dangles a variety of cat licenses. The patient almost knocks it over and the client looks at him and laughs. “I think that he does not want the shot.” Doctor Curtis chuckles and casually walks over to the counter. He begins talking to the client about how patients are “often afraid at the vet.” Wriggles crouches as low as he can behind the stand. While continuing to speak, Doctor Curtis glances at him and then looks at the client, shots in hand, stops speaking and smiles. Following his cue, she leans over and picks Wiggles up. Wriggles struggles to get out of her grasp as she calmly sets him down between her and the doctor. Doctor Curtis laughs, “well, he is a bit Wriggly isn’t he?”

Once the shot is carefully administered, with both client and Doctor holding him, Doctor Curtis pats Wriggles on the head “there now, you are all done” and releases him. Wriggles quickly moves closer to the client, leans into her stomach, and looks up at her face. She gently smoothes his fur, leans over, and kisses him on the head. Doctor Curtis laughs, “now he is going to be by mom...somewhere where he knows he is safe.”

In the above encounter, Doctor Curtis points out that patients are “often afraid at the vet.” This is a common statement made by both clients and staff members in the hospital. Not only are they “afraid” at the veterinarian’s office, but they are often described as “anticipating” the trip and trying to stop it. In the event below, the client has just finished explaining to Doctor Curtis how his cat Manny will sleep in a carrier if he “lets him.” However, the minute that the carrier is to be used to go to the veterinarian, the cat disappears. In this account, the client has brought both of his cats in for vaccinations. While one cat did not realize at first that they were going to the veterinarian, the other certainly did.
“Sammy was all excited for awhile like 'hey cool' then he realized where we were going...but he is not too bad. Manny, however, knew right when I brought out the carrier what was going on. He ran and hid. I had to bring him in a picnic basket today...there was no getting him in the carrier. That was a challenge as well though.” Dr. Curtis looks into Sammy’s eyes intently, then smiles at him saying, “Your brother is just more astute than you are isn’t he?”

After Manny has been given the injection, he tries desperately to get in the carrier [pawing at the door and scratching at the bottom]. After some amusement over his fear, the client helps Manny, by positioning the carrier in a more accessible spot. Manny quickly enters, spins around, and lies down. Doctor Curtis laughs and looks at the client, “you see, not only do they know when it is time to go to the vet; they know when it is time to leave.”

In most cases, in the context of check-ups, the patient’s fear does little to create tension in the human participants. This lack of tension attests, I believe, to the powerful impact that the preventative health ideology has on human-feline encounters in the clinic. The members believe that the fear is understandable, but “uncalled” for. It is inappropriate in this context, but “they don’t know better not to be afraid” and sometimes it is just something that “has to be done whether they like it or not.”

While it is a rare encounter during the practice of preventative medicine, that a client becomes tense, it is significant to point out that sometimes they do because they recognize that their cat, “their family member,” is afraid. On one occasion, when he was giving a patient a shot the male client looks at the doctor and says “that is not him trembling...that is me. I hate putting him through this.” After administering the shot, Doctor Curtis looks at the patient and says, “Dad’s all upset.” Then he looks at both myself and the client, “it’s like bringing a child in to the pediatrician to get shots. It is upsetting and sometimes more so for the parents then for the child.” In another encounter, a client cringes as Dr. Curtis brings out the needle. He looks at her and says with a smile, “like a pediatrician, sometimes I have to calm down the parents as
much as the patient...but you know that it has to be done.” In a way, I think that playing this role is an effort to keep the clients’ emotions calm and peaceful so the exam runs as efficiently as possible. He can “calm a client down” by speaking about his role, comparing it to a pediatrician, and pointing the clients’ discomfort toward “it’s in their best interest, just like with a child.”

The Mechanic

The atmosphere of encounters with the mechanic (Doctor X) is significantly different than with the Pediatrician. Because of the role, there is little humor, heavy silences, and less compliance by both patients and clients. Doctor X is more distant than Doctor Curtis during exams as he is concentrating on efficiency and medical problems. While he is more distant and experiences tension himself, he has little impact under preventative health on the degree of tension for clients or patients. There is, however, a slight decrease in affectionate displays under the influence of the mechanic. I utilize this example below because it is typifies the encounters with Doctor X present.

Dr. X and I entered and see a middle-aged Chinese woman in a pressed white oxford and silky black slacks. She was standing next to a very regal long hair tiger cat with a white stomach. In the middle of the room was an older white male leaning against a cane. He had on a rather worn red and white plaid shirt with jeans that were fraying on the bottom. In the corner of the room was a teenaged African American female with a rather bright orange shirt and faded out blue jeans. She was looking at the black and white domestic long hair kitten who was grabbing at the shoelaces which hung untied on her red sneakers. When we entered the room, the patient on the exam table walked toward the sink, seemingly unconcerned about our entry. He had an air of confidence and independence about him. He sniffed the sink and looked over at the adult female client. She smiled and said “Taabi” placing a heavy emphasis on the last letter. Taabi meowed at her and turned away. She laughed and smiled at me. Dr. X interrupted, mentioning the reason for their visit – check-up and
vaccinations. The adult male client confirms and the woman tells the doctor “Taabi
...ah...healthy and eat well just need...shots. Fluffy just check-up need because he
not feeling well.” The Male adult interrupts “yes, Fluffy is usually tearing around
the house, but the last couple of days he just sleeps...which for him is unusual.” The
girl interjects “yeah, but he does seem a bit better today.” The clients laugh and look
at the kitten who is now pulling the shoelace and jumping around as if trying to
dislodge the snake from its hole. Doctor X nods sets down the syringe that is filled
with vaccines on the left side of the sink and then moves toward Taabi. Taabi looks
up at him but remains still. Doctor X reaches over, feels his lymph nodes and looks
in his ears without complaint from the patient. He then picks up the patient and
moves him to the middle of the island on the counter. He waits for a second and
looks at the adult female client. She makes no move to hold the patient. The doctor
looks back at the patient and sighs. He then places his hands around the patients’
face and pries open Taabi’s mouth to peer inside. Taabi makes no move to get away
but growls as the doctor pushes his mouth open. After the doctor quickly looks into
Taabi’s mouth he lets go. Taabi shakes his head and looks at the adult female who
smiles at the patient. The male client snorts. Satisfied that all is well, the doctor
reaches over to pick up the syringe. “This is a multi, so we only need one.”

“Good luck” says the male client with a chuckle. The doctor stops approaching
the patient and looks at the man. “Oh, is he not going to take this well?” After
receiving the shot, Taabi walks over to the female client and she pats his head. He
looks up at her face then turns, walks over to the sink in a regal manner, and resumes
his original spot.

All attention turns to the kitten, who had been running around sniffing corners all
the while Taabi was being examined. The girl had stood very still until now, notes
that our attention has turned to the kitten. She walks over to the kitten to pick him
up. He skirts from her hands and jumps at her shoelaces. The clients and I laugh
and shaking her head she pries him from her shoelace and lifts him up to the exam
table. She places the kitten on the end of the table and the kitten quickly jumps off
again. Doctor X, not amused by the kitten’s antics catches him in mid-jump and
methodically places him back on the counter. The kitten squiggles in his hands
trying to place his back legs on the doctors’ hands to get a grip firm enough to jump
down. The kitten continues to squiggle and squirm throughout the exam. Doctor X
appears to look a bit frustrated while trying hard to keep the patient still. After a few
minutes of struggling to feel the patient’s lymph nodes and inside his mouth, the
doctor lets go of the patient and reaches for the stethoscope that is hanging around
his neck. As soon as the doctor lets go, the patient scrambles toward the end of the
counter and takes a flying leap off of the counter.

Recognizing that the he would not mind if I help at this point, I catch Fluffy [the
kitten] and place him on the counter close to the adult female client. I smile at her
hoping that she will get the drift that she is expected to hold the kitten in place or that
I would be doing it. The client smiles back at me places her hand on Fluffy’s back,
and leans into the counter to keep him in place. Doctor X looks at me and smiles
with a slight sigh as he places the ends of the stethoscope in his ears. I move back to
“my spot” against the wall. Once the doctor has placed the stethoscope on the
kitten’s chest, the female client begins to stroke Fluffy’s head [probably to get him to
stand still]. For a few seconds, Doctor X listens. Then he stops abruptly looks up at
the client and says with what I have come to know as exasperation “could you please
stop petting for a second so that I can hear something other than petting in the
stethoscope?” The client immediately puts her hands down to her sides and fluffy
begins to squiggle. Doctor X sighs and holds tightly to the patient’s underarms and
listens while the patient tries hard to get away. He looks up at the female client,
“let’s check his temp.” She nods and Doctor X continues to look at her for a second.
Then he sighs again and says to her “could you?” Then looks down at the flailing kitten. The client nods and grabs Fluffy on both sides, forcing him to stand somewhat still by placing her body against his head. Doctor X quickly grabs a thermometer out of the cupboard and places it gently inside of the patient. Fluffy tries harder at this point to struggle from the client’s grasp. The client, however, succeeds in keeping him still enough to finish the job. We all stare at the thermometer in silence. Finally, Doctor X looks up at the female client and states, “his temperature is only slightly elevated, I think that he probably has an upper respiratory. He is on the back end of it but we will give him a shot of penicillin just in case. I will be right back, I just have to go get it from the back.” I follow him out of the room.

He informs Nell, while handing her the chart, that he needs a syringe of penicillin. She smiles and says “sure thing.” She has it in a manner of minutes. When we reenter the exam room the client’s are laughing and looking at Taabi. The client looks at me and then back at Taabi. She calls to Taabi (placing emphasis on the aa again) and he looks over at her and meows. The clients laugh. Taabi then looks at doctor. The woman continues to look at Taabi and she chuckles and says “Taabi” as before. Taabi looks back at her and says “meooow” with a slightly longer emphasis on the o this time. I laugh. Doctor X shakes his head with a frown and closes the door. Fluffy, noting the closing door makes a wild jump and dashes toward it, hits the door, shakes his head and zooms away in the other direction around the teenager’s feet. Because Doctor X does not seem amused by the scene I try hard to suppress my laughter, but my eyes are watering and I am smiling. The adult female client looks at me with a smile then back at Taabi and says “Taabi.” Taabi, who had watched Fluffy’s antics, looks at the female client and meows again – this time the meow sounded like a question with the inflection on the end of the meow. Doctor X sighs again and interrupts them. “Ok,” he looks at Fluffy who is being picked up by the teenager and placed on the exam table “penicillin stings a bit so he probably won’t like this…we will probably get a reaction” while speaking he moves to inject the kitten in the right rear thigh. Before he is completely done fluffy jumps out of the doctor’s grasp and does a 360 in mid air. The doctor moves back and looks at the syringe, which is practically empty, “ooohh I didn’t expect that much of a reaction” he laughs. The clients all laugh as well and the adult male client says, “he is always jumping.”

It is not that Doctor X has no sense of humor. Backstage, he is very funny. There is a great deal of bantering and joking occurring when he is in the prep room with Nell and Ezra. However, his demeanor changes drastically when he is examining a patient. He is very serious and expects clients to control the patient so that he can “do his job.” Interestingly, clients tend to interpret his lack of affection toward the patient and his lack of discussion with them as an indication to “back off” and let him do his work. He then ends up receiving less help from the clients than the doctor who plays
the role of Pediatrician. This lack of compliance from the clients tends to increase Doctor X’s tension. His concern it seems to be focused on the patient’s health more so than the client’s comfort and balancing these interests appear to be more problematic for him than for the pediatrician. While his tension is increased however, Doctor X’s mechanic role and his own tension does little to influence the degree of tension experienced by the clients and the patients during preventative check-ups. His role does, however, slightly decrease the degree of affectionate displays. He interrupts client-patient affectionate interaction and thereby decreases a client’s affectionate display. He displays very little if any affection toward the patients and they seem to reciprocate this distance. Although Taabi was affectionate toward the clients (more so with the female client) he did not attempt to offer any affection toward the doctor. During my observations in the field, I never noted a patient to be affectionate toward Doctor X. What this suggests is that patients, do respond to human interactional dynamics as they do to the social context.

Client Presence

While encounters within the context of ideological consensus of preventative health are notably affectionate and lack a significant degree of tension, I wish to point out that the client’s presence appears to have a significant impact on the degree of tension experienced by some of the patients regarded as “companions.” While most often, preventative health encounters occur with client presence, sometimes a patient will need to be brought in the prep room to run blood-work before vaccinations are
given. In this situation, the Doctor will generally have the veterinary technician or veterinary technical assistant come pick up the patient while the client waits in the exam room. Very often, the distance from the client will increase or create the patient’s tension. If the patient begins to scream in the prep room, this also creates tension in the staff members, as they fear that the client will hear and believe that they are “hurting” the patient and become upset. Staff members belief that clients will interpret this behavior in this manner is not unfounded, as the below example is intended to help illustrate.104

Two clients (an older female and her teenage daughter) came in today with a young Calico kitten. The doctor was in surgery and both exam rooms had clients waiting. The woman expressed distress that they “could not wait.” She asked if they could just quickly vaccinate her in the back room. While Marcie went to ask the doctor if that was acceptable the woman and the daughter waited. While they waited, the daughter took the kitten out of the carrier. Both clients snuggled the kitten before they set her down. They also talked to their “pretty baby” and played with her. The patient pranced around next to the girl who was sitting on the floor and frequently stopped playing to rise on her hind feet to rub the girl’s face.

When Marcie returned with permission to bring the patient into the prep room, the woman gathered the patient up and walked over to the counter. The second that the woman handed the patient over to Marcie the patient began to hiss, claw and spit at anyone who came near. She struggled desperately and aggressively to get out of Marcie’s grasp. The woman looked shocked. “Wow. I never saw her act like that.” The girl, who had remained on the floor jumped up and ran to the counter as Marcie was moving into the prep room. “What are you doing to her! I don’t want you to hurt her bring her back right now!” Marcie and Lisa tried to explain to the girl that they were simply going to give her a shot and that she “has to have them.” The woman interjected and offered to go back with them. Marcie agreed that “maybe that would calm her down.” It did not. Marcie and Lisa decided that they should scruff her to vaccinate her. The Scruffing made the patient scream hysterically and the girl starting to yell from the waiting room “Mom what are they doing to her?” The female client went quickly out to explain the practice to her daughter. After a few failed attempts to inject the kitten, Marcie decided that maybe some time with the girl could calm the patient down. She hurriedly brought the patient back to into the waiting room. “I just don’t want to try right now...here...” The woman took the kitten and the kitten spit at her. The girl ran over and as soon as she gathered the kitten in her arms, the kitten calmed down and began to purr as they looked into each other’s eyes. Then the girl let the kitten climb up to her shoulder and sit there. “This is her safe place,” she said to all of us watching them. The woman walked over to them and the kitten, seeing her, reached out to her. The

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104 Further evidence of these definitions will be provided in other practice chapters.

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woman picked the kitten off the girl’s shoulders, held her next to her face as the kitten reciprocated the gesture with a short rub. The woman smiled then and explained to us, “she is our baby, you know.” A few minutes later, Doctor Curtis came out of surgery [there is a glass window between the rooms so he saw what had transpired], “why not let us vaccinate her when she is under for her spay?”

Notice that there is evidence of a strong bond between the girl and the kitten. The kitten is extremely distressed at the separation from the girl and not even the woman (whom she was also affectionate toward) can calm her down. Only the presence/absence of the girl appears to dramatically change the degree of tension felt by the patient. Likewise, the girl is extremely distressed by the patient’s fear. Other members try to “help the girl understand” that, despite the patient’s fear, “it is in her best interest” to get the shot. If the girl had actually continued to define Marcie’s behavior as “hurting” the patient, I am certain that she would have run back into the prep room to stop it [as her mother appeared to understand as well]. After talking to Marcie later, she was visibly upset by the encounter. “I wasn’t hurting her. That girl thought that I was hurting her.” Lisa reassured her, “of course you weren’t, the girl just didn’t understand that is all.” Marcie nodded and looked at me “we should have shut the door, clients get really upset when they hear their cat screaming...and we are doing what is best for them.”

Discussion: Controlling Nature

Out of the recorded encounters, 49 of are for the medical purpose of preventative health. While types of encounters defined by affection and tension in the primary
participants of an encounter (staff, clients and patients) can feasibly amount to sixty-four different variations—five predominated. Collapsing this into the patient-staff encounters 16 possible types can occur, five do, and three predominate. This is significant because it provides strong evidence that human-feline encounters are not individualistic experiences, but rather influenced by the social context in which they occur. Of these encounters, most of them are notably affectionate. With the exceptions of Doctor X’s frustration over the lack of compliance by the clients and Marcie’s concern that the girl was defining her behavior as “hurting her cat,” staff members experienced very little tension. In fact, only 10% of all the encounters analyzed with the purpose of preventative health presented tension for staff members. Doctor X experienced a significant majority of these.

Ideological consensus regarding preventative health has a significant influence on the staff members’ degree of tension in human-feline encounters. They honestly believe, as do I, that vaccinations and parasite control are in the patient’s best interest. They feel that they are doing what “is right” and helping to protect animal welfare. As such, they are relatively unconcerned about a patient’s experience of tension.

Because staff members adhere to this institutional ideology, they employ sanctions and work to “educate” clients in order to maintain this consensus. While trying to increase awareness of the needs of “companion animals” may be viewed by some as morally responsible and “good,” it does not negate the possibility that joining economic and political forces (as done through “educational campaigns”) creates a formidable wall for other voices to hurdle. The construction that vaccinations for
instance must be included in the “proper” care of “companion animals” is a culturally contested idea. Many “holistic” veterinarians believe that because “vaccinating sets up a permanent disease state that prevents the body from getting that specific disease (since it "already has it") [it] weakens the vital force when it comes to everything else” (Bernstein 2001:1).

Holistic medicine encompasses many fields of medicine from acupuncture to herbal therapy and chiropractic to massage therapy. Many of these “alternative” medicines have been around for a very long time and therefore have a great deal of empirical and traditional knowledge behind them. Acupuncture, for instance has been practiced in China for over 4000 years. However, holistic veterinarians are frequently painted as “non-scientific;” which, although it is slowly changing (in large part because of the Internet which increases the availability of alternative discourse), is still largely a death sentence in the United States. Western scientific medicine and the pharmaceutical industry have great economic interest in keeping resistant voices silent and thereby limiting the choices that subjects have to choose from when caring for others. Often, as in the case with the rabies vaccination being a legal requirement of “owners,” these limitations are very real, and resistance can have serious social consequences.

Although clients are sometimes painted by staff members as “ignorant” to the prevailing institutional consensus that preventative health is important for “companions,” my analysis provides evidence that they are far from ignorant. Rather, they tend to conform to this practice ideology and the underlying assumptions
supporting it. This consensus then, hinders any tension they might encounter when their “family member” is experiencing “emotional” tension. In fact, when the purpose of visit is preventative health very few clients express any tension and express the greatest amount of affection.

While patients are generally “afraid at the vet,” preventative health presents the least amount of tension for them. This is most likely due to the fact that the client’s are present and are experiencing very little tension. The increase in tense behaviors when a client is separated from a patient suggests that felines, like humans have the ability to bond with another species and that this bond is socially powerful. This finding supports other research on an animal’s experience of the human-animal bond.105

While the distinct roles played by the two doctors have an impact on the overall atmosphere of the encounter, their influence on client and patient tension and affectionate displays is not as significant as I expected. I expected clients to respond to the social cues of the authority figure in their interactions with patients. This expectation came from the empirical findings from Arluke & Sanders’ (1996) ethnography of human-animal interactions in a laboratory setting. In their study, technicians appeared to take their cues on how to interact (displaying affection or not) by the attending scientist. In the laboratory where the authority figure treated lab animals with affection, so did their staff. In the laboratory where the authority figure

behaved toward lab animals as objects – displaying little affection, the staff members behaved likewise.

The lack of influence on displays of affection and tension by the veterinarians (one acting more affectionate toward the patient than the other) could indicate that clients do not define veterinarians as "authority" figures. Veterinarian-client relations are service oriented, while laboratory scientist-animal technician is occupationally oriented. However, clients did recognize Doctor Curtis’ authority as he lectured them about patient weight gain. Clients felt somewhat embarrassed about it and often promised the doctor that they would “try harder” to comply.

This lack of influence could also attest to the power of the patient-client bond. Likewise, humans that are distant toward their companion in other medical contexts, are similarly unaffected by the type of doctor present. When a client is considerably distant toward a patient under other medical contexts, despite the calls for attention from a patient, Doctor Curtis, would sometimes try to bring a client’s attention to a patient’s social cues for comfort “awww she is upset.” Clients tend to ignore his comments in these situations. In other words, other members of an encounter, whether authority figures or not, may have little impact on the affectionate displays because of factors involved with the relationship between the dyad that could not be explored here.

Arluke & Sanders (1996) suggest that the labels that humans place on ‘other’ animals have a significant impact on encounters with them. The closer that the ‘other’ animal is to human society, the greater the degree of affection will be
experienced within an encounter. Felines are defined in the veterinary institution by their perceived inclusion in the domestic realm; by the distance from “nature:” companion (owned), rescue (waiting for adoption), and stray (straying from human protection or society). From this, one should expect that companions will be offered the greatest amount of affection by all human participants. Supporting this theory, strays are treated with a great deal of distance, through concern over contagion (they are placed in isolation, not pet, and gloves are sometimes worn by staff) and they are not vaccinated. However, rescues in this context (preventative health), are accorded the same amount of affection that companions are and in this sense, the labels are not as influential as expected.

The age of the patient has an impact on human-feline encounters in the sense that staff members show younger patients more affection in the waiting room when the purpose of their visit is preventative health. In part, this may be because people have been known to be more attracted to younger animals than older ones. If the reader will recall, I pointed out that during his interviews with 40 “pet-owners” for the purpose of understanding the way that they talked about and related to “their pets,” Belk (1996) notes that several participants claimed to have lost their fascination with their pets as they got older. Likewise, through interviews with people “giving up their pets” to an animal shelter Tuan (1984) finds that growing out of kitten-hood or puppy-hood is one of the expressed reasons for relinquishment. One theory behind this is that “pets” and particularly the “cute” and “active” kittens and puppies bring much needed “playfulness” into otherwise “serious” and mundane human existence.
Animals have long been a source of human amusement and a source of and vehicle for folk wisdom. With pets we proclaim that perhaps there is too much sense in our lives and we need a little nonsense in order to give us an opportunity to see our small, cute, and guileless pet (and potentially alter ego) improbably succeed in getting his or her way in a world of larger animals, including human adults. And the "cuteness" that provides both amusement and strategic advantage to our pets is often a result of neonatal features... (Belk 1996:3)

In other words, people might be more affectionate toward kittens because they are fun and playful. This "cuteness" fulfills a human desire for enjoyment. We keep them around because they "make us laugh;" they serve a social function. Possibly, this greater attraction and desire to be affectionate toward kittens plays into a human desire to nurture. Maybe the Biophilia hypothesis as developed by Edward O' Wilson (1984) can answer this question. It is possible that kittens are simply more receptive to human affection and this reception helps humans to fulfill the inherent desire to connect with beings other than human. I don't deny that these might be factors explaining why humans tend toward younger animals. However, I believe that there is also another reason, much more mundane, for why kittens in a veterinary hospital are more likely to receive affection; one that conforms to an idea about the place of felines in human society. I will discuss this in the next chapter. Whatever the reason, it remains that in the waiting room (many people were just as affectionate toward adult cats in the exam room), in the context of preventative health, encounters with kittens are slightly more affectionate, at least for staff members, than encounters with cats.
From my analysis, I am convinced that more than any other social factor, the practice ideology, which conforms largely to animal welfare ethics in the veterinary institution, has the most significant impact on the tension and affectionate displays that define an encounter. When human participants agree that a practice is in the ‘other’ animal’s best interest little tension is experienced by human participants even when that ‘other’ animal is defined as experiencing negative emotions. If a client does become tense because of the patient’s fear, the pediatrician will remind the client that “like children, animals don’t know what is best for them.” This reminder functions not only as maintenance of ideological consensus, but also as a tension management strategy employed by the pediatrician to control the emotions of the clients. The implicit assumption here is that humans can and should control the lives and the bodies of ‘other’ animals, even against their will, if that control can be defined as a part of their larger “welfare.”
CHAPTER 5

NEUTERING

*My Scalpel is My Sword*

While many people are unaware of it, there is a war going on in America. I am not referring to the current “War on Terrorism,” but rather the war on feline overpopulation. This war is against the overpopulation of felines and the “irresponsible” people who support this “problem.” This war is fought in defense of helpless felines who can not control their own population and end up being “destroyed” at animal shelters. The primary soldiers in this war include the veterinarians and their staff, the animal shelters and their employees and responsible “owners.”

In this chapter, I first present the war on feline overpopulation as the participants in the cat hospital and the larger institution define and understand it. As with any social problem, participants have their own ideas, conforming to the larger institution on what the problem is, what contributes to this problem and what “weapons” must be used to fight the battle. As such, I outline the problem, causes, and solutions to this problem defined by the participants. Included in this, is the ideological consensus that neutering is the most legitimate solution to fighting the war against
'overpopulation.' After the ideology of the practice and its consensus has been demonstrated, I move on to present the human-feline encounters most associated with the practice of neutering. As I hope the reader will come to appreciate, the ideological consensus, which conforms to the animal welfare ethic, and social maintenance of this consensus help to structure these encounters. However, the interactional dynamics of human-feline encounters are also highly dependent on the material and social context, the patient's social status and age, as well as the manner in which the patients express their tension.

**Neuter Ideology: The Social Construction of a Problem**

"Too Many Unwanted Animals"

From the perspective of the veterinary institution and staff participants, there are simply too many "stray and unwanted cats out there."

"The problem of overpopulation of unwanted cats in the United States is insidious and relentless"107

"There are so many of them. You see them running around the roads more than wild animals even"108

"In Massachusetts, we have learned that 200,000 human-cat relationships end every year. Of these cats, 120,000 die, but 80,000 go somewhere else....There are 16 open-admission shelters in Massachusetts, and in 1993, they admitted nearly 56,000 cats. About 41,000 of those cats were euthanatized. Approximately 60% of the cats admitted were owned, and about half of the total were kittens. Because of the seasonal nature of cat reproduction, most of those kittens arrive between May and October. It is not unusual for MSPCA shelters alone to admit 2,500 kittens less

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106 The battle metaphor is frequently used in the *Journal of the American Veterinary Medical Association* and sometimes used by staff participants to describe solutions or "weapons" in "fighting" the "overpopulation problem."
108 Interview response by Victoria (Veterinary Technician) to the question "do you believe that there is a cat overpopulation problem?"
than 6 months of age in a single summer month. In a good month, we will find homes for 500 kittens. Yes, we are overwhelmed by the volume.\textsuperscript{109}

"The U.S. Census Bureau estimates that 450 citizens are born every hour. In contrast, the Humane Society of the United States estimates that 2,500 to 3,000 dogs and cats are born every hour. This birth rate results in a surplus of animals and contributes to the pet overpopulation problem."\textsuperscript{110}

Felines that are "out there" are subject to crowding, disease, parasites, weather conditions, starvation, and shortened life spans from human ignorance or cruelty.

"The life expectancy of an outdoor cat is two to five years, whereas indoor cats may survive for 17 or more years. Free-roaming cats are in danger of injury or death caused by vehicles, attacks by other animals, human cruelty, poisons, traps, and disease."\textsuperscript{111}

"...Additionally numerous other unwanted animals die from exposure, starvation, or trauma."\textsuperscript{112}

While being 'out there' in nature is painted as dangerous, by far the greatest effect of this problem is the "mass extermination" of millions of "unwanted and homeless" felines.

"I sit on the companion animal advisory board and I see the number of healthy animals that are euthanatized because of the overpopulation of unwanted animals so...most definitely I know that there is an overpopulation problem."\textsuperscript{113}

"An estimated 5 to 7 million cats are euthanatized in animal shelters in this country annually. That number equates to 1 death approximately every 5 seconds..."\textsuperscript{114}

"Currently, 63 percent of animals going into shelters are euthanatized."\textsuperscript{115}


\textsuperscript{111} From an AVMA animal welfare policy statement. Journal of The American Veterinary Medical Association. 2001 219(2): 164

\textsuperscript{112} Howe 1997:57.

\textsuperscript{113} Staff member response to an interview question "do you believe that there is a cat overpopulation problem?" (Doctor X)

\textsuperscript{114} Akrow, 1991:1170


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"This is the major reason for the Council’s continuing studies into the problem of pet overpopulation."  

“Between one tenth and one fourth of our nation’s pets are destroyed annually because they lack owners who are paying clients.”

“One day, one of her veterinary students asked Dr. Patricia N. Olson, ‘How would the veterinary community respond to a disease that resulted in the deaths each year of between one tenth and one quarter of the entire pet population?’

Dr. Olsen answered confidently, ‘We would respond with great fervor, similar to the way we did with parvovirus.’

The student’s next question jolted her. ‘Why is it, then, that for decades, millions of unwanted dogs and cats have died each year because of pet overpopulation?’

‘The student was asking me about the ‘disease’ of euthanasia.’

In other words, the problem is not only that there are large numbers of felines, but that there are not enough owners to accompany this ‘vastly overpopulated species.’ Without these “owners” these “excess cats” are being brought to the humane shelters annually by the millions and many of them “have to be euthanatized” or die from the “disease” of euthanasia.

**Ignorance, Irresponsibility and Disposable Attitudes**

The major causes of this problem include public ignorance and irresponsibility fostered by a general attitude toward animals as disposable items. First, people are ignorant of the general nature of cats.

"People let their cats out and they think because they are in sight that they won’t get pregnant...but then the cats slip away and get pregnant...people just don’t realize that cats will make babies...it’s natural.”

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117 Olson et al. 1991:1151.

118 Interview with Doctor Patricia Olson, a leader in the “battle” of overpopulation by Kahler 1992:973.

119 Thorton 1992:660

120 Interview response by Pam (Caretaker) to the question “What do you believe causes the cat overpopulation problem?” This question was only asked if respondent said that they believed that, there was one. All the staff respondents believed that there was a problem.
"Many of the problems now faced by municipalities related to poorly supervised or unwanted pets are the result of a poorly informed public." 

From this perspective, people don’t realize or don’t care that human “desire” to be close to nature or socializing children to the “wonders of nature” can also contribute to the “problem.”

“As parents, we want our children to experience the ‘miracle of birth’ as it relates to the family pet. However, if 1 litter is allowed to be born, the effects on animal overpopulation can be overwhelming. If 2 cats produce 8 kittens/y, production of 174,760 cats in 7 years could potentially result.”

Some of the public, participants believe, just want to “capitalize” on the “miracle of birth” and this “greed” is understood to add to the problem.

“Breeders don’t help the situation...oops sorry...Well, the problem really is people not really thinking about it...especially in smaller towns where there may be a lot of barn cats...and of course the breeders make money off what they do and that is all they are interested in!”

In addition, some staff members argue that some humans are simply irresponsible. They fail to “care for” the welfare of felines because they foster sentimental beliefs about how felines should be “free.”

“I guess some people feel bad about it...they don’t get a chance to experience it [have sex or babies] but once the animals are domesticated there really is no choice in the manner. You can tie them up or make sure that they stay inside if they are not fixed. It’s a responsibility thing.”

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121 Beck 1981:238
123 Ezra had mistakenly thought that I was a breeder throughout our fieldwork together...results from my observations with her may be influenced because of this role *see methods section for discussion.
124 Interview response by Ezra (Veterinary technician) to the question “What do you believe causes the cat overpopulation problem?”
125 Interview response by Laura (Veterinary receptionist) to the question “what do you believe causes the cat overpopulation problem?”

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This failure to control pets out of ignorance or irresponsibility contributes to the problem. Here a part of the solution to the cat overpopulation problem becomes glaringly evident; “humans ought to control felines.”

“A new position statement titled ‘Free-roaming, Owned Cats,’ which the Executive Board approved states: ‘The AVMA strongly encourages owners of domestic cats in urban and suburban areas to keep them indoors.’126

“The focus should be on the offenders, such as those who are letting their animals run free.”127

While greed, irresponsibility and ignorant or sentimental beliefs about feline freedom contributes to the problem according to both the larger institution as well as many staff participants, by far, the largest contribution to the “cat overpopulation problem” – the phenomenon that nurtures ignorance and irresponsibility -- is the larger public’s attitude that animals are “disposable objects.”

“This problem is not simply the result of the breeding of unowned cats; it is also a reflection of irresponsible and negligent owners, coupled with current societal attitudes that everything is disposable.”128

In an article published in the 1993 Animal Welfare Forum section (dedicated to the overpopulation of dogs and cats) published in the American Journal of Veterinary Medicine, Roger Caras recounts two stories to illustrate the cultural attitude that animals are disposable items.

“In a shelter in Virginia, a woman came in and said to the woman behind the desk, “I want to have my cat put to sleep.” When the shelter worker opened the cage, the young cat inside, in excellent condition, arched its back, purred, and rubbed. It

was a sweet and loving cat. Before the shelter worker could ask what was wrong with the cat, the woman said, “I’d like to go to the adoption section and adopt a new cat.” The worker asked, “What’s wrong with this cat? She’s very loving, and she’s obviously in very good health.” And the woman said, “I had my apartment painted, and the eyes are the wrong color.”

... “In East Hampton, New York, typically on Labor Day, the people from the Animal Rescue Fund sweep the town dump; the one time I was involved, we picked up 27 dogs that had not been there the day before. It was Labor Day weekend, the weekend when people dump their summer pets and go back to Manhattan. They adopt pets in spring and throw them away in autumn.”

This cultural attitude towards animals is widespread in the United States.

“...Why have we not matured here in the United States and Canada, where animals are routinely thrown out of cars along the highway? Why does the ASPCA see 100,000 animals per year in New York City? Because we have an attitude, that, in large measure, has evolved as simply ‘throw it away.’

“Some people think that animals are disposable items!”

“...or that their lifestyle cannot accommodate animals and then the animal ends up in a shelter.”

“We are a nation that considers its dogs and cats to be disposable.”

From the perspective of the larger institution and many staff members, the reason that there is a cat overpopulation problem and that so many felines are euthanized, is because a large amount of the human population believe that felines are disposable objects. Cats become homeless because of this irresponsible attitude; shelter workers are then “forced” to reduce the population in the most “humane” way, euthanasia.

“Irresponsible owners are primarily responsible for the problem of surplus dogs and cats. Within a 1-year period, approximately 15% of pet dogs and 35% of pet cats are no longer in their original home.

“Only a few of the excess pet animals will find a home, and the closest to welfare we can provide the vast majority is a humane death. The kindest thing we can do is to collect and euthanatize them.”

129 Caras 1993:911.
130 Interview response by Lisa (Office Manager) to the question “What do you believe causes the cat overpopulation problem?”
131 Interview response by Doctor X (Part-time Veterinary Doctor) to the question “What do you believe causes the cat overpopulation problem?”
133 Beaver 1991:1241.
"...euthanasia is probably the most humane option for healthy and unhealthy pets without homes..."\textsuperscript{135}

Leo Bustad (1996), one of the most notable veterinary practitioners and active in fostering the humane welfare of ‘other’ animals sums up many of the above assumptions in one statement:

In 1974, an estimated 15 to 18 million dogs and cats were killed in our animal control centers. Some said that they were just stray animals, but 80% had been owned by somebody....Animals were regarded as recyclable items, throw-away items....Pets were not being controlled... (204).

The institutional assumption is that much of the public thinks about and treats animals as disposable. They do recognize that some individuals try to help felines that have been disposed of by feeding them and sometimes bringing them inside temporarily in harsh weather conditions. These people, according to veterinary medicine and some staff participants care in the wrong way.

"People dump off their cats which are not neutered and then people feed these strays and they breed."\textsuperscript{136}

"People are not taking care of their pets, not getting them neutered in a timely fashion. And people are not taking their part in the community to eliminate the problem...such as feeding strays. If people are feeding strays in their neighborhood then those strays will be satisfied and be better able to breed. Also, not helping to spay/castrate the feral and stray population."\textsuperscript{137}

The “proper” way to care about felines is not to let them “run around free” but to control them. Felines are better off as property ‘inside’ human society or even better off dead than free ‘outside’ in nature. However, there is general agreement that

\textsuperscript{134} Thorton 1992;\textsuperscript{135} Olson et. al 1991\textsuperscript{136} Interview response by Lisa (Office Manager) to the question “what do you believe causes the cat overpopulation problem?”
restricting a feline’s ability to go outdoors is simply not enough. As Pam remarked in the earlier interview, “they can slip out of sight.” Humans must also control their bodies; must make it impossible for them to breed so that this “rampant overpopulation” can be stemmed. According to many staff members and AVMA, the most effective method to date is the medical practice of neutering; and the earlier the better.

The Arsenal and the Most Legitimate Weapon

The veterinary institution, along with all staff participants currently agree with the various National Humane Organizations that neutering is the most legitimate weapon in battling this overpopulation problem.

"Pet overpopulation continues to be a substantial problem in the United States. Because all methods of pet birth control involve veterinarians, they play a critical role in battling pet overpopulation. Although many methods of pet birth control have been examined, gonadectomy [early-age neutering] remains the mainstay."\(^\text{138}\)

"Pet owners can do their part by having their companion animals spayed or neutered. This is the single most important step you can take. Have your pet sterilized so that he or she does not contribute to the pet overpopulation problem."\(^\text{159}\)

"Well, number one is spaying/neutering. You can only adopt out so many animals. Then you have to euthanatize because what are you going to do with them?"\(^\text{140}\)

"As an animal rights advocate, I feel very strongly that we are obligated to have our animals spayed or neutered."\(^\text{141}\)

"Spay/castration at a younger age."\(^\text{142}\)

\(^{137}\) Interview response by Doctor Curtis (Owner and full time Veterinarian) to the question “what do you believe causes the cat overpopulation problem?”

\(^{138}\) Howe et al. 2000:1661-1662.

\(^{139}\) http://www.hsus.org/ace/11855

\(^{140}\) Interview response by Dr. X (part time Veterinarian) to the question “in your opinion, do you think that neutering is an effective control for the pet overpopulation problem? Are there other policies that you might find effective for this problem?”

\(^{141}\) Interview with Dr. Taylor (V.M.D. and animal rights activist) by Susan Kahler 1993:844.
In fact, gonadectomy or "early-age spay/neuter" where "cats as young as 6 weeks, instead of the traditional 6 to 9 months, are surgically altered" (Mahlow & Slater 1996:2017), is officially endorsed by the American Veterinary Medical Association in the United States in 1993 in order to "target" the shelter populations. While this medical practice has been used unofficially since the early 1900's for dogs (Salmeri, Olson & Bloomberg 1991), it is promoted officially for dogs and cats in 1993 because AVMA wants to "take a leadership role" in "combating the overpopulation problem" (Kahler 1993:593). Neutering before adoption from animal shelters is understood to be more effective in reducing the overpopulation because litters born from shelter adoptees before they are neutered can be eliminated. It is believed, and supported by empirical evidence (see Tuan 1984), that people often wish to have kittens and are failing to neuter before the feline is "allowed" to have at least one litter.

"Early-age spaying and neutering—because overpopulation can continue when just 1 litter is allowed to be born, methods of preventing pregnancy must be permanent and must be used prior to the birth of the first litter. For this reason, humane organizations were the initial promoters of prepubertal surgical sterilization."144

"Well, I think that it certainly has cut down on the amount of kittens we are seeing. You know that before cats can be adopted out CAT and Animal control have a requirement that cats must be neutered before they can leave or there has to be a deposit if the cat is too young. The deposit does not always insure that people will have it done. With early spay/neuter then, we can often make sure that kittens are neutered before they go to the home."145

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142 Interview response by Lisa (Office Manager) to the question "in your opinion, do you think that neutering is an effective control for the pet overpopulation problem? Are there other policies that you might find effective for this problem?"
143 The official position stated 8-16 weeks.
145 Interview response by Dr. Curtis (Owner and Veterinarian) to the question "Do you think that early spay/neuters employed by yourself and CAT has diminished or lessened the amount of healthy-pet euthanasia in your clinic?"
In 1999, the position statement is updated by the Animal Welfare Committee of the American Veterinary Medical Association to broaden the “target population” to include any “unwanted” dogs and cats (Monti 1999:1754).

Resolved, that the AVMA supports the concept of early (prepubertal, 8-16 weeks of age) gonadectomy in dogs and cats, in an effort to reduce the number of unwanted animals of these species.146

This official recommendation is accepted by the owner of the hospital and the staff members, and this recommendation is frequently cited to clients. In fact, in a portion of the new employee package, staff members are expected to reply to client queries “Isn’t 3 months too early to spay/neuter my cat?” in one way:

We participate with early spay/neuter recommendations of the Humane Society which is also endorsed by the American Veterinary Medical Association. Some facilities spay/neuter as early as 7 weeks of age. There’s no increased risk to spaying/neutering and they actually recover quicker and have less pain at this age.147

Answer number nine of this employee script, relates the medical and social benefits of neutering not only to the client but also to the employee who is expected to learn this script and respond to clients accordingly.

Spaying reduces the chances of breast cancer, uterine infections, and uterine & ovarian cancers. Neutering also reduces the chances of prostrate problems, perianal tumors, and testicular cancer. Neutering also reduces roaming, which can reduce the chances of you pet getting hit by a car and other dangers. Most importantly, spaying and neutering reduces the population of unwanted pets. It is estimated that every 3 minutes a pet is euthanized at an animal shelter in America.

147 Question and answer #1 to employee handout titled “Frequent Client Questions.”
This script helps to maintain ideological consensus that neutering is not only an important part of feline welfare, but participation in this practice saves lives.

Because neutering is an accepted solution and part of “quality care,”148 and the public is often recognized as ignorant of the importance of neutering, the institution and many participants believe that education ought to be included in the arsenal.

“Well, I think that education is important. Teaching the public of the importance of neutering.”149
“Unless people know the facts about pet overpopulation and sterilization, they are virtually helpless to do anything about the problem.”150
“I don’t know...maybe educate people is the only other thing that we can do...teach people the importance of spaying and neutering their cats.”151

In conjunction with the promotion of preventative health for felines, educational campaigns are utilized by the institution (combining forces with animal welfare organizations and pet food industry) to attain public compliance to their construction of quality feline care. These educational campaigns officially endorsed by AVMA calls for the public and practicing veterinarians to “take direct action” in the battle of overpopulation. For instance, boasting that the first annual National Spay Day held on February 28, 1995 is a success that "resulted in more than 28,000 dogs and cats being spayed or neutered,” the second annual “spay day” (focusing specifically on the

149 Interview response by Dr. Curtis (Owner and Veterinarian) to the question “in your opinion, do you think that neutering is an effective control for the pet overpopulation problem? Are there other policies that you might find effective for this problem?”
150 http://www.hsus.org/ace/11855
151 Interview response by Angie (Receptionist) to the question “in your opinion, do you think that neutering is an effective control for the pet overpopulation problem? Are there other policies that you might find effective for this problem?”

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importance of neutering) in 1996 is promoted as a "unique opportunity for veterinarians" and a further call for responsible public action.

Spay Day USA is designated as a time for every humane American to take direct action by assuming responsibility for taking one dog or cat to a veterinarian for spaying or neutering.¹⁵²

The underlying message is that if you care about feline welfare, if you are a "humane American," then you ought to neuter not only your own pets, but also other populations of felines. The media message does not simply say, neuter your cat or dog, but rather assume responsibility for "one dog or cat" by bringing them in to be sterilized. This is important, because it suggests that the larger human community is responsible for animal welfare. However, someone still has to assume responsibility for the cost of the procedure.

While preventative health focuses on the responsibility to individual companions, the neuter ideology focuses on public responsibility to whole feline populations. In this case, rather than controlling the lives of individual creatures, humans are assumed to have the right and responsibility to control the bodies and lives of whole populations. Animal welfare depends on human control. Control over 'other' animals is morally equated with humanity.

According to Dr. Barry N. Taylor, "You can’t force people to care enough about their animals to do what’s right by them. What you can force them to do is abide by the law. You can force them to spay and neuter...Sometimes you have to enforce

humanity.” (Kahler 1993:843). Doctor X agrees with Doctor Taylor. Enforcing population control through mandatory licensing and neutering laws is the more effective solution. Education, from their perspective, just won’t cut it.

“Education doesn’t do that much, think about it ... we grew up with the Price is Right ... you know idiots will always be idiots – you can’t teach people what is right or what is wrong...they just know what is right and wrong. You know that there is a regulation in [present state] a law now stating that animals have to be neutered before adoption or a deposit has to be made to promise to have your animal spayed or neutered. A law! This is a good start.”

“If people will not voluntarily stop breeding their animals, then I propose we make it mandatory that many sterilize their animals...meaning people will have to 'spay or pay.'”

Neutering is such an accepted solution that some participants and sections of the veterinary institution believe that it must be mandated. While education about the importance of neutering is supported by the larger veterinary institution, not everyone agrees that education is an effective weapon. This is because disagreement arises about why people fail to neuter their companions.

People who refuse to spay or neuter their animals share a large part of the blame. Some of the reasons people will not alter their animals include that these people simply do not realize the extent of the problem, they do not believe the offspring of their animal are contributing to the problem, they cannot afford the surgery, they are unaware that spaying or neutering their animal is an option, they do not want to have a sterilized animal, and they simply want to breed their animal.

In other words, the public not only plays a role in the pet overpopulation problem through ignorance and irresponsibility, but also some simply can’t afford neutering.

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153 Interview response by Dr. X (Part-time Veterinarian) to the question “in your opinion, do you think that neutering is an effective control for the pet overpopulation problem? Are there other policies that you might find effective for this problem?”
154 Sturla 1993:930

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People just...some...a lot of it probably is by accident or they can't afford it...people just don't think about it comes down to in the end to money. The situation of overpopulation is that you can't care for...to get neutered...but it is your fault...they don't put enough effort to neuter animals.\footnote{Sturla 1993:929}

In this way then, veterinarians and shelter organizations are expected to assume some responsibility toward lowering the cost of this practice to help those who cannot afford it.

"Well, I think that people don't do it a lot cuz it is expensive. Now if we had more doctors doing what we had here a few weeks ago – where Dr Curtis did a low cost spay/neuter and at ___[name of other hospital owned by Dr. Curtis and his wife] they are going to do it again...and they advertise it better and more vets offered this service, that it would help."\footnote{Interview response by Laura (Receptionist) to the question “in your opinion, do you think that neutering is an effective control for the pet overpopulation problem? Are there other policies that you might find effective for this problem?”}

"Spay/Neuter day, like we had here. It helps on the local level. You know I just had this question during my interview at the school...and the Humane society launching media campaigns to educate people helps and to help out with money for it for people who can't afford it helps too."\footnote{Interview response by Ezra (Veterinary Technician) to the question “in your opinion, do you think that neutering is an effective control for the pet overpopulation problem? Are there other policies that you might find effective for this problem?”}

Because Dr. Curtis wants to do “his part for the community,” he has a low-cost\footnote{He referred to it as a “free” spay/neuter day. For people who signed up, they were required to pay five dollars to have the surgery performed. The proceeds went to the animal rescue organization, not to his hospital so he was doing the work free of charge.} “Spay Day.” Many staff participants, including myself, volunteered time on that day to help out. Caring for cats, being a “humane American” meant doing what we could to help reduce the cat overpopulation by removing their ability to reproduce. According to the Webster’s dictionary, the word “spay” originated in the French word
espeer, "to cut with a sword." In this way, Dr. Curtis uses his scalpel as his sword to battle the pet overpopulation problem.

**Ideological Consensus**

There is a strong ideological consensus among staff members regarding the neuter ideology and many of the underlying assumptions relating to the animal welfare ethic that accompanies this practice. This consensus, that neutering is a weapon used to battle the feline overpopulation, and the underlying assumptions that felines ought to be controlled for their own good and brought into the folds of human civilization if at all possible, helps to structure the human-feline social encounters in the hospital. Although some of the staff participants and the larger institution believe that the public is either ignorant of the importance of neutering or regard animals as disposable items, the clients that enter the hospital accept the definition that neutering is essential to the quality of life of their feline companions. It appears that the scripts and the public education campaigns have been successful in their educational efforts to control the definition of the situation. Neuters are, by far, the most frequent surgical procedure in this hospital. Not only do many clients bring in his or her own companions but some even assume the cost and responsibility for strays that they bring in to be neutered and "released." The staff especially respects these clients. Like clients who "take such good care of their cats" by vaccinating strays these clients are accorded gold star service. CAT clients *require* neutering or neutering
deposit before they let someone to adopt their rescues. This requirement works to
structure an alliance between CAT and Doctor Curtis. Both believe that this alliance
has served the community well.

The belief, however, that the larger public is ignorant or uncaring about animal
welfare, functions to bring the clients and staff members who are assuming
responsibility for the welfare of feline populations through neutering together in a
moral crusade. Because they are doing what is right by neutering the patients, the
social encounters with the patients, for staff members and clients are relatively free of
tension. Tension that does arise for staff members or clients, because patients are
understandably afraid or upset is easily removed by the same tension management
strategy employed during preventative health; “it is in your best interest.”

Similar to the five encounters experienced under preventative health, clients and
staff members experience very little tension and frequently express affection toward
the patients although to a lesser degree because of the physical ecology of the practice
itself. Unlike preventative health encounters, however, some patients experience a
significant degree of tension. The degree to which patients experience tension or
affection in the human-feline encounters is highly influenced by the neuter ideology.
For staff members this ideology structures the encounters. However, the social status
and age of the patient, as well as the material social context relating to various steps
in the procedure also impacts the encounter.
"Checking in" and "Dropping off"

When a client calls to make the appointment for their companion to be neutered, the receptionist will inform the client of two things. First, the patient is not to be allowed to eat during the evening and not allowed to drink after midnight. Controlling their diet in this case is intended to make the surgical procedure less traumatic for the patient and less messy for the staff members as sedation makes the patient throw-up. Second, the client is to drop-off the patient in their carrier between the hours of 8:30 and 9:00. In other words, the staff member informs the client that their cooperation (of control over the patient) is needed for this practice to run smoothly.

For regular clients with companions, check-in is the same routine as it is for preventative health except that the client leaves the clinic rather than wait with the patient. Often clients will “say good-bye” to the patient in the physical location of the waiting room. These good-byes are notably affectionate and present very little tension either for the client or the patient. Usually the staff member (office manager or receptionist) stands back for this affectionate interaction while they wait to transfer the patient in the carrier into the back room.

A young man walks into the hospital with a carrier at his side. It is 8:30 am. Angie looks up at him from behind the desk and smiles. “Who do you have with you this morning?” The client lifts the carrier and peeks in with a warm grin “This is Shell and I am just dropping her off so that she can get fixed.” Angie nods and brings up Shell’s file on the computer. “You are bringing her in for a spay correct?” The man answers “yep...a spay” as he sets the carrier down on the counter and opens the door.
As the orange and black young calico patient, timidly steps out of the carrier, Angie asks "No food or water since midnight?" The man shakes his head and scoops Shell up in his arms. "Nope...actually earlier...and [to the patient] you were not to happy about that were you?" Shell pushes her face into his. Angie turns to fill out Shell’s file card as the man speaks to her softly and rocks her back and forth. Angie finishes filling out the card and moves over to the swinging door that adjoins the counter. She stands with file card in hand and waits silently. The man notes her movement and gives Shell a gentle hug. "Well, see you tomorrow...be good little one." Shell purrs as she looks into his face. The man smiles at Angie and places Shell back into her carrier. He picks up the carrier and hands it to Angie. "We will see you tomorrow," Angie says to him. "Ok" he smiles brightly at the carrier "see you."

Clients often use the language “get fixed” to refer to neutering. The implication, of course, is that something in their companion “is broken.” This is far removed from the biological reality that the patient’s reproductive organs are healthy and functioning and she is being brought in to actually have them not function – to break them. A feline’s natural ability to reproduce must be “fixed” to fit into human culture. The reality reversal attests to the powerful impact that neuter ideology has on the definition of the situation for human beings. Moreover, this language seems to point to a certain ambiguity in human-feline relations.160 The mechanical metaphor “to get fixed” implies an object status. Simultaneously, the patient has feelings (she was “not happy” about having no food or water) and is a “you” – a subject.

While clients may utilize the mechanical metaphor of getting fixed, staff members work to correct this language. Note that Angie did not fall in line with the client’s metaphorical term, but rather uses the medical terminology relating to neutering of a female patient – “spay.” This subtle sanction of language use is effective in this case as it is in others observed during my nine months of field research; the client corrects

160 See also Sanders (1999), Sabloff (2001), and Taun 1984 for further discussions on ambiguity in human-animal relations.
his language. The sanction, I believe is used [no doubt unconsciously] for four reasons. First, the explicit function of this correction is to clear up any uncertainty that may result from the possibility that the client has a different definition of what needs to be fixed. Consider the legal ramifications if a client meant that they wanted the patient’s teeth fixed and that client picked Fluffy up to find out that her ability to reproduce was removed. Implicitly, this language sanction also corrects any implication that a patient is an object. Third, it ensures that this language paradox remains invisible. Finally, the word “spay” is used in the educational campaigns; the word functions, to “prime”\textsuperscript{161} the public to automatically equate “spay” with “quality care” and “in the best interest” of feline health. The term is used, in other words, to maintain the ideological consensus within the veterinary institution that patients are subjects that deserve quality care and that this quality care, taking the form of control over the species’ reproduction, is in their best interest.

This ideological consensus limits hesitation (or tension within the encounter) that a client may have over electing to have their companions’ body medically manipulated. It also quells any concern that a client may have over a patient’s emotional discomfort of separation anxiety. In fact, the one time when a client expresses concern over the “dangers of the procedure,” pain that a patient might experience or fear about being alone, she is described by some staff members as being “too finicky about her cat.”

An older female client was in the waiting room holding a small Himalayan kitten and speaking to Lisa as I walked into the hospital. “Just make sure that she is comfortable ok? I want her to have pain medications too...are you sure she will be ok here? I mean...it is surgery and she will be alone...all by herself all night...she

\textsuperscript{161} I am referring to the “priming effect” theories employed by social psychologists relating to automatic associations. For earliest theory of this effect, see Thaibut & Kelly 1959.
will be afraid...and in pain...this is the right thing though right?” Lisa smiles at the client. “She will be just fine and we will take good care of her. He only makes a small incision...Spaying reduces the chances of cancer and uterine infections...yes you are doing the right thing.” The client looks down at the patient who is pawing gently at her face and says “Mommy will be back don’t you worry...everything will be ok. [then to Lisa as she places the patient into the open carrier that is on the counter] I will call later today to make sure she is ok...ok?” Lisa nods and closes the carrier door. The patient meows as Lisa lifts the carrier off the counter and the client “mom will see you later honey.” Lisa looks at me, her back turned to the client, and rolls her eyes. Later Marcie explains that Sugar is “spoiled” and that the client is “very finicky about her cat.”

It seems that from these staff member’s perspectives, while it is understandable for clients to be concerned about medical practices that may interfere with a patient’s quality of life such as declawing (which will be discussed in the next chapter), it is totally unacceptable for clients to worry over a practice which is institutionally defined as in the patient’s best interest. Questioning the rightness of this practice is constructed as simply absurd. Consensus in this context is so powerful that when a client calls to check on a patient three months into my fieldwork, I write in my notes: “today a client calls to inquire about the status of Pickles even though she is just here for a spay.”

For CAT clients and rescues, checking in and dropping off a patient for neutering is more informal and has an air of camaraderie. In this context, CAT clients seem to move in social status from gold-star client to “extended staff” as they are not only invited to the back room with a staff member, but when staff are busy, they are asked to “go right ahead” and “put them into the front cages.” Moreover, the greeting frequently changes from “who do you have with you” to “how many do you have with you today?” Usually the CAT client will smile proudly and offer a number relating to the number of kittens being brought in to be spayed or castrated. This
number does more than tell the staff how many neutering surgeries are scheduled, but rather symbolizes how many felines are being placed into homes; how many have been saved from impending death or suffering under natural conditions outside of human civilization.

If the hospital is busy, the CAT client will quickly bring the patients back, transfer them into the surgical cages themselves, and leave with a quick goodbye to patients and staff. If no other clients are present, the CAT client and staff will talk about the adoption status of the kittens as the receptionist or office manager clips their claws, plays with or snuggles the patients “isn’t he/she cute” and sometimes let the kittens down to run around the office. Similar to the drop-offs of companions, the encounters are notably affectionate and lack any tension. However, unlike with companions, staff members do not hang back to allow the patient and client to say their good-byes. Rather, the staff is more intimately involved with felines that are labeled rescue.

*Front, Surgical Cages*

Companions are considerably more upset than rescues are with the transfer from their carrier or arms of the client to the staff member with the purpose of putting them into a front cage. While rescues sometimes express tense behaviors such as shaking or huddling together, companions often begin to cry and are more resistant to getting into the cage. In other words, companions are more distressed by the separation from
a client, suggesting that a greater bond exists between companion and client than rescue and foster.

While waiting for surgery, some companions express their tension by huddling in the back of the cage, many, however, meow loudly and reach their paws out between the bars. Staff members define this behavior as expression of feelings and emotional needs. These patients “want to get out,” are “afraid,” and “need attention.” Sometimes, staff members will respond to these “requests for attention” through affectionate displays intended to comfort a patient. Toys are placed in both companion’s and rescue’s cages “to keep them occupied,” and to “help them from becoming too bored.” The patients are given toy mice with real fur; “they love these” I am told. Small pouches filled with catnip are provided to patients that “look like” they would like it or “really needed something to do.” I walked into the back room on many occasions to hear Pam speaking to one of the patients about which toy they would prefer. Sometimes staff members open a cage and gently caress a patient as they speak soothingly to them. “Its ok baby...its ok.” In other words, staff members are attempting to manage a patient’s tension through affectionate displays.

Front Surgical Cages and Social Status of Patients

Despite the observation that companions are experiencing more tension, and calling out more frequently than rescues; companions’ requests for attention are ignored by staff members significantly more so than the rescues’ calls. This indicates that the social status of the patient is, at least in part, influencing the degree to which
staff members will respond affectionately to a patient. Moreover, affectionate interaction between staff and rescues is qualitatively different. The most telling evidence of the impact that a patient’s social status has on human-feline encounters within the context of neutering is that rescues (most often kittens) will be “let out to play.” On many occasions, I entered the hospital to find a number of kittens running around behind the reception desk and in the back room. Kittens are also allowed to roam during lunchtime and after appointment hours. Sometimes I overheard staff members speaking to the kittens before the cage door is opened. “You don’t want to be in there much do you? Want to come out and play? Are you bored?”

“Would you like some ‘tention’ huh…do you need to come out and play?”

Other times, one staff member will ask another staff member to “let them out for a bit.”

“Andy has been in there all day, can someone let him out…the appointments are over.”

“Dana, if you would like to let the kittens out before clients come in that would be great…they need some time to run around…” The staff participants most often engaged in this practice includes the receptionists (Angie and Anna), the cleaner (Pam), and one veterinary technical assistant (Nell). However, other staff participants did not seem to object. I watched them play with the kittens that were out of their cages and smile when they would see them running around. Moreover, all present

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162 “The kittens” meant rescue kittens.
staff members, including Doctor Curtis, stop to display affection toward these kittens. "Hey there little one...how are you doing today" or "aren't you a cutie." Sometimes the staff will play with or pick up the kitten and snuggle them as they prepare for work. Rescues, and not companions, are given this freedom.

Often it does not even matter whether or not a rescue seeks attention.

As soon as Marcie (veterinary technician) arrived for work that morning, she walked into the back room to see who was waiting surgery. As she was checking over the cards, she stopped short at Zip's cage. Zip is a small gray rescue kitten. She opens the door and scoops him out from between his brothers. Marcie carries him around as she continues on to check the cage charts to determine what surgical procedures were scheduled for the day and to see how many anesthesia injections were expected that morning. Zip snuggles close to her chest for a bit and then works his way up towards her hair as she speaks to me about how "much she loves this kitten and would like to take him home." While we talk, Zip tries to climb up toward her hair. Marcie helps by repositioning him so that he can reach it. He begins to knead her hair and purr loudly. I ask her why she doesn't take him home and she replies to me "Oh, my husband will not allow it." Then she looks at Zip and speaks to him in a tone much like many people speak to an infant [her head close to his and her voice pitch is slightly raised] "I already have two cats at home."

Zip had been snuggling next to his brothers when Marcie arrived. The two companion kittens that were waiting for neutering surgery in the adjacent cage, (one of whom looked similar to Zip) had been reaching their paws out between the bars and meowing. Marcie had looked into their cage "oh, its ok there" but did not bring them out to be comforted.

**Front Surgical Cages, Social Status and Patient Age**

Similar to encounters during preventative health, kittens are most associated with affectionate human-feline encounters. Rescue adults are not "let out to play," and

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163 This was only observed when Dr. Curtis was scheduled for the day. On Fridays CAT patients were
sometimes, like companions have their calls for attention ignored (though not to the
degree that companions adults are). Quite infrequently, companion kittens, although
not usually allowed to run around, are brought out of their cages to be comforted or
held. However infrequent, this is usually because the companion is described as
especially “sweet” and “friendly” and is “really unhappy” being in the cage. To
comfort these kittens, staff members bring them out of their cages temporarily and
carry them around for a few minutes. Because adult cats are described similarly, my
suspicion is that the physical ecology of the room (the cages are located nearest the
doors) is one reason that these companion kittens are comforted in such a way because
of the manner in which they more frequently express their tension: loudly.

After Sugar, the small Himalayan kitten had been sitting in the front cage for a few
minutes, she begins to meow. When I walk up to her cage she rubs against the door,
stops, and looks up at me. Her tiny body is trembling slightly as she reaches her
paws out to me through the cage doors. I open the door and pet her for a few
minutes before returning to my task of folding towels. She can see me folding the
towels and she stares at me for a few seconds before beginning to wail. Her meows
get louder and louder and fewer time elapses between the cries. I feel bad, but want
to finish folding the towels. After a few minutes, her meows begin to take a different
tone. “meowma,” she cries “meowmaa.” It sounds like she is calling for her
Mama. Angie comes in from behind the reception desk and shuts the door behind
her. “Wow!” She says looking at me and then looking over at the surgical cages.
“Who was that?!” Pam comes in soon after Angie and looks with hands on hips at
the cages. “That was Sugar” I explain, “I was petting her and when I came over to
fold the towels she began to cry more.” Pam nods and opens Sugar’s cage. Sugar
almost leaps into her arms and we laugh. Angie shakes her head with a smile and
leaves the room, leaving the door open this time. Pam looks down at Sugar who is
now snuggling against Pam’s chest and purring. “Well, now aren’t you a sweet
girl...what a little purrbox.” I come over and pet her too. Pam hands Sugar to me
and I put her back in her cage. She begins to cry again and Pam closes the door. I
speak softly to Sugar for a few minutes and offer her a toy mouse. “Want a mouse
little girl...hmmm....want to play?” Pam smiles at me and walks over to the dryer to
finish folding the towels.
Most of the staff members at the Loving Care Cat Hospital are self-defined “animal lovers.” They do not like to see or hear patients upset, and comforting a patient is understood by staff participants as a way to meet a patient’s emotional needs. However, not all patients’ emotional needs are met at all times. Kittens’ emotional needs in the context of neutering are met more often than adult’s needs. Although, companion kittens sometimes experience encounters that are affectivity fulfilling in this context, they are not associated with affective and tension-free encounters as often as rescue kittens. This suggests that there is more to comforting than what participants explicitly state. Notice that when Angie enters the back room, she closes the door. She leaves the door open when she returns to the reception desk-after Pam has succeeded in quieting Sugar down. Not only is experiencing another subject’s tension uncomfortable for staff members, but staff members are concerned that clients will hear the cries. As I will discuss shortly, closing the door to “shut out” the sounds of emotional suffering is an attempt to manage the definition of the situation that this practice is indeed in the best interest of the patient.

The point remains, however, that even loud adult patients are not brought out of their cages in this context. They will be offered toys and sometimes they will be petted. However, the door will be shut or a towel placed over the front of their cage door if they become too vocally insistent. Sometimes adults will be spoken to in a manner that suggests that the staff believe that the patient has nothing to be upset about: “hey...what are you fussing about? You are not hurt, be quiet in there.” In
other words, the "fussing" is unjustified, because their well being is being properly cared for – they are in the hospital to be neutered.

I mentioned in the last chapter the reason that kittens are more associated with affectionate encounters is that it conforms to the underlying assumptions about the place of felines in human society. The evidence that rescue kittens receive even greater affection further supports this contention. Companions already have a place within the protective folds of human society. Therefore, they don't need to be comforted as much as rescues do. Rescues are on the cusp of the nature/culture divide. Thereby they need more socialization. The increased affectionate displays accorded them by staff members is in-line with the underlying assumption that felines need to be socialized into human society for their own good. No where is this more evident than the encounters in the veterinary hospitals with mother and child rescues while they wait to be neutered.

In the back room, I watch as Marcie opens the front cage door holding Pear (a rescue) and her four kittens (also rescues). She pets Pear and the kittens. Then she opens the cage next to them and begins to transfer each of the kittens into the other cage. I ask Marcie what she is doing. "I am moving the kittens into another cage." I smile and extrapolate "yes, I see that...but why are you separating them?" Marcie answers as she pets the frolicking kittens, "these kittens need to get used to being away from their mom and they need to stop feeding. They are old enough now to go to new homes and they need to get more accustomed to human touch." Later, Pam notes this separation because Pear is crying and Pam asks a similar question. "How come you are separated from your kittens?" I recount Marcie’s explanation. Pam replies, "oh, that makes sense...but you miss them don't you? How 'bout some cat nip huh? You want some of that?"

It is generally expected that clients regularly attend to the needs of their cats and therefore, one or two days in a cage will not hurt them. The CAT kittens, however, are sometimes in cages in their foster homes. According to staff members, although
the “foster” parents spend a considerable amount of energy and time “attending to the emotional needs of kittens” and “playing with them when they could,” they only have so much time and usually have quite a few kittens and cats at home to attend to. Therefore, the CAT kittens are understood to receive less emotional attention outside of the hospital than client’s cats. Since staff members generally participate in finding these fosters cats permanent homes, it is more important to them to make sure these kittens “are happy, healthy, and properly socialized to go to their new homes.” Sabloff (2001) notes that the socialization of ‘other’ animals is widespread throughout the United States and Canada:

There is every evidence that a significant degree of animal socialization to the demands of human environment takes place, as the pet-owning respondents in my fieldwork, as well as animal trainers, are quick to point out.164

Greater affectionate interaction with rescues and especially with kittens by staff members is intended to help bring them into the human world. It is part of the moral crusade meant to keep felines in the protective folds of human society.

*Scruffing in the Prep Room*

Before a patient can be neutered or given anesthesia, blood must be drawn from the patient to ensure that the patient is healthy enough to undergo the surgery and not allergic to anesthesia. In addition, blood carries disease, staff members, and other patients must be protected from any such menace. Victoria (veterinary technical

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164 See also Hearne 1986.
assistant) and I spoke about this practice. I asked if this was mandatory for all veterinary hospitals to check a patient’s blood before surgery.

“It should be. It is dangerous. A patient could be cut open and carry a disease that has a long shelf life [can live outside of a host for a long period of time]. While hospitals sterilize as much as possible, you can’t be too careful...you know...at [another local veterinary hospital not affiliated with this one] they don’t check blood before their surgeries...they are going to have an outbreak and infect patients someday...they will be out of business and lots of people and pets will suffer because of it...really it is just a simple thing too.”

For staff members who participate in taking blood this is a necessary part of their job to ensure the safety of their patients as well as themselves. For patients, this is often very scary.

We were very busy today and Marcie let me help her by holding down some of the more “docile” patients for blood work. To take blood, the patient is laid down on his or her side and one person holds the patient down by grabbing the scruff of their neck with one hand and pushes down on the top of the back leg with the other. This practice is called “scruffing.”

It is amazing how the staff keeps the patients still while drawing blood. It is not easy – many of the patients struggle against being held down and then poked with a needle. Some meow and kick, and some hiss and scream.

Scruffing looks easy, but really isn’t. I had difficulty learning the skill as the below excerpt from my auto ethnographic field notes illustrates.

Wow. Scruffing is really hard. When I first tried it I could not get enough of the scruff in my hand and the patient got loose. Marcie had to show me repeatedly how to do it, which made me feel bad for the patient that I practiced on. “Ok Dana. Now look grab his scruff like this...no...you have to get it all or you will not be able to restrain them...here [she grabbed my hand and guided me along]...now you try.” I looked at her “like this?” The patient was struggling and meowing pitifully. She shook her head “you don’t have enough of the scruff to keep him still. Let me get Anna for this one and you can practice with the patients who are under ok?” It had looked so easy, but it clearly was not.
Holding a patient by the scruff of the neck feels cruel and it seems to me to scare the patient more than anything does. However, according to Marcie and other staff members, it is important to hold them that way or the patient may get hurt; 'blow a vein' which means that it causes bruising around the vein used. In addition, the patient, being afraid, may hurt the staff. While scruffing functions, according to staff members, to protect the patient, I believe that focusing on protecting the patient masks any unpleasant feelings associated with controlling a patient and "making them upset." In other words, it functions to keep any tension at bay, thereby in part also functioning as a tension management strategy. This strategy is effective because as blood work and scruffing is defined in everyone's best interest, these encounters, although tense for the patients, presents very little tension for staff members.

Although staff participants empathize with the patients' feelings, the medical practices still have to be accomplished and done in such a way as to maintain the definition of the situation for clients. When a patient is too loud during the practice of scruffing, staff members will blow in the patient's face. The function of blowing in a patient's face is to manage tension that a client, who may be in the waiting room, may feel when they hear a patient scream and possibly define that screaming as suffering. In other words, blowing in a patient's face is not done for their best interest, but rather to convey a specific image to the clients. I was perplexed when I first saw a staff member do this. When I asked Nell (veterinary technical assistant) what the function of it is she simply stated, "This is to get them to be quiet."

"Why?" I ask.
"Because it upsets the clients when they hear their cat screaming."

If a patient fails to stop making noise even when the staff member is blowing in their face, a towel is placed over their head. When my own cat had to get "toweled," I was embarrassed. I looked at my cat and spoke to the towel, "Muir you had to get toweled you problem patient you." Nell and Ezra laugh and shake their heads as I speak to her. Then Nell says to me, "well sometimes it makes the patient feel better when they can't see what we are doing."

It is important at this point to note that I had not heard a staff participant refer to a patient as a "problem patient." I used the term because Sanders (1993) brought it to my attention in an article exploring the practices used by veterinarians and their staff to deal with "problem patients." I was embarrassed because Muir (my own cat) was presenting a problem by not complying with medical procedures. Nell and Ezra laughed because they did not expect a patient to comply; they recognized that she was afraid.

While Nell defended placing the towel over Muir's head as "making her feel better," protecting the client from any suffering that the patient might be experiencing under their care took priority to the actual care. This is simply an accepted norm to staff participants employed without real thought behind it. Blowing in patient's faces seems like a harmless practice. However, by protecting the clients' interest before the patient's and working to maintain the definition that neutering and any related practice is in their best interest, they are unintentionally playing a role in the
reproduction of the unequal structure of human-'other' animal relations in Western society.

Anesthetizing the Patients

After blood is drawn and patients are returned to their cages, Marcie or Ezra (veterinary technicians) is responsible to prepare and administer the anesthesia and the sedative. Human-feline encounters during this process are notably tense for the patient, particularly as the veterinary technician is slowly approaching them with a sharp object. Marcie and Ezra are cautious but display affection toward the patient, to keep the calm. The caution and attentive observation of a patient’s physical cues enables the staff member to construct their next line of action. As others who have worked with and study those who have worked with ‘other’ animals on a daily basis point out, failure to attend to the emotive and physical social cues provided by ‘other’ animals can lead to serious injury for both staff and patient.165

When I went in today, I note that a male “rescue” named Bark is waiting in the surgical cages to be castrated. Bark is very affectionate. He reaches out between bars when I approach his cage. Pam stops at his cage, smiles at me as I caress his paws, and speaks to him. “How are you today little one?” He responds with a soft meow. Pam opens the door and holds him for a minute. He snuggles close and begins to purr and she kisses his head and puts him back in his cage with a toy mouse. He throws the mouse around for a bit and we laugh and return to cleaning the back cages as we realize that he is relatively happy and content. His behavior takes a sharp turn when Marcie approaches him with his injections. He looks at that needle and moves far back against the wall cringing and hissing. Marcie speaks to him as she slowly approaches with one hand carefully outstretched to smooth his fur and the other hand prepared to quickly inject him with the needle, “its ok honey…come on Bark…sweetie.” Bark is even more “angry” after the first injection. He desperately struggles to stay away from the second needle. He lets out

a rather loud screech this time. Marcie replies to his screech, "hey, sweetie I am so sorry but this has to be done..." When it was over Bark crouches against the back wall, ears back, staring intently at Marcie. Marcie smiles for a second, then looks at him and says in a ‘baby’ tone of voice through pursed lips, "man get away from me you make me mad."

Marcie observes Bark’s tension and works to manage this tension through affectionate displays, such as comforting speech: “its ok honey...come on Bark...sweetie.” When Bark screeches, she apologizes to him: “hey, sweetie I am so sorry...” Apologies within human encounters are noted to be a form of “aligning action.” It is a way that people preserve consistency between their social acts and their perceptions of their own social identities. In the case of an apology, the social actor (Marcie) takes responsibility for an act that she feels violates some shared cultural value (Hewitt 1997) between social subjects. Marcie caused Bark pain and that went against her own social identity, in part situated in the veterinary institution, as someone who works to “relieve pain and suffering.” She is telling Bark, or more likely herself, that she is not someone who regularly causes another pain and this makes her feel better about the action. “But it has to be done.” It has to be done, because ultimately, from her perspective, this is in his best interest.

Marcie also “speaks for” Bark. “Man get away from me you make me so mad.” In Arluke & Sanders’ (1996) ethnographies of a veterinary clinic and a guide-dog program, they describe this common behavior as “giving voice” or a “mode of interlocution.” Interlocution is a mode of speaking in which the actor who has more social power “speaks for” the less powerful other in order to take the role of the other to construct “an understanding of the animal-other’s subjective experience” (56).
Given that the patient can not verbally express his or her feelings, the language user is presumed to do it for him or her in order to help to structure the encounter. As Arluke & Sanders (1996) suggest, "the verbalizations help define the [other] and ground [his or her] behavior in an understandable context, thereby aiding in constructing the practical interaction chains that constitute collective action" (67). This "mode of speaking for" is also commonly found with humans who have a perceived diminished language capacity such as Alzheimer’s patients, mentally retarded adults, and children.

According to Bogdan & Taylor (1989), the purpose of this behavior is to preserve the ‘other’s social identity as a minded co-actor (a social agent) and express what one believes to be the thoughts and intentions of that other in order to maintain some semblance of “normal” interaction. Accepting Arluke & Sander’s (1996) and Bogdan & Taylor’s (1989) analysis, I think that Marcie is working to maintain Bark’s social identity as a minded social actor – a subject. Further, she is taking the role of the other to understand his actions as normal given the situation. I also suggest that what she is doing is reaffirming her assessment of her observations of his behavior (hissing, screeching, moving up against the back wall) to herself. Finally, the use of this behavior, at least in this context, is an extension of the apology. She is reaffirming that she recognizes that she violated acceptable behavior.

Note too that Marcie employs a “virtual voice” (Arluke & Sanders 1996) for Bark. She “speaks for him” through pursed lips in a tone and style of voice referred by other

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social researchers as “baby-talk” (Arluke & Sanders 1996), “motherese” (Katcher & Beck 1991), or “doggerel” (Veevers 1985). Marcie is actually presenting what she believes Bark would say, and how he would say it. As the reader will recall, she also speaks to Zip in the same tone of voice. It might be inferred then, that this style of speaking is a form of infantilizing the animal other – a way to construct the greater relationship as protector/protected or caretaker/caretakee. In this type of relationship, it is generally expected that one “reasonably” controls the subject other for their own good. On the other hand, both of these patients are quite young.169 “Baby-talk” among170 mothers and their young children is thought to be used by the caretaker as both an engagement device and an expression of affective intentions. In other words, the tone of voice may simply be another display of affection to comfort a patient who has been wronged (Bark) or to engage in a mutually affectionate encounter for pleasure (Zip).

169 I have to note here that during my 9 months observing at this clinic, some female human participants (both clients and staff) spoke this “baby-talk” with the patients. Only a few male clients spoke to a patient this way. Doctor Curtis rarely spoke this way; the two times observed were with kittens. Dr. X was never observed speaking that way to a patient. While there may be gender differences in this style of speaking, I must clarify what other researchers have, as far as I have found, failed to clarify: the patient is usually a kitten! Rarely did I hear or observe a human participant speak to an adult cat in that same tone of voice. While Beck and Katcher (1983) do point out that about 80% of the clients in their study speak to other animals in the “same way they talked to people” (44), they do not specify if there is an age difference between the patients who are spoken to in “motherese” and those who are spoken to “like other people.” There might not actually be one. It may very well be that people commonly speak differently to cats than to dogs (which would not be surprising, as they are different species). Anecdotal evidence suggests that people do sometimes speak to their animals as they would infants. Analysis of the function of this type of talk and who engages in it and to whom would be valuable to understanding human-animal interaction.
170 New research on “baby-talk” between mothers and infants suggest that it is not simply mother speaking to infant, but rather a turn-taking that until studied by microanalysis of videorecordings of mothers-infant interactions, had been ignored (Dissanayake 2001).
The sedative, Ketamine, is noted to be painful for the patients; "it stings a bit." However, it helps in the healing process as it reduces the postoperative pain that patients are understood to experience. As it helps patients feel less pain after the surgery, this practice is also understood to be in the patient's best interest. Anesthesia although temporarily painful, is defined in the best interest of the patients because during surgery, they are spared from the physical and emotional trauma of being cut open and having their reproductive organs removed. Because it is defined as such, staff members, although cautious, do not experience a significant degree of tension—particularly when the patient is being anesthetized for neutering.

Surgery

After patients are successfully "under" (unconscious from the anesthetic) they are carried on a surgical pad to the surgery room by the veterinary technician. Obviously, patients are not expressing any notable tension, and in the context of neutering nor are the staff members. Staff members do not regularly express any affectionate displays toward an unconscious patient who is being neutered only. One might infer that a patient is at this point transformed into an object to be manipulated and controlled.\textsuperscript{171} There seems to be some evidence for this as Marcie will inform Doctor Curtis, for example, that "a neuter" is on the table. However, Doctor Curtis still identifies patients by their names during the procedure. In this sense, one could also infer that a

\textsuperscript{171} See for example, Lydia Birke 1994 for an analysis of scientific texts and practices that encourage both medical students and researchers to conceptualize the animal as objects in order to make it easier to manipulate animal bodies.
patient’s identity as a subject is still defended – at least by Doctor Curtis. Doctor X, on the other hand, fully conforms to the patient as medical object paradigm and refers to a patient not by name, but as an “it” or by the surgical procedure. In the context of neutering, these contrasting definitions of the patient by the doctors do little to influence the type of encounters. In both social contexts, the encounters are relatively distant.

However, the type of doctor does influence the number of human-feline encounters experienced by participants at the Loving Care Cat Hospital because of the different “types” of neutering procedure each offers. While both doctors conform to the ideology that early/age neutering is “better” and “more effective” in efforts to fight the overpopulation problem, Doctor Curtis has more practice with the “key hole” procedure for spays which is most often associated today with early/age spays. This procedure entails making a small incision on the side of a female feline and using a surgical tool – which looks like a small metal hook (sort of like a rugging hook) to grab and bring the ovarian tube out of the hole. Then the ovaries are cut off and the end stitched up.

According to Doctor Curtis, this procedure is associated with a quicker healing time because of the small incision. I was amazed at his speed and agility at this medical practice – taking no more than 10 minutes total and most often less than that. The speed is due to the lack of stitches required to close the incision; only one stitch is required as opposed to the traditional “midline” procedure where the whole front needs to be sewed up. When I asked why the “key hole” has not completely replaced
the "midline" (which Doctor X uses), Doctor Curtis explains that it takes practice and training. He is fortunate he explains, that the earlier owner knew how to do this surgery and taught him how to do it. Some practitioners, he suggests, are concerned about the lack of visibility of the reproductive organs. Once learned, however, this practice is quicker and more "efficient." He can accomplish a greater number of spays with this procedure.

Most clients prefer the side spay. CAT clients only want this specific procedure done on their kittens, so out of simplicity, they schedule all of their patients on the days that Doctor Curtis is on staff. Clients generally prefer this type of procedure because it is understood to be in both the patient's and the client's interest. It is believed to quicken the healing process, thereby better serving patient interest. In addition, the "keyhole" procedure is associated with less time under anesthesia. The longer a patient is under anesthesia, the more dangerous. This procedure is also more aesthetically pleasing for clients as the belly of the patient is not shaved; in this way is understood to better serve client interest.

Although Doctor X appreciates the "side spay" or "key hole" spays, he works only part-time as a practitioner. He simply does not have the time learn it. However, he seems to be socially pressured to do so. He is often teased about the lack of surgeries scheduled for that day by other staff members. He is also teased about the time it takes him to perform a spay. In the context of an interview with Doctor X, while he is in the process of a spay (the only one scheduled for that day) Ezra and Nell stand by and watch. At first, I had believed that they wanted to know how he was going to
answer the questions. However, I soon realized, by their frequent gestures toward the clock, that they were timing him. Below is an excerpt from the interview with most of the dialogue cut out:

"Well...[doc X stops and looks down at the patient. Satisfied that the ovaries are removed, he looks at the tray next to him and picks up a needle and threads it. He again looks down at the patient and sticks the “needle,” which looks like a bent nail, into the skin. I look over at Ellen who is now sitting on the floor preparing the “surgical pacs” with a funny grin and then at Kate who is standing in the doorway watching the doctor with an amused grin] hmmm...[he pulls the suture line which makes the left side of the open wound come closer to the right side and then he sticks the needle into the left side pulls up and the skin in that section come together. I am thinking that this is going to take awhile because, unlike Dr. Curtis’ side spays, the surgical opening is much longer. I look at doc, he has not said anything now for about two minutes and I am beginning to get uncomfortable. I hear Ellen giggle.] I ask Doctor X if I should talk to him later? Immediately both Kate and Ellen begin to laugh. The doctor looks up quickly at Ellen and Kate and says defensively “no. I can talk while I do this.”

Kate interrupts “well, you will have plenty of time anyway.”
The doctor is silent but looks over at Kate with a smirk...

...Ellen says to Dr. X “You sure are opinionated today Dr. X.” He laughs and his body relaxes. Kate chimes in “how much coffee did you drink before you came in today?” Ellen adds “yeah…you shouldn’t drink coffee before coming in here….you are hyped up today.” I stay still. The three of them laugh together. Kate looks at the clock. “only 25 minutes this time...[referring to surgery]...” She smiles at Dr. X and he looks at the clock and shakes his head. He looks back to me. “Well, that is how I feel.”

Simply because Doctor X fails to conform to the more contemporarily legitimated type of neutering, the human-feline encounters are less frequent. The reason that this procedure is more accepted today is, in part, because it is defined as better serving both patient and client. The other staff members socially sanction Doctor X in an attempt to bring him more in line with the ideology surrounding neutering; the faster the better because more lives can be saved.

“Tucking them in”
After the surgical procedure, patients are brought back to the front cages and covered with a towel while they wake from anesthesia. The towels are meant to keep patients from catching a chill. Despite the fact that the patient is unconscious and is experiencing little tension or affection, covering the patients’ in this way is affectively fulfilling for the staff members. It makes one feel as if one is tucking in a child for long nights’ sleep. Although, the purpose behind this practice is defined as a medical practicality, it also serves, at least from my perspective, to protect staff members social identity as someone who “really cares for” felines. It makes one feel as if one is caring for a patient – like one would a child. While, from the staff’s perspective, all the medical procedures are not unanimously “in the patient’s best interest” as I will discuss in the next chapters, this specific simple “affectionate display” enables staff to feel good about what they personally are doing for the patient – making them as comfortable as possible.

Recovering In the “Window Cages”

After a patient regains consciousness, he or she is moved to the “window cages” for recovery. These cages are located in the back of the back room. They are furthest removed from traffic in the hospital. Sometimes patients are both tense and tired after neutering. Some patients are shaking and some are crouching in the back of their cages. However, many still seek affection from staff members. Rescues, however, are noted to seek less affection than companions in this context. Companions are also considerably tenser and are understood to need more comfort.
Although, the patients are sometimes tense and seek affection, these encounters are one of the most distant human-feline encounters in the Loving Care Cat Hospital. With the exception of Pam, most staff members do not display a great deal of affection toward patients while recovering from a neutering procedure. This distance is intended to aid in recovery; patients should be left alone so that they remain still. The lack of affectionate displays is further influenced by the location of the cages. While the need for patients to rest is the reason that the cages are located in a low-traffic spot, it remains that this location is most associated with distant encounters – attesting to the influence that the physical ecology of the room has on social encounters with humans and felines.

The Caretaker

Pam, the caretaker, is most associated with mutually affectionate encounters.

There is a young female kitten named Star in the window cages. Yesterday she was very quiet in the cage that she shared with her “brother.” Staff participants and client had called him her brother even though they were not litter mates, but rather were rescued from animal control on the same day. Today she howls and meows constantly. Her brother was picked up last night because he had had a castration and those patients can be picked up that evening, while spays have to remain overnight to be monitored. Pam comes in while I am cleaning out some of the cages and walks over to her “are you upset that your brother is gone little one?” While Pam is leaning toward her cage to speak to her, Star violently tries to push her nose through the bars of the cage door. Pam laughs and says “I guess so...do you need to be held...are you sad?” Pam opens the cage door and Star tries to jump down. Pam laughs and catches her in mid-air. “Nope, but I can hold you for a bit.” Star seems content in Pam’s arms as she walks around with her and speaks to her.

When I asked Pam what her official title was she simply said “cleaner,” but she would be better described as a caretaker; her “official” job title. Informally, caring for the emotive needs of the patients is understood as a part of her job. Although,
every one spends time infrequently with the patients when they are free of other activities, it would seem that Pam really is the most attentive to their emotional needs. Pam is the person most often observed giving patients toys, holding them, speaking to them and generally attending to their emotional pleas. She is also very good at it. She gains the trust of many patients that I am afraid to approach. She is often warned about one patient or another and will ignore the warning, open the cage door and reach her hand in unafraid. “Oh he is all talk” or “she is just mad right now” and “cats don’t scare me” are frequent comments from her as she swings open the cage door to comfort someone, feed them, and to change their soiled towels or litter pan.

Attending to patient’s emotional needs in a veterinary hospital is an important, but often invisible part of the job – not often taking main stage in the coordinated activity of the hospital. However, all staff members appreciate this activity. I don’t remember a single time when I, or any other participant, was spending time attending to patients by offering them toys, petting, speaking in soothing words, or holding them and another participant said “hey, get to work.” It is an expected part of everyone’s job, even though it was often unintentionally pushed down the priority list of activities. However, unlike research in human hospitals (Diamond 1992), the doctor with the most authority in this hospital, considers this part of veterinary care one of utmost importance. Despite the reality that this “caring labor” in veterinary institutions, as in human hospitals, remains virtually invisible in the textual organization of the institution, it is highly valued by most participants as a part of the coordinated activities that make up the institutional culture of one veterinary hospital.
"Pick-up"

When a client comes to pick-up a patient after neutering, staff members generally retrieve the patient from the back-cage, put them into their carrier, and bring them out to the waiting room. Although the encounters can sometimes be tense for the patient when they are being transferred back into their cage, these encounters are notably pleasant experiences for staff. It feels good to return a crying patient to their loved ones or their foster parents (who are most often taking them to their adopted parents). Human-feline encounters in the context of pick-ups in the waiting room with CAT clients, rescues and staff are fairly distant, lacking affectionate interaction and tension. Generally, the rescue is kept in the carrier as the client and staff member talk about the adoption status of the patient or the people who are planning to adopt the patient.

On the other hand, the regular client usually lets the patient out of the carrier so that they can be held. These encounters are notably affectionate and tension free for all participants. It is interesting to note that a companion patient can be screaming or trembling in the back cage and purring the second that they are in the client’s arms.

Riddles, a one-year-old female, is very unhappy in the back cages. She is howling and reaching her paws between the bars, although no in is paying much notice (except to close the door). She is worse today, after the spay. Much more upset, trembling and howling and reaching out to people. When we saw her clients, I guess that I was not the only one happy to see them come as Lisa stood up smiling and announced that they were here and "could we please go get Riddles...right away." I went to get Riddles, and she seemed pleased to be out of her cage, but starting growling and struggling when I tried to get her in her carrier. Once in, she continued to meow, but this time quieter more pitiful sounds. "Hey there is my baby." Says the female client with a smile. She quickly opens the carrier and pulls Riddles out. The client examines her stitch for a second and then holds her to her chest, "there
now, that was not so bad was it.” Riddles looks content for the first time today, and she begins to purr -- a loud rumbly purr.

The fact that the pick-up and the drop-off encounters are affectionate and lack a notable degree of tension attests to the strong influence that a client’s presence has on human-feline encounters within the veterinary hospital; indicating again that a reciprocal social bond exists between companion patient and client.

**Discussion: My Scalpel is My Sword**

During the process of my fieldwork, I recorded a large number of human-feline encounters with the purpose of neutering. I analyzed the most detailed of these encounters: 42. Of these 42, I noted only 15 various types. Of these 15 types of encounters, six predominate. Collapsing these encounters into patient-staff encounters, there were only six types and three predominate. As with preventative health, which is also defined cohesively as in the patient’s best interest, little tension is experienced by staff members and clients. In fact, less than 7% of the analyzed encounters were notably tense for staff members and only one client expressed concern or slight tension when she dropped off a patient. The lack of client tension in the context of neutering procedures might be an indication that the tension management strategies or control over the sounds of suffering from within the back room are successful.

Encounters are notably more affectionate and lack any significant degree of tension for patients in the presence of the client, during pick-up and drop off. This
makes sense as companions are taken from their homes and brought to an unfamiliar place and left by their “significant other.” This notable change in tension is an indication that companions do indeed bond to the client. Although, rescues also experience little tension in the same context, they are also less likely than companions to be tense in other social contexts. From discussions with staff and CAT clients, many rescues are used to being in cages and moved around from place to place. They also have less time to bond with the CAT client.

It must be noted however, that while time might be a significant factor in the ability to bond and thereby experience tension in the absence of another, some rescues seem to experience more tension in the absence of a given staff member (of whom they just met). If the reader will recall, Marcie had taken an immediate liking to Zip and encounters when they were together were notably affectionate. Although, the companions in the next cage were seeking affection, they were not brought out of their cages to be held. Rather than the social status of the patient, this differential treatment could be the result of some special immediate connection to another being. In fact, after Marcie had placed Zip back in his cage, he began to scream loudly whenever she was around. He seemed to want to be near her as much as she to him, so this connection was, no doubt, reciprocated.\(^{172}\)

Setting aside that there is probably some confounding variable in the above case (as there are in others) such as a mutual connection between two beings influencing

\(^{172}\) See for example Amaye. 1998 “Healing with the Wild Ones” Pp. 293-304 in Kinship with the Animals edited by Michael Tobias & Kate Solisti-Mattelon. Hillsboro, Oregon: Beyond Words Publishing Inc. She suggests that connections between humans and ‘other’ animals are mutual and cooperative connections of the soul.
the social encounter between Zip and Marcie. The fact remains that, in general, in the context of a patient waiting for a neutering procedure, rescues were accorded special privileges and affectionately interacted with more frequently than companions. In other words, the social status of a patient plays a role in the degree of affection experienced between participants at least in this social context.

The finding that a patient's social status has an influence on human-feline encounters supports other empirical research\textsuperscript{173} exploring the influence of status on human-'other' animal encounters in various occupational settings. It also lends further credibility to Arluke & Sanders' (1996) theory that the given social status of an animal (determined by how much they “fit into” human society) will have an impact on human’s perceptions of the “animal’s relative worth.” From their theory of the “sociozoologic” scale one might infer that regardless of other social contexts, companions should be most associated with affectionate displays as they are already “fitting into” human society. Rescues, who are on the nature/society cusp should enjoy the second most affectionate encounters and finally strays ought to be treated with the greatest amount of distance by human participants.

As expected, and in-line with other research, strays are most associated with distant encounters. On the one hand, respect is accorded them as they are “captured, neutered, and released,” paid for by “generous clients who care about the welfare of the larger feline population.” However, in the hospital they are placed in isolation cages (in closet with glass door), set aside and apart from other felines and staff.

\textsuperscript{173} see for example Birke 1994; Herzog 1988; Arluke & Sanders 1996.
members. Not only are they separated physically by the door, but also affectionately. They are hardly noticed by staff members in the context of the medical practice of neutering. This lack of affection is the same whether or not the patient is crying out for attention, or huddling in the back of the cage.

Companions and rescues too are accorded different treatment by staff members, and as such, are associated with different encounters. However, the direction of treatment in the context of the medical practice of neutering does not support Arluke & Sanders (1996) theory of the sociozoologic scale uniformly. Rescues are associated with more affectionate encounters than companions are. What this indicates is that it is not simply the social status of an animal that structures social encounters between humans and felines, but the social status couched within an ideological framework. From this framework, felines need to be under the control of humans and to conform to human social environment to be successful members of a “family.” Staff members, then are more likely to be affectionate toward rescues and attend to their emotional needs in order to play their part in the socialization of felines.

Akin to this idea that socialization of felines is important, is the finding that not all rescues are associated with affectionate encounters. Adult rescues, while receiving more attention than adult companions in the contexts of the front surgical cages and rear recovery cages, are not given the freedom to “run around and play,” nor are their calls for attention responded to by staff members as often as kitten rescues. There appears to be a hierarchy of attention accorded to patients relating to this idea of
socialization: kittens need the most socialization as any young human would. Companion kittens already have a home – already exist within human society; rescue kittens are therefore in need of greater socialization than companions as they are still without a permanent place within civilization. Adult rescues also need to be placed and thereby, letting them get “too upset” is detrimental to later interactions with people. Adult companions, in the context of the medical practice of neutering are least associated with affectionate encounters in the back room and most associated with tense encounters. Adult companions don’t need to be socialized – their emotional pain is only temporary, and since the surgery is in their best interest, it is more often acceptable to leave them alone.

One way that felines are controlled for their best interest within this framework is the medical practice of neutering. Maintenance of the ideological consensus that neutering is in the patient’s best interest is challenged by “loud patients” as this behavior threatens to usurp the client’s definition of the situation. To manage possible client tension and to control the definition of the situation, staff members will blow in the patient’s face to “shut them up” during bloodwork. Staff members will also close the door to the back room when a rescue kitten is particularly loud, or place a towel over the front of the cage if an adult rescue or companion is too loud. Sometimes patients will be comforted to manage their own tensions, however, this comforting also functions to manage the client’s definition of the situation that neutering and accompanying practices “relieves” suffering, not increases it. This is not to serve the patient’s interest, but rather to control or manage the client’s
definition. These behaviors provide some evidence that not only the social status between patients, but also the relative social status between humans and felines has an impact on the everyday encounters within the field.

Who is present in any given encounter does have an influence on the social encounter. However, the “who” seems to have less to do with some individual beliefs about human-animal relations, but rather with the social role one plays or social status one occupies. Although all staff members have expressed concern over, and responsibility toward felines, and most staff members are self-defined “animal-lovers,” the role that they play may be more significant in the association between various types of encounters.

The caretaker (Pam) is most associated with affectionate encounters throughout many other social contexts within the neutering procedure. This has less to do with her personality as an individual animal lover than it is with the role that she plays as “the caretaker.” It is her job to comfort and “provide a pleasant atmosphere” for the patients. While part of this job includes maintenance of a sterile environment (which protects the image of a “responsible” and “nature-free” environment for the clients) an often institutionally unrecognized, but locally recognized task is to make certain that there are warm towels and content patients. Marcie and Ezra, on the other hand, in the context of neutering are more associated with tense encounters, at least tense for the patients. A large part of their job is to do a task that is particularly unpleasant for patients – injections. Because of their roles that they play in the social institution, and not their self defined stance on animal welfare, human-feline encounters are
significantly different than they are for the caretaker. Interestingly, the role that the doctors play (pediatrician versus mechanic), has very little impact on the social encounters during the context of surgery. Similar to the context of preventative health, this finding calls into question the theories that suggest that encounters with other animals are necessarily “destructive” if animals are recognized as “object” and “constructive” if animals are regarded as “subject.” One does not have to be regarded as an object to be controlled and manipulated nor does one have to be regarded as subject to be cared for and loved.

The strong ideological consensus that neutering is in everyone’s best interest within the veterinary institution, has a profound effect on human participants ideas about the practice when they enter the local setting. While some of the staff participants mentioned that their beliefs about the “overpopulation problem” was derived in part from the media and seeing more cats running around than they believed should be, most of them told me that this “problem” was not “salient” or “thought about” until after they began working in the hospital or “began their veterinary education.” This is important because it attests to the socializing effect of institutions, in this case, regarding the social construction of a problem and the “proper” way to care for other species.

While I was participating in the research, I neutered two of my kittens at the earliest age possible. I also made certain that the person performing the surgery was Doctor Curtis. After all, he practiced the keyhole procedure, where there is little scar and “less damage.” I did this because I had bred my Maincoon so that she would
have a litter of kittens. After working in the hospital, I felt extremely guilty about it. I felt guilty about “allowing my cat to have kittens.” I felt guilty about my desire to “let my child see the miracle of birth.” In fact, one of the veterinary technicians believed that I was a breeder because of it. I remember defending myself the second that I realized her mistake. I did not want her to believe that I was part of the “problem.” I also shared my guilt with her and promised her that I had repented by having everyone neutered. The guilt that I had felt is significant because it attests to the powerful social impact that ideological consensus and others around you can have on individual behavior and feelings.

Before entering the field, I understood about the “problem” and the “accepted solution.” I believed that humans should have their companions neutered. However, my belief about the practice of neutering and the attendant ethical assumptions about human-feline relations did not outweigh my desire to “let” my cat “a purebred” have kittens. I had felt a slight unease about my desire, but nothing like the guilt that I felt while in the field. After the field research, my behavior quickly conformed to these beliefs, because of the social influence of my participants and their ideological consensus surrounding it. I wanted them to accept me. I did not wish them to believe that “I was ignorant” or that “I was part of the problem.” In other words, I wholeheartedly felt guilty for not conforming to the institutional ideology surrounding neutering, and quickly rectified it.

Conforming to this practice ideology had an impact on the encounters I had with my own cats when they were in the hospital to be neutered. My cats were scared
when they were placed in the cage. I worried that the female had to be alone after the male was picked up and even made him stay with her so that her fear would not get worse. However, I felt little concern about them being there. It was, after all, for their own good. It was the “right thing to do.” They cried out in their cage. I did not attend to these cries as much as I might have in another context. I paid less attention to them and they experienced more tense encounters because the calls from other patients who were in for declaws or euthanasia or who were rescues simply took priority. These patients needed more affection because they were not being accorded as much quality care as my cats who were in the hospital for a surgery that is defined as in their best interest.

In a letter to the JAVMA editor, a veterinary doctor asks why early-age neutering is constructed as unproblematic while other invasive or “elective” medical practices are not condoned.

The position held by those individuals who advocate abolishing ear cropping and tail docking (JAVMA, Aug 15, 1999, pp 461-462), while at the same time endorse spaying and neutering smacks of hypocrisy. Why is ear cropping and tail docking deemed mutilation and the removal of a dog’s healthy gonads considered a benefit? It would appear to me that, from the animal’s point of view, destroying its ability to reproduce is the ultimate mutilation.174

I am not suggesting that neutering is an immoral practice. Neutering may be a more legitimate or humane solution to the perceived “pet-overpopulation” problem than euthanasia. However, the construction of the problem itself and the solutions to it are human constructs, vested with political interest and power. The statement made

174 McCormick 1999:926. This, by the way, is the only dissenting or questioning voice that I found during my analysis of the Journal of the American Veterinary Medical Association.
by many doctors and humane society officials that the cause of euthanasia in animal control facilities is the overpopulation of cats intrigued me. To diminish the population and the "forced" euthanasia, then the most legitimate weapon would be neutering and not other alternatives. Remember because the larger "ignorant" public can not be trusted. Of course, it is not the population of cats that is causing the euthanasia, but a human constructed solution to a human constructed problem.

I am reminded of a public radio broadcast that I heard on Jan 30, 2003. The broadcast informed listeners that 600 special hunting licenses are being issued to Wisconsin's bow hunters. These licenses allow the hunters to hunt in parks and special reserves. The deer population is "getting out of hand;" they are "overpopulated." Residents, the broadcaster remarked, are complaining that the deer are eating shrubbery and interfering with the roads and highways, increased automobile collisions are occurring because of some of the densely populated areas.

What goes without question is that humans have encroached on their habitat and therefore are forcing the deer into smaller and smaller locations. As humans reduce land size available for other species, humans are "forced" to manage their populations. This management is constructed in the deer's best interest as their increased population density increases the likelihood of starvation and disease. What is unquestioned is the underlying human ethic of an inalienable right that humans have to the land and to the management of another species.

Under the structural conditions that the institution is set – human needs come first when it comes to habitat – allowing felines to roam free and reduce the populations
naturally or coexisting with free-roaming felines in a shared natural environment are solutions that are ridiculed or not even considered. An alternative problem to the “pet overpopulation problem” might be that within a capitalist economic system, where private property exists and animals are constructed under that category, humans compete with rather than cooperate with other species in any given ecological niche. Other animals and less powerful humans become “overpopulated” in smaller and smaller areas and can not attain the natural resources to live a life where disease and hunger are controlled.

The problem is not the overpopulation but the domination of habitat and resources by the more socially powerful groups. The solution then would be a moral restructuring of the relations between the species or between human groups – one that accorded each inherent value. Conceptualizing neutering as a weapon or a scalpel as a sword to battle the “feline overpopulation problem” is a social construction vested with political interest and not an inherent solution to a “natural” condition. Despite that it is a human constructed solution to a human constructed problem, it remains that this solution and the ideological consensus supporting this solution has a powerful impact on the types of human-feline encounters experienced in the veterinary hospital.
ONYCHECTOMY

"Death or Declaw"

Cats are born with claws. They use these claws for a variety of reasons including maintaining their balance, climbing, hunting and defense. Cats also use these claws to scratch. Most people are probably aware of this although no research has been done to verify this specifically. Do people know why cats scratch? Informally, I asked about twenty people why they thought that cats scratch. The two common answers: to sharpen or to dull their claws. This anecdotal evidence supports Fogle’s (1983) contention and Morgan & Houpt’s (1989) empirical research that some humans lack awareness of the normal behaviors of their companions. For the feline species, scratching objects is a normal behavior engaged in for a variety of reasons. One of the primary purposes of scratching is to shed the outer layers of their claws – the claw is an extension of the bone in their foot and this claw grows sort of like an onion. Another very important purpose for scratching is territorial marking – through the senses of sight and smell. Cats also scratch to aid in social interaction and to stretch.

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175 It would be interesting to see research relating to common misperceptions of animal behavior and anatomy and how this influences relations with those animals. Of course, it would be highly preferable if this research was conducted through coalitions with various fields in animal science.

176 Yeon et.al 2001; Overall 1998; Viner 1998; Landsberg 1991

177 Yeon et. al 2001; Viner 1998; Dodman 1997; Landsberg 1991

178 Yeon et. al 2001; Viner 1998
Onychectomy or more commonly referred to as declawing is performed on felines to permanently eliminate scratching behavior because, for some people, this behavior is defined as a “behavior problem.” How is it that normal behavior in cats can be constructed by humans as “problem behavior?” To come to a greater understanding of this question, it would be important I believe, to find out how declawing started in the first place. In other words, one would need the history of declawing. This is beyond the scope of my research. There is, however, case study and survey research indicating that some people declaw their cats because this normal behavior interferes or could interfere in their daily lives. As such, some humans recognize this interference as a “behavior problem” although it is widely recognized by animal scientists as a normal behavior of this particular species. Reasons given from 39 people in Yeon et al.’s (2001) survey for “electing” onychectomy (declawing) includes: scratches on or concern over the destruction of other property in the house (69%), worry about people getting hurt (49%), and worrying about other “pets” getting hurt (26%). Many of the participants at the hospital along with informal interviews of staff members at other clinics also indicate that these are the major reasons clients express for having their cats undergo onychectomy.

Declaw Ideology

179 Yeon et al. 2001; Dodman 1997
180 Their categories are not mutually exclusive.
In the veterinary institution, onychectomy or “declawing” is a controversial practice. This controversy seems to revolve around interconnected ideas relating to a patient’s quality of life. For some, the removal of claws fails to serve the patient’s interest and for others, it maintains a cat’s quality of life given the structural inequality between humans and felines. Many believe that humans will look out for their own interests at the expense of felines’ interest to maintain their own quality of life. If declawing is not offered, patients will be abused and discarded. Others believe that humans will not always look out for their interest first (that interests do not necessarily conflict) and that if declawing is not offered, humans will use alternatives such as nail trimming, nail caps and simply think before taking on the responsibility of caring for a feline companion.

In order for the reader to have a better understanding why this practice fails to enjoy ideological consensus and has an influence on the human-feline encounters, it is important first to understand exactly what the practice entails. To aid in reader comprehension, I offer a story from my fieldnotes that describes the practice in detail. This story recounts the first time that I experienced declawing (a practice that, until working in the field, I unilaterally opposed).

I am to see my first declaw today. The patient is a very affectionate companion kitten named Sunshine. Marcie [the veterinary technician] is required to wait until she has the doctor’s ok before she prepares the patients for surgery. Surgical preparation for declawing is the same as for neutering (the hair is not trimmed if the surgery is declaw only) except that the paws are rubbed with alcohol and a metal surgical tool called a guillotine-type nail trimmer is placed next to the instruments used for neutering. I watch as Marcie places Sunshine on the surgical table and prepares her for the doctor. Marcie explains what she is doing, but I can’t hear her really. I am staring at Sunshine and feeling sicker by the minute. I am interested in my feelings in that it is the declawing and not the emergency surgeries or the necropsies (autopsies on other species), which are far more “messy” that is causing...
my head to spin. I am swallowing hard knowing that I am standing by, as this poor unsuspecting cat is about to have her fingers amputated. I say nothing of my feelings to Marcie, partly because I want her to respect me and partly because I feel so guilty about being a human at that moment that I could burst in tears if I spoke. I stare at Marcie as she finishes prepping Sunshine, and then watch as Dr. Curtis walks in. He does the spay first and I am able to relax a bit and talk to him about veterinary education while I watch amazed at his precision and speed. I fall silent when he begins the onychectomy.

During the surgical procedure of declawing, a tourniquet (surgical tubing tightened with a metal clasp) is tied at the top of Sunshine’s legs. The doctor picks up one of her paws that only an hour ago had reached out to me between the bars of the cage. He squeezes the blood from each of her paws to the top of the leg. This activity reduces bleeding from the hole in the paws created during the surgery. The doctor then grasps the nail and positions the guillotine between the first and second digit – where the tendon attaches the two bones in Sunshine’s feet. Dr. Curtis then slowly pushes the dual handles of the tool together; this makes the top bone move away from the blade so only the tendon remains to be cut. Then the doctor squeezes harder on the blade and you can hear the snap and pull of the joint being removed from the patient’s paw. It sounds a bit like someone cutting the thin branches of a raspberry bush.

I watch carefully as Dr. Curtis amputates each of Sunshine’s toes on her front left foot. I ask questions about the procedure and this distracts me until I look at her face with her staring eyes. She twitches. I look up at Dr. Curtis and he explains that “she is getting light,” which means that the anesthetic is wearing off, and he motions to Marcie who is in the prep room. She reaches passed where I am perched on a stool for a machine that holds a gas anesthesia. Marcie holds the mask around Sunshine’s face making certain to not leave any wide gaps while the doctor completes the amputations. When the amputations are complete, Marcie turns the machine off and walks back to the prep room while Dr. Curtis applies tissue glue to the holes that have just been created in Sunshine’s front paws. He then wraps white bandages – like gauze but thicker – around her paws. I offer to take her back to her cage when I realize that his part of the practice is over. He picks her up and places her on the “pad” (which is a white wooly looking mat with rubber on the bottom so that it doesn’t slip). I carry her limp body into the back room, place her gently down in her original cage, and cover her with a warm towel. She is not moved into the “window cages” (recovery cages) until after her bandages have been removed and her paws checked by the veterinary technician.

It is important to point out that neutering and declawing are both elective surgical procedures that remove a functioning portion of a patient’s body. However, while neutering enjoys ideological consensus, declawing does not. Interestingly, in the above story, I “was able to relax” while Dr. Curtis did the spay, but felt horrible about declawing. These feelings influenced by the ideological consensus or ambiguity of the practice have an impact on the everyday human-feline encounters.
In the rest of this chapter, I first outline the institutional conflict surrounding declawing. Next, I show how this conflict survives at the local setting. Declawing is not a black and white practice. It is not recognized as “ideally” in the best interest of the patient but is paradoxically practiced by the doctors “from the patient’s perspective” as in their best interest within the home. After outlining the ideological conflict surrounding declawing, I present the most common human-feline encounters experienced by participants under this conflict. Most significantly, for staff members, these encounters are notably tenser than encounters within the context of ideological consensus. I argue that the institutional ambiguity of the practice enables this tension to exist because the staff members have a difficult time accepting the practice as an ideal method of care. In order then, to diminish the tension to engage in declawing, staff members need to employ further tension management strategies. As such, I outline some of the individual and professional tension management strategies employed by staff and maintained by Dr. Curtis to engage in a “professional” practice that “personally” many of them disagree with.

**Conflicting Ideology**

In veterinary medicine as well as in the public, there are various ethical positions regarding the “declaw controversy.” Veterinary medical doctor and animal behaviorist Dr. Nicholas Dodman is a well-known veterinarian, author, and director of the Animal Behavior Clinic at Tufts University School of Medicine. In his book,
The Cat Who Cried for Help (1997) he outlines the various "camps" taken on declawing:

Feelings run strong on declawing, and there are several different camps. There are those people who have their cats declawed without so much as a second thought. These are the same people who believe that it is quite painless to castrate a camel by crushing its testicles between two rocks—unless you get your fingers caught between the rocks. Sadly, some vets fall into this category and offer declawing as part of the well-kitten package along with vaccination and deworming. At the other end of the spectrum are people who would like to see the procedure banned. There are, of course, many positions between these extremes, but to my mind the most reasonable one is that of attempting to avoid the procedure at any cost—except when the alternative is euthanasia. (141-142)

Another veterinarian and author, Gary Patronek (2001) describes the "ground" on which the "camps" stand:

Onychectomy is an emotional issue. Some people believe that onychectomy is inhumane because of the associated pain and postoperative discomfort and condemn it on ethical grounds as needless mutilation performed strictly for the convenience of the owners. Others are concerned about the adverse effects of depriving a cat of the use of its claws and the ability to engage in hard-wired species-specific behaviors such as scratching, grooming and defense. This frustration of natural behaviors has been proposed as a cause of chronic stress. It has even been suggested that removal of the claws inhibit normal isometric exercise of the back muscles during scratching, and that changes in how the paw contacts the ground can cause back pain, similar to that which occurs in people wearing ill-fitting shoes....[On the other side of the spectrum] some veterinarians...argue that onychectomy is not associated with adverse long-term behavioral effects and that short term complications, particularly pain and hemorrhage, can drastically be minimized, even eliminated, with proper surgical technique and use of analgesics. Some veterinarians maintain that declawed cats even appear to have a normal behavioral repertoire (catching birds and climbing trees) when they are allowed to go outdoors. (932-933) emphasis added.181

Even though, Patronek tries to imply that veterinary medicine is on the "pro" side of the camp, there is no clear ideological cohesion regarding this practice in the veterinary institution. This ideological ambiguity about declawing reaches across the

181 I like how he words this, although I don't think that it is intentional. He places people on one end of the camp (the anti's) and veterinarians on the other (the pro's).
globe. Many countries, including Great Britain, Germany, Austria, Switzerland, Norway, Sweden, Denmark, Finland, Brazil, Australia, and New Zealand, define declawing as “abuse.” As such, legal sanctions are in place to prevent or discourage veterinarians from offering it to their clients unless the practice can be proven to fall under “extreme circumstances.”

Various veterinary medical organizations, state, educational institutions, and interest groups stand in a variety of camps. In North America, the leading feline interest group, the Cat Fanciers Association “disapproves” of the practice. Tufts University will not offer onychectomy to their clients. The Humane Society of the United States and the Association of Veterinarians for Animal Rights both try to discourage the practice but recognize that this surgical alteration may be used as a last resort. Both the Canadian Veterinary Medical Association (CVMA) and the American Veterinary Medical Association (AMVA) consider this surgery a “justifiable” procedure to prevent a cat from scratching especially when training has been attempted, but do not “recommend” it as an “ideal medical procedure.” In other words, the veterinary institution in the United States does not endorse the practice as they do with vaccinations and neutering, but they do not condemn it as abuse either.

182 Dodman 1997; Patronek 1996
183 The rest of the list can be found cited online at http://maxhouse.com/Truth%20About20%Declawing.htm.
184 People who have cats and find out that they have a severe illness worry that scratching may cause the human loss of limb or even their life. Such diseases pointed out by participants and the Journal of the American Veterinary Medical Association includes AIDS and Geriatric Diabetes.
186 Dodman 1997; Patronek 2001
188 http://www.avar.org/cat_declawing.htm.
It is solely up to the practitioner to decide whether to offer declawing to their clients. In addition, it is up to the clients to decide whether to have their cat declawed.

As Patronek (2001) above indicates, there are two basic reasons that declawing is controversial. First, ideological conflict exists because of the possible medical and behavioral complications with the practice. Second, not only might this practice cause complications; it is understood to be a particularly painful procedure. Through clinical studies, many veterinarians point out that there are complications involved in declawing a feline. Some of the studies indicate that short-term medical complications arise in about half of patients who undergo this procedure. These complications may include “pain, lameness, bleeding, swelling, incisional dehiscence, nerve trauma secondary to the use of a tourniquet, and tissue necrosis resulting from improper bandaging” (Jankowski et. al. 1998:370). Long-term complications are reported in about a fifth of the cats who undergo onychectomy. These long-term complications include “lameness, infection, regrowth of claws, development of chronic draining tracts from remnants of the distal phalanx, protrusion of the second phalanx, and development of palmagrade stance” (Jankowski et al. 1998:370). It must be noted, however, that many of these complications (pain, bleeding, swelling and incisional dehiscence [swelling of the tissue around the surgical opening] are also indicated as complications of other elective surgical procedures such as neutering.

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190 AVMA Policy Statements and Guidelines, 2001
191 Tobias 1994; Lin, Benson & Thurman 1993; Martinez, Hauptmann & Walsh 1993; Fowler & McDonald 1982
192 Tobias et al. 1994; Martinez, Hauptmann & Walsh 1993; Pavlick 1980; Fowler & McDonald 1982
193 Tobias 1994; Fowler & McDonald 1982

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Other studies indicate that declawing could have an “adverse” effect on the patient’s behavior. These studies suggest that declawing could increase the cat’s likelihood of more “severe behavior problems” such as house soiling,\textsuperscript{194} biting,\textsuperscript{195} and jumping up on counters.\textsuperscript{196} Many people, including veterinarians, take data on the possible increase in “behavioral problems” quite seriously because there has been some indication that “behavior problems” increase the likelihood of “relinquishment” (bringing a companion to an animal control or shelter facility).\textsuperscript{197}

The other reason that this practice fails to enjoy ideological consensus in veterinary medicine is because the surgical procedure is recognized as one of the most painful medical procedures that a cat can undergo. Evidence of this is that declawing is the “optimal” procedure used to test analgesics (pain medication). Dodman (1997) describes how painful the procedure is from observations of patient behavior during recovery and argues that this procedure is used to test analgesics:

The inhumanity of the procedure is clearly demonstrated by the nature of cat’s recovery from anesthesia following the surgery. Unlike routine recoveries, including recovery from neutering surgeries, which are fairly peaceful, declawing surgery results in cats bouncing off the walls of the recovery cage because of excruciating pain. Cats that are more stoic huddle in the corner of the recovery cage, immobilized in a state of helplessness, presumably by the overwhelming pain. Declawing fits the dictionary definition of mutilation to a tee. Words such as deform, disfigure, disjoint, and dismember all apply to this surgery. Partial digital amputation is so horrible that it has been employed for torture of prisoners of war, and in veterinary medicine, the clinical procedure serves as a model of severe pain for testing the efficacy of analgesic drugs (140).

\textsuperscript{194} Yeon et al. 2001; Landsberg 1991; Morgan & Houpt 1989; Bennett & Houpt 1988
\textsuperscript{195} Yeon et al. 2001; Landsberg 1991; Morgan & Houpt 1989; Bennett & Houpt 1988; Borchelt & Voith 1987
\textsuperscript{196} Morgan & Houpt 1989
\textsuperscript{197} APPMA 2000
Some of my field observations lend support for Dodman’s argument that recovery from declawing, for some patients appear to be particularly traumatic.

When Sunshine wakes up, she is obviously upset, in pain and confused. She is howling and shaking. It is unclear, however, whether she is violently shaking her paws because she has bandages on them (cats often shake their paws vigorously when they have tape stuck to them) or because she is in pain. I suspect that it is a combination of the two. ...Later that day, after her bandages have been removed I note that her paws are slightly bloodstained. When I move closer, she stands up but as soon as she puts weight on her front paws winces and sits back down. She looks up at me with her big brown eyes for a second; then looks away. I watch as she curls up in a ball and lies there shaking. She does not make a noise. Her behavioral change between drop-off and surgery is extreme.

While many patients seem to experience significant pain during declawing recovery, it is important to point out that not all patients respond in the same way. For instance, right next to Sunshine, two companion kittens named Billy and Bunny are recovering from the exact same surgical procedure (a front declaw) however, they do not appear to be in the same degree of pain that Sunshine is.

Feeling very depressed after looking at Sunshine, I focus my attention on the patients in the next cage. Billy and Bunny sit up when I say hello. They meow at me, just as they had yesterday and reach out between the bars with their paws. I reach up to the top of the cages where there is a small box with various kitty toys in it and squeeze a mouse between the bars. Billy bats at it and Bunny reaches over and tries to wrestle with him. I open the cage and pet them both; Billy leans against my hand purring. After I close the cage door they both begin to meow louder than they had yesterday. However, except the more insistent cries for attention, they seem much the same as they did yesterday. I look at the two cages and think about how I had assumed all cats would respond in the same way. I admonish myself for making such a speciesist assumption. Of course, individuals respond differently to surgery!

During my analysis of the *Journal of the American Veterinary Medical Association* over the eleven-year period (1990-2001) I found two letters to the editor, three clinical studies, and one review article that focuses specifically on declawing.
This relative lack of discourse might indicate that this practice is not recognized as in the best interest of the patient. The clinical studies major goals are to compare two surgical procedures designed to eliminate scratching behaviors\textsuperscript{198} and test the effectiveness of a specific analgesia.\textsuperscript{199} The later clinical articles lend support for Dodman's (1997) contention that onychectomy is used to test the effectiveness of analgesia and as such, is institutionally recognized as one of the more painful procedures for felines.

Between the years of 1966 to 2001, Patronek locates 25 articles, mostly conducted by veterinary faculty and their students using two medical computer searches along with snowball bibliographies. In Patronek's review, 19 out of 25 (76\%) of the articles "provided data on some aspect of medical complications or behavioral problems" (933). Out of the 19 studies, two of them...

\begin{quote}
were specifically designed to evaluate complications of routine onychectomy, whereas the primary purpose of the others included evaluation of catecholamine response or analgesia, assessment of the usefulness of medical records for determining complication rates of all elective surgeries, comparison of the effectiveness of different types of wound closure or surgical technique or comparison of tendonectomy and onychectomy (935).
\end{quote}

Because of the possible complications and the recognition that it is a painful procedure and one that cats most likely would not choose, declawing is a particularly ambiguous practice in veterinary medicine. Although ambiguity about this practice is evident throughout the \textit{Journal of the American Veterinary Medical Association},

\textsuperscript{198} Jankoski et al. 1998
\textsuperscript{199} Carroll et al. 1998; Franks et al. 2000
there is a framework that the “legitimate” voice leans on. This framework, is the same one that Dr. Curtis employs in his hospital: “it is up to the owner to decide.”

Conflicting Ideologies in the Local Setting

In the local setting, declawing is not recognized as an “ideal” medical practice by any staff participant. Staff participants do not see declawing as the simple black or white issue that both preventative health and neutering is. Rather, there is a continuum of acceptance regarding this practice and not all staff members stand on the same point on that continuum. This ethical continuum centers on the age of the patient, the number and placement of amputations, and whether or not the patient is “allowed” to go outside.

Although not “ideal,” the front declawing of kittens, particularly combined with neutering, is more acceptable to many staff members. This is because with younger patients, the healing time is understood to be much quicker and less pain is involved because the patient is smaller and less weight is placed on the paws.

“It is ok...if the surgery is done before the kitten is four months old. Really because the healing time is faster...also if it occurs at the same time that they do another surgery...you know neuter them...”200
“A front foot declaw of a kitten? Well, it is ok if they are younger.”201
“Oh...I am pretty much for it...if it’s something that they [clients] really want done, they will do it even if at another clinic... with kittens, I don’t like it...you know...but as I said before they are going to do it anyway.”202

200 Interview response by Lisa (office manager) to the interview question “What is your ethical stance on the declawing of a kitten.”
201 Interview response by Victoria (veterinary technical assistant) to the interview question “What is your ethical stance on the front foot declawing of a kitten.”
202 Interview response by Nell (veterinary technical assistant) to the interview question “What is your ethical stance on the front foot declawing of a kitten.”
"I think, if someone wants to get their cats declawed, then it’s their decision. It’s painful yes, [no prompt] but if it gets done at an early age, well, then...I have nothing against it."

"Well mine are not. If they’re young enough it’s not much of a problem."

Twenty amputations on a kitten (front and rear) is less acceptable than front declawing. Again, kittens are understood to “bounce back” from such a surgery both physically and emotionally faster than cats are. In addition, “one never really knows” what will happen and the kitten could get outside, thereby leaving them defenseless.

"Less agreement here [than with front foot declaw of a kitten]...you know they bounce back so much faster."

"I don’t like it...but if they are going to do it...which they really shouldn’t...it is better if they are younger cuz they seem to get over it faster."

Adult front declaws are less acceptable for many staff members than kitten declaws.

"...Often a student will get a cat and not have it done when the cat is young because they really don’t have furniture that they care about but then the student gets older and graduates, gets nice stuff that they don’t want wrecked...have children...then they decide to have their cats declawed. This is worse than if they would have done it in the first place...when the cat was younger because now the patient will have a longer recovery time and it is much more traumatic because the cat is used to having their claws...it’s much more traumatic for the cat when they are older both physically and emotionally. So, if a client would ever consider having it done, then I think that they should early and not later."

"With adults I like to warn clients that the cat may start biting and it is painful...but really as I said before..."
Although some participants' point out that a rear declaw of a patient of any age is bad, for some staff participants, adult rear declaws, especially if they are “allowed” to go outside is simply “cruel.” Often when a patient is in the process of being declawed, some staff members will comment on it.

“You poor kitty, how can you defend yourself out there?”

“I can’t believe that they let him/her outside! Why did they [clients] declaw an indoor/outdoor cat? And all four paws too!” If the patient is scheduled to have his/her rear claws “removed,” then staff participants are even more upset or indicate greater disapproval. Common “backstage” remarks about four-foot declaws include:

“A four foot declaw? How can clients be so unfeeling?”

“How are they to defend themselves without their back claws?”

Front stage comments come in the form of “recommendations.”

“I would not recommend a four foot declaw, most people don’t have that done...anyway it is not the back claws that usually cause the damage...but it is your choice...”

“I recommend only a front foot declaw...in case for some reason that Fluffy happens to get outside...I have seen many patients come in here hurt because they could not defend themselves out there.”

While there does appear to be a continuum of acceptance toward declawing in the field, not all staff participants agree about when and how the declawing ought to be done on patients. Dr. X, for instance, is “100% for it” because “it makes them better
pets.\textsuperscript{209} Other staff, as noted before, accepts it for kittens and not adults. Some claim that no rear-declaw should be practiced at all, and still others stand firm that with kittens it is at least less problematic, given that “clients will do it anyway.” Finally, two staff members, completely disagree with the practice. Pam, for instance, believes that the practice “ought to be outlawed.” In addition, when I asked Laura about the practice she shudders, “eewhh...I don’t agree with it.”

Not surprisingly, clients are also widely dispersed in their ideology surrounding declawing. Some clients defend their cat’s rights to their claws at all costs. For instance, a young male client scheduled an appointment to have his two cats’ nails trimmed under anesthesia and despite their noted aggression, refused any suggestion or implication that they should be declawed.

When I hand their chart to Lisa, I note three asterisk’s (***)) written on it and ask her what that signifies. “Oh, now these are very aggressive patients and we know from this to be careful.” When the client arrives, he has two large black cats, one in a carrier and the other in his arms. The patient in the carrier is growling and hissing. The patient in his arms has his paws wrapped around the client’s neck and his head hidden underneath the man’s chin. Lisa knows who they are and why they are here but reaffirms the purpose of visit; “you want us to trim their nails?” The client sighs and nods, “well, they let me do their front nails but the back ones are impossible.” He shakes his head and looks down at the patient in his arms. Doctor Curtis walks in and from behind the reception desk asks the client “did you bring them in for a trimming under anesthesia?” The client nods and says, “I think that is the only way.” The client looks at the staff members and the doctor and then his gaze stops for a second on the “soft paws” (nail caps) that are advertised on the counter. “You know some people are telling me that I am crazy and that I should have them declawed...but I am not doing that to them!” He pets the patient in his arms and looks down at the carrier with a grimace. Doctor Curtis looks at the patient in the carrier who is still growling and says “well, that is a pretty costly nail trim though...you don’t want to have to do that every couple of months. Why not bring them in when they need something else done. Are you going to neuter them?” The client tells him that they are already neutered and then states, “I just want their nails trimmed today whatever it takes...it has to be done.” I note that the client has deep scratches on his arms...

\textsuperscript{209} Although the reader will see that he does not think that it is ideal but rather ideal within human homes.
This client refuses to declaw his cats even at cost of personal injury and financial burden. Others will have an adult completely declawed to protect the value of their furniture. “I would like to have Mister declawed on all four paws. He is heavier now that he is older and I am afraid that he will ruin my new leather couch.” Still others believe that front declawing of kittens is ok, but rear declawing of any patient is unacceptable. For instance, in the context of an exam, a client asks if she can have her kitten declawed when she is brought in for a spay. Doctor Curtis asks if she is “just doing a front declaw or do you want them all to be declawed.” The client responds taken aback, “I would never do a four foot declaw on her! That is so mean!” Further evidence that some clients find front declawing of kittens more acceptable is that of all the declawing practiced in the Loving Care Cat Hospital, front declawing of kittens is the most common.

Staff participants suggest that their personal stance on declawing is influenced by experience in the hospital. For some staff members this experience has “mellowed” them and helped them to be more accepting of the practice.

“I guess I didn’t really think about it much ‘till working here...but...Since I began and learned ‘bout it...I guess actually I have mellowed.”

“Pretty much always...though I am more for it now that I have worked here for awhile. I find that I have more empathy with the client than I used to.”

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210 Interview response by Ezra (veterinary technician) to the question “Do you believe that you have always felt this way about declawing? Or have your feelings on the issue changed over the years, and if so what made you change your position?”

211 Interview response by Victoria (veterinary technical assistant) to the question “Do you believe that you have always felt this way about declawing? Or have your feelings on the issue changed over the years, and if so what made you change your position?”

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Other staff participants claim that seeing the practice done has actually lessened their acceptance of the practice.

“Well, I really didn’t know about it ’till I saw it. Now I really don’t like it. I saw one claw removed and it was horrible and their paws afterwards and they wake up and find that they don’t have them and don’t understand...I don’t like it even more...I am more against it now that I know what it is all about.”212

For others, experience with the consequences of the practice has influenced their stance on the practice more so than experience with veterinary medicine. In the interview response below, Lisa argues that her stance on the continuum changed from experience with the traumatic loss of her cat.

“Again, as I said before, under the age of four months it’s ok. Over that forget it! I have personal experience with this and that is why. I once got a cat a four foot and even though I thought she would never get outside, she got outside and was torn apart by a dog. I swore to myself, for myself, I would never get it done again. I am not against it when they are young...but you have to keep them inside and not get the back done. When they are young they heal faster and only go through the anesthesia once.”

These staff participants argue that a personal ethical stance is not derived from “somewhere” out there, but rather is shaped by situational forces. The context of the situation and experience with patients and other felines has helped to shape their ideas on declawing.

For some staff members, declawing and a patient’s quality of life are unrelated. For others, given the current structure of relations between clients and patients, it is.

While it may serve the interest of the patient to retain his or her claws, it will not do

212 Interview response by Laura (receptionist) to the question “Do you believe that you have always felt this way about declawing? Or have your feelings on the issue changed over the years, and if so what made you change your position?”
so in certain social contexts. As such, some staff participants indicate that, despite their personal ethic relating to the practice, the professional ethic must account for the complexity of other structural and social issues in the U.S. social structure. Laura, for instance, does not agree with declawing and as stated above, she argues that she does not like it even more since experiencing it at work. However, in the context of an interview, she distinguishes between personal and professional standpoints regarding the medical practice of declawing.

“eeehhh...I don’t agree with it!...Well...unless...well...but I understand at work...why...I mean...you know, it can be necessary...Well, like in an old folk’s home, some people can’t keep a cat unless it’s declawed because of the rules of the place and I would rather see them declawed than have to put them out or give them away...make people get rid of their cat...that would be worse for both of them...”

When asked about four-foot declaws, Ezra explains that, at work, she takes the context of the situation into account when thinking about declawing.

“I try to let clients know that there is a possibility that their cats will turn to biting. But I understand that in some situations it needs to be done...older clients...especially with geriatric diabetes can’t get scratched or they could really get hurt...people must look out for their own interests too.”

In the context of interview, Dr. Curtis explains that he has to refrain from judging a client who wishes any declaw because he “simply does not know the context” at home.

“It is up to the owner, I believe, to make that [declawing] decision. Really, I simply don’t know the context of the situation. Many times a woman...ah...not to be sexist here...but it usually is a woman...will come in here and ask to have her cat declawed because her husband will not allow her to have the cat inside or even keep the cat if she does not get it declawed...I hear that story quite often...and I am not in the situation to make judgments about her decision.”
He further argues that declawing in some home contexts given the structural inequality between humans and felines, actually helps to preserve a patient’s quality of life. Dr. X agrees with Dr. Curtis, and he argues that although it is better if the declawing is done at an earlier age, the practice itself “from the cats’ point of view” is better for them “in the long run.”

"Really, I think that it diminishes the abuse of the animal. They are not getting yelled at or punished for ripping up curtains or furniture...they are not hurting children...if they are getting punished and cowering it does little for their quality of life and eventually the client gets frustrated enough the cat gets kicked out of the house or worse...you know...I get that story all the time. In this society...animals are property and although I may not like it...really...what is the alternative?" (Dr. Curtis)

“I am 100% in favor of it. It makes them better pets. It is better if it is done between the ages of 8-12 weeks...the earlier the better...but come on...from the cats point of view this is the better alternative. I mean it takes the stress out of the household. People aren’t chasing them from the curtains or off the furniture...being chased around or punished for being a cat is much more stressful than a 24-48 hour surgery pain. And the cat won’t even relate that to you. It’s better than cowering behind furniture afraid of getting yelled at. You must look at it from the cat’s point of view...it is better in the long run to be declawed.” (Dr. X)

For some staff participants the idea is that there is a conflict of interest between clients and cats when it comes to a cat’s claws. Many clients have an interest in the removal of a cat’s claws while cats have an interest in keeping them. Some clients will look out for their own interests sometimes at the expense of patients’ interest. If a patient is not declawed, they are more vulnerable to abuse as clients get frustrated with normal feline behavior. As many clients, from this perspective, are inherently selfish and will subject the patient to a “worse quality of life,” declawing is the lesser of two evils. Because it is the lesser of evils, surgical control, while not “ideal” is actually in the patient’s best interest. Despite the lack of consensus on the practice of
declawing by staff members, this practice is engaged in anyway as the owner's definition of the situation takes precedence. The lack of ideological consensus and the necessity of some staff participants to engage in the practice cause a considerable degree of tension for them; tension that they must manage. For me, the participation in the practice of declawing was particularly problematic.

The night after I watched my first declaw I had horrible nightmares. In these nightmares, I heard the snapping and pulling sounds of the tendon. I dreamt about kittens with bloody stumps. Sunshine visited me in those nightmares and I could hear her howling in pain. I kept telling her that I was sorry and that I didn't know what else to do. At the end of the night, I dreamt that I was trapped in a horrible web and could not find my movement to run to her. I didn't know how to help her from where I struggled in the web.

While watching Dr. Curtis perform a declaw the next day, I disclosed my assumptions and feelings relating to declawing. I also told him about my nightmare. He nods as he grabs the guillotine from the small metal table next to him. He puts it in position. "Well Dana. I have to tell you...I don't like it either...[he depresses the handles and I hear a sickening snap]. I really think that [he pulls the bone out]...a person ought to accept the reality and the responsibility [he drops the bone onto the metal table and it makes a clinking noise]...that cats have claws and they will need to be trimmed and may slice up the furniture before getting a cat...[he begins on a new toe]. But...you know...[snap]...many people get cats [pull]...and then they realize that their furniture is being ruined [clink] or that people are getting scratched and believe that they have...[snap]...one of four ... options ... [pull] ...animal control
[clink]...and as you probably know most animals are put to sleep there, they could kick the cat outside which happens all the time...[pull]...and outside they usually get hurt...[clink]...they have a much shorter life span and often die because they don’t know how to survive out there. The third option is euthanasia...[snap]...and the last option [pull]...is declaw...[clink].” He sets down the tool for a second. “You know if I was a cat, I would look at the options that a person is giving me...Death or Declaw...and you know...I would pick declaw for sure!”

_Human-Feline Encounters in the Context of Ideological Conflict_

_Claim Presence_

In the context of the ideological conflict centering on the medical practice of declawing, human-feline encounters are notably tense and sometimes affectionate. As an elective surgical procedure, the practice of declawing follows similar patterns as neutering. Clients drop-off the patient to be declawed most often, but not always, in conjunction with neutering. Encounters in this context are similar to neutering with one exception; clients are noted to express concern about the consequences of this practice. In other words, declawing drop-offs are slightly tenser for clients than

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213 According to the United States Humane society 4 to 6 million animals are "put to sleep" in shelters and control offices annually. "Although the number of animals euthanatized varies by geographic region, approximately 30-60% of all animals brought into animal shelters are euthanatized nationwide."
neutering drop-offs. However, the encounters are still notably affectionate. In both of the human-feline encounters below, the clients (both well known by staff members) are bringing in their kitten feline companions to be neutered and declawed. As with neutering, the staff members stand back to allow clients and patients to say their “good-byes.” The clients and patient typically express mutual affection. The clients though express concern or guilt about declawing.

“I was saying that these clients are pretty nice. They are bringing in their new four-month-old kittens. Do you think that you can bring them into the back? Make sure to put the card on the front of their cage.” I nod and move quickly to pull an index card from the drawer underneath the fax machine. I hear the clients walk in. I grab a pen, stop poised to write and look up at Lisa. “Oh...Billy and Bunny...and the client’s name is Smith. Also, on the bottom of the card remember, write spay/castration and Front declaw X2/ Hi you have Billy and Bunny with you right [to client]...hmmmm...[I was busy trying to write the card out perfectly]...no food and water?...Good.” Lisa looks at me. I stand up straight and say hello to the client as I move toward them out the swinging door into the waiting room. The carrier is on the ground next to the door. I reach down to pick it up. The woman stops me. “Wait.” She quickly leans down and opens the carrier door. “Come out Bunny, come here girl.” She pulls out a bundle of fur. The kitten has long gray and white hair and as she is picked up, she looks quickly around. Bunny leans into the woman as the woman pulls her close. Mrs. Smith gives Bunny a quick hug. Then she looks over at the girl who is standing a foot away watching quietly. “Here honey.” She says. She hands Bunny over to the girl who immediately begins to brighten up. The young girl snuggles her face into the kitten’s long fur. Bunny stretches up a bit in the girl’s arms and puts the back of her neck against the girl’s face. The girl laughs and then kisses the kittens’ neck. Meanwhile the client has pulled Billy out of the carrier. Billy squirms quite a bit when the client tries to pull him close. Mrs. Smith just laughs and pats his head, seemingly unconcerned at his lack of affection. Mrs. Smith hands Billy over to the boy. Billy stops squirming immediately, and the boy looks triumphantly at his mother. She just shakes her head, looks over at me and explains “they had to say their good-byes.”

Meanwhile Mrs. Flannigan comes through the second door of the entrance. She is struggling to carry the pink carrier, which I now know has Sunshine inside. I walk over to help her with the door. She smiles at me and walks in. Lisa greets her warmly and the two clients look at each other. Lisa reaches over to pull out another index card and Mrs. Flannigan sits down in a waiting chair on the side of the room and places the carrier on the ground next to the chair.

Mrs. Smith has a difficult time taking the kittens away from the children to put them back into their cages. The children look upset and she has to scold them a bit to get them to let go of their snuggling companions. Then, once that feat is accomplished, she has to struggle with Billy to get him back in the cage. She looks over her shoulder at Mrs. Flannigan and laughs. Mrs. Flannigan smiles back. Finally Mrs. Smith has won the struggle and closes the door to the carrier with both
Billy and Bunny inside. She picks up the carrier and hands it to me. Mrs. Jones watches as I lift the cat carrier with Billy and Bunny in it over the swinging door. Then she turns to Lisa with a worried expression. “This won’t change their personalities will it? I have heard horror stories...” Lisa responds, “well, I have seen plenty of kittens go through front declaws and I don’t think it affects their personalities if that is what you are concerned about.” The client stares at Lisa for a second and then looks in through the carrier door [I am holding it so that the door faces her] with furrowed brows. Noting the client’s concern, Lisa says, “they will be fine, we will take good care of them.” The client looks in again at Billy and Bunny and say “well, I feel pretty mean...see you two later.” At that, I quickly turn around with the carrier before the participants can see my own expression.

After helping the kittens into their cage, giving them toys to play with to keep them occupied, I go back out to the waiting room to collect Sunshine. I note that Mrs. Flannigan now has the carrier on her lap and is speaking softly to Sunshine as she holds Sunshine’s paw that is extended from the carrier door. As I reach for the carrier, Mrs. Flannigan looks at me and then at Sunshine’s paw and says with a troubled look on her face, “I feel so mean.” I smile and turn away, carrier in hand realizing that she must have heard the other client worrying about Billy and Bunny.

In both of the above encounters, the client’s concern is over declawing and not neutering. Without the ideological consensus that the practice is in the patient’s best interest the encounter itself is influenced in the sense that the client expresses more tension.

It is important to point out that the client uses the language “this” and not “declawing.” However, Lisa assumes that the client is referring to declawing and not to neutering. Note too that Lisa appears to reassure the first client that from her experience with the front declawing of kittens that their personalities are not aversely affected. However, she does not suggest that declawing is something that is good for the patient as she has with neutering. Further, she leaves the opening for the client to ask more questions with the statement “if that is what you are concerned about.” The client does not use this opening. According to some staff members, “clients rarely ask” for the specifics on declawing. Possibly, when clients do inquire about declawing, they are looking for reassurance of “doing the right thing” rather than
actual details of the practice. It might be safe to assume that Mrs. Flannigan is looking for reassurance from me when she tells me that she “feels so mean.” Of course, she receives little more than a smile from me because I had not yet learned to think about the context of the situation when a client brings their companion in to be declawed; from my perspective at that time, she “was mean” or at the very least “ignorant.”

Lisa further reassures the first client with “we will take good care of them.” While staff members do not always reassure clients, when they do, it is only with the front declaws of companion kittens. I did not observe a staff member reassure a client that a rear declaw patient or an adult companion “will be just fine.” In fact, some staff members actually try to get clients to change their minds when it comes to rear declaws of adult companions. In the below excerpt from my field notes, rather than reassure a concerned client, Anna works to make the client more concerned about the practice.

Entering the reception room, I note a client walking in with a large carrier. Anna looks up as she enters. “Good morning...So who do you have with you?” The client sets the carrier down on the counter and looks in the carrier door with a smile. “My Guy.” Anna pulls the chart up on the computer and after a few seconds appears to look up rather quickly, a frown on her face. The woman is placing her fingers in the door of the carrier and the patient appears to be licking her fingers. Anna asks, “you are bringing him in for a rear declaw?” The woman nods “I just got new pine furniture and I don’t want him scratching it up.” Anna’s frown deepens and Angie who had walked in a second earlier takes in a quick breath and walks back into the prep room. Anna says “a rear declaw on an adult...you know...that large too...will be painful for him...maybe trimming his nails or applying soft paws on the rear would be a better idea.” The woman looks at Anna. “I think that this will be better for him and for us...I don’t want to be chasing him around all the time with the squirt bottle...[I notice that the woman is beginning to glance more often at the carrier and blinking her eyes rapidly...she appears to become nervous]. Anna sighs, “yes but it is usually not the rear claws that causes damage to the furniture.” The woman starts rocking back and forth, and her voice becomes strained “I am getting him declawed

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[she pushes the carrier closer to Anna]. Anna sighs again louder this time. “Ok, any food or water...”

If the reader recalls from the last chapter, the client that expressed concern over the practice of neutering is defined as being “too finicky about her cat.” In the context of declawing, however, clients are expected to be concerned about their companions being declawed. While front declawing of kittens is more accepted and therefore reassurance of being cared for in the hospital is offered by some staff members, clients who bring in their adult companions for rear declaws and fail to express concern are painted as uncaring and are subtly sanctioned for their behavior.

In the presence of the client, human-feline encounters are typically associated with mutual affection between client and patient and while clients express some tension, patients experience very little. However, when brought into the back room, companions become notably more tense as they did when they were brought in to be neutered. Sunshine, for instance, begins to howl incessantly. Billy and Bunny huddle together in the back of their cage. My Guy expresses the greatest degree of tension and becomes considerably aggressive toward all staff members. In the context of declawing outside of the presence of the client, some staff members are also noted to express a greater degree of tension in human-feline encounters.

I am standing in the back room speaking to some of the patients waiting surgery when Pam walks in. Pam smiles at me and reaches up for the small cardboard box that holds various cat toys in it. As she reaches up, she leans close to My Guy’s cage; he spits at her and lunges toward the front of the cage. “Oh goodness. You are unhappy aren’t you?” Then she looks at his card on the front of his cage that informs her he is having a rear declaw. “Oh, I see why. Poor Boy.” Anna walks in and hears Pam. “Yes, he had his front ones done when he was a kitten. The client wants the rear done because they ‘just got new pine furniture and does not want him wrecking it.’” Anna states the last part of the sentence in a sarcastic tone of voice.
Pam shakes her head and looks at My Guy who is now growling at her with his ears flat against his head. Anna continues, “I tried to explain to her that it is not good for him...that it is traumatic and painful...especially for an adult cat...but she just did not care.” Anna looks in at My Guy. “Poor guy, I tried to tell her that it is probably not the back claws that will hurt her precious furniture and she would hear nothing else...was adamant about the declaw.” Angie joins us in front of My Guy’s cage during Anna’s last sentence and says in a disgusted tone of voice, “I just can’t believe some people. I mean I am really angry about this! How can the client be so unfeeling?” Marcie came in from the prep room with his anesthetic and must have overheard part of our conversation. “I totally agree, why don’t people think about this kind of thing before they even get a cat?”

**Patient Age**

While tension is expressed more often outside of client presence, the degree of tension noted by staff members seems to fall along the ideological continuum of the practice. As I described earlier, a part of this ideological continuum includes the age of the patient. With kittens, the practice is defined as “less painful” as “kittens bounce back faster.” The encounters with many kittens are, not surprisingly, less tense for staff members – particularly if the practice is combined with neutering. With these patients, some staff members may comment on the procedure in a disappointed tone of voice, “oh...a declaw huh...poor baby.” For other staff members, little or no tension is observed during these encounters. On the other hand, with adult patients, as in the example of My Guy above, staff members are notably more upset. As staff members believe that the practice is “more painful” for these adults, their participation in the surgical procedure becomes more problematic.

**Patient Resistance**

Staff member’s tension is heightened when a patient like My Guy resists and staff
participants are expected to increase their control over the patient to force the feline to have a surgical procedure that many disagree with. In the field note excerpt below, My Guy violently resists (expresses his tension in “aggressive” ways) getting anesthetized. Because of his resistance, Marcie and I engage in greater control efforts to force him to get a shot. This is extremely traumatic for the patient, but also causes both Marcie and me a considerable degree of tension.

When My Guy is to have his injections, he will not let Marcie get anywhere near his cage. So she decides to “use the pole.” I do not have to wonder for long what “using the pole” is because Marcie comes out with a very short needled syringe attached to a very long pole (size of a broom handle). She tries to inject My Guy, who is hissing and spitting, from his cage. Even this strategy, saved routinely for the more “aggressive” patients, fails to work because he violently attacks the pole when it gets anywhere near his body—and this is one strong patient.

After three unsuccessful attempts to anesthetize him in his cage using the pole, Marcie looks at me and tells me that we were going to have to resort to using the “bucket.” In other words, we have to use the Tupperware bucket that is used to gas cats before short surgeries to trap him. I look at her anxiously. I look at the patient who was now staring at us intently with his ears flat against his head and emitting long low growls. Marcie shakes her head, “I am so sorry...but it can’t be helped [to patient].” Then she looks at me with her eyebrows raised in a questioning expression “do you mind helping me?” I quickly reply that I would love to help, trying to cover for my anxiety. I wanted to help, the more I participated in the activities, the less that I felt like an outsider and the more I felt that I was giving something in return.

Marcie returns to the prep room to retrieve the bucket while I speak soothingly to the bundle of growling fur huddled in the back of his cage. I look at the muscles in his back—trembling, but obviously very well toned. She comes back to position herself in front of his cage and hands the lid to me. Without a word, she swings open the cage door and stuffs the bucket, patient and all, against the rear of the cage. She has trouble holding the bucket in place as My Guy’s muscled body writhed in resistance. She opens the top slightly and I slide the lid over the top and then between the bucket and the wall and close the lid tight. Now trapped tightly inside of a Tupperware bucket, My Guy begins to howl as he continues to struggle for freedom. Marcie then quickly carries the patient filled bucket to a larger freestanding cage with no walls; only bars. This is the cage generally reserved for strays or diseased patients that are placed in isolation. The cage enables the staff members to get to a patient from all sides.

Marcie places the bucket on its side near the far end of the cage, removes the lid, and quickly closes the cage door. My Guy begins to hiss, spit and attack anything that comes near the cage—including the toy on a long stick that I am using to try to distract him with so that Marcie can get the shot in his behind. I note that Marcie’s hands are shaking. She looks at me and says, “this is so horrible...I hate doing this.” He is strong and very fast. My guess is that he is terribly afraid and angry and that he will probably be traumatized from this. Marcie keeps apologizing to him for her
method — but says to him, “you give me no choice.” She also apologizes to me. “I am so sorry that you have to see this, Dana. But really what else can I do?”

Once My Guy is successfully anesthetized, Marcie looks at him as he sleeps. “You know, he is probably just fine at home. He was just so scared you know?”

“I don’t blame him” I reply.

While how a patient expresses tension influences the encounter, it does so only under a human constructed ideological framework. Patients do “aggressively” resist in the context of other practices such as getting vaccinated and neutered. In the context of preventative health, however, most often a client is present. In the presence of a client, poling is not used because it is understood to upset the client and damage the hospital image of working in the patients’ best interest. If the reader recalls, the companion kitten who aggressively resists getting vaccinated had her vaccinations rescheduled rather than force her through poling to be vaccinated.

Outside of client presence, poling is used in other medical contexts such as neutering. For example, in the context of neutering a “resistant” stray, Marcie and I had used the pole through the isolation cage in the same way that we did to My Guy. However, neither of us felt that this practice was particularly problematic. While we did apologize to the patient for “upsetting” her, we actually laughed at her resistance. In the ideological context of a stray being neutered, the resistance is simply “uncalled for.”

Neither Marcie nor I expressed the same degree of tension or guilt over traumatizing her because we defined what we were doing as ultimately in her best interest. One might suggest that the differential encounter is a result of the patient’s social status more than the ideology of the practice. We felt less tense poling a stray
than poling a companion. However, if the reader recalls, the social status of the patient influences the encounter only because it is couched within that specific ideological framework.

Patient Status

Because declawing is an elective client choice and it is not recognized as in the best interest of the patient, particularly if the patient spends his or her time outside, strays are not declawed. Staff believe that declawing strays would be extremely detrimental to their health as they are understood to be “defenseless out there” without their back claws. Sometimes, but rarely, rescues are declawed if the future “owner” requests the practice along with neutering.

Encounters with rescues for the purpose of declaw, are associated with a recognizable tension for staff and patient and affectionate displays between staff and patient. This association is heightened if a patient is to have a rear declaw. I suspect that this heightened tension for some staff members and greater degree of affectionate displays is related to the fact that staff members have greater emotional investment in these patients. In other words, staff members are playing a significant role in the placement of these patients in human society. Given that some staff members do not agree with declawing and simultaneously feel that they are responsible for the placement into a home where the patient is subject to declawing, this increases some staff members feelings of participation in the practice. In the encounter below, Pam laments over a kitten’s scheduled four-foot declaw.
I am folding towels as Pam enters the back room. She stops at the front cage and delights over being able to see Mickey again. “Hey Mickey...you cutie...you are back huh? Come here you.” She opens the cage door and picks him up. “Awww you are such a cutie...I just love you.” She closes the cage door and looks at his “chart” as they snuggle each other. “Oh no!” I ask her what is wrong. She looks over at me and she says, her voice quavering a bit, “Mickey is scheduled for a four-foot! How can they do that to you? I can’t believe it...[she snuggles her face up against Mickey’s and he begins to purr] I am so sorry...so sorry...sometimes people can be so mean!” She kisses his head and puts him back into his cage. Then she turns and looks at me, “I feel so bad you know...I helped with him...I even named him...you know and now he is getting declawed...and all four paws too!” She gets angrier as she speaks to me about declawing. “You know if God wanted them to have no claws he would have made them that way...people just don’t care or don’t realize...I will never alter an animal again for human supposed benefit!” I ask her what she means by again. “Well, I once had a boxer and when he was a puppy I had his ears clipped. When I picked him up I felt so bad. I didn’t really understand that they actually cut off part of the ear. So what if his ears flop? You know...it wasn’t like we were going to show him anyway...I just would never declaw a cat...it is just mean! My kitties have all their claws...especially since I have worked here and have seen it. I would never do that to my cats!”

While Pam is usually upset about a patient’s declaw and verbally expresses this tension; it is increased by her participation in bringing the patient into the human social domain. In her mind, her involvement in this practice that “ought to be outlawed” becomes harder to ignore. Moreover, while Pam is also associated with the most affectionate encounters in the back room, she expresses even more affection toward patients that are scheduled for a practice that she disagrees with; particularly if she has participated in a patient’s “rescue.”

When human participants do not define a practice as “in a patient’s best interest,” aggressive resistance by the patients makes the participation in a problematic practice less easy for staff participants to ignore. Patients that staff members have emotional investments in, such as rescues, can also increase some staff members’ tension as their participation in finding them homes has indirectly caused the patient to have their toes partially amputated. Patients whom a staff member defines as particularly
"sweet" also influences the degree of tension and affection involved in human-feline encounters in the veterinary hospital. "Sweet" patients are patients that are understood to be "totally trusting;" they allow staff members to do their jobs – without resistance. For example, in the context of declawing, an adult companion is about to have his front toes declawed. Marcie is particularly upset. He is already "under" and she is carrying him to the surgical room.

"I just love big kitties." Marcie says as she hugs him close. I smile at her and she continues. "He is having a front declaw and being neutered. He is so big, I had to put him in the bucket, and he just went in it without a word. He just trusts me so much. I feel so bad for him...you know...having him declawed at his age. I get so mad at clients who do this to older cats...and he is so sweet too."

Marcie is upset about having to declaw an adult patient. This conforms to her disagreement over the practice of declawing adult patients. However, his compliant behavior increases her degree of tension in that encounter. From her point of view, he "trusts" her to do what is in his best interest. She feels however, that she is not living up to this "trust."

The Pediatrician and the Mechanic

Because of the ideological ambiguity over declawing, the role that the doctor plays appears to influence human-feline encounters more significantly than in other medical contexts. In the context of declawing, when Doctor Curtis (pediatrician) is around, staff members are often observed speaking to, hugging, and petting the patients – even when patients are "under." In contrast, when Doctor X (mechanic) is on staff,
staff members are more likely to focus their attention to interactions with him, their 
tasks, and each other than affectionate displays toward the patients.

In their study of human-animal relations in two different laboratories, Arluke & 
Sanders (1996) observe two very different norms of animal treatment. In one setting, 
technicians and caretakers, known as “cowboys,” take a utilitarian standpoint toward 
their “charges.” From this standpoint, the lab animals are defined as “work” and 
affectionate displays toward them are highly uncommon. In fact, cowboys are noted 
to be indifferent and sometimes abusive toward the lab animals. In the other setting, 
employees known as “animal people” “morally elevated their animals” and are 
known to treat their animals with care and respect. Affectionate displays and even 
bonding between employees and laboratory animals is common among the “animal 
people.” Interestingly, Arluke & Sanders find that, in part, this differential treatment 
toward the animals is a function of the norm set by the person in authority at the 
laboratory. This is particularly true, they claim, in ambiguous situations. In other 
words, employees often modeled their behaviors toward the 'other' animals after the 
person in charge.

My findings lend further empirical support, that given an ideological ambiguity, 
employees are more likely to conform their behaviors to model an authority figure. 
Doctor Curtis is regularly observed being affectionate toward the patients. He 
regularly pets them and speaks to them. In the context of declawing, he even speaks 
to patients that are under anesthesia. For example, walking by the surgery room I 
heard Doctor Curtis speaking. I stop to see whom he is speaking to and note that
there are no other humans in the room. I watch as he strokes the patient and leans near his ear, “a rear declaw huh? I am so sorry.” When he looks at me observing him he directs his last comment to me, “rear declaws are particularly hard on adults.” By contrast, Doctor X is not affectionate toward the patients. While he is respectful, he is not observed petting or speaking to them. His role is to treat them medically, not to be affectionate toward them.

While the role the doctors play influences the degree that staff members display affection toward patients, the dynamic of tension is not directly influenced by these roles. However, indirectly, staff members are noted to experience a greater degree of tense encounters when Doctor Curtis (the pediatrician) is present. As described during the last chapter, the hospital is busier when Doctor Curtis is there to do surgical procedures. When the hospital is busier, staff members are notably more tense. This is because the larger number of patients increases the occupational tasks that staff members must perform before “clocking out” for the day. With greater occupational tasks, less time can be devoted to attending to the emotional needs of the patients. For staff members who define themselves as animal lovers, having to ignore patient’s pleas for affection is problematic. Not only does this time constraint influence the staff members’ experience of tension within the encounters, it influences the patient’s experiences because when they seek affection and it is ignored, they often become even more upset.
Social Psychological Influences

Defending Subjectivity

Given that so many staff participants disagree with and experience significant amounts of tension in some contexts within the practice of declawing, how does the practice continue? How do employees cope with the disjunction between personal ideals and occupational demands? According to empirical evidence from research laboratories, and farms, one mechanism employed by members who may engage in problematic animal practices is to erase the animal’s subjectivity. In this way then, one might expect staff members to objectify the patients doomed for declaw in order to lessen the guilt involved in the participation in this practice. This is far from what I found. Staff members actually work to preserve the patient’s subject identity even in the tensest encounters. To provide evidence of such an assertion, I offer more of My Guy’s story:

My Guy stayed overnight after his surgery. He is being picked up today. I go to check on him and notice that he is all huddled up against the back of his cage trembling. I speak to him and he growls at me so I leave him alone to go help Pam with the towels. While Pam and I are folding towels next to the washer and dryer, Angie walks by My Guy’s cage to pick up another patient. As she walks past, My Guy lets out a very loud meow, hisses, and reaches out of the cage toward her. She jumps and looks back at us in embarrassment “oh...that cat is just delightful.” Pam and I laugh and then Pam leaves to check on the “boarders” in the adjoining building. She mentions that she “has to go check on the kitties and give ‘em some lovin.”


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215 Serpell 1999
216 See also Carol Adams (1990, 1995) and Lynda Birke (1994) for excellent theoretical explorations on erasing animal subjectivity as a mechanism of domination and control.
“Oh, poor baby... I need to check his feet.” She walks over and slowly opens the
door speaking soothingly to him. When she opens the cage most of the way, he
rushes her. She backs away and he jumps out of the cage. Marcie yells, “the doors.”
I speed over to the door next to the reception desk and quickly release it. Then I run
to the prep door, which happened to be closer to where I had been originally
standing, and shut it with a bang. Thinking about it later, I realize that the reception
door was more urgent because clients might see the upset patient. Without even
thinking about it — I had taken on that institutional priority -- protecting the clients
from what happens backstage.

My Guy skids across the floor and hides behind the water tank, which stands in
the corner across from the window cages. Marcie and I both move closer in to keep
him in that corner. At that moment, Angie opens the door. “Shut the door” we both
yell simultaneously. She backs out mumbling an “oops...sorry.” Marcie sidles over
to the garbage next to the sink and slowly picks up the broom that had been stored
between it and the side of the cages. She speaks to My Guy as she gently pushes the
broom toward one side of the tank. “Its ok boy...its ok...come on...you have to get
back in your cage.” I realize that he is going to dart toward me if the broom
swishing worked enough to scare him out of the corner. I grimace not knowing what
to expect, but move closer to the tank. My Guy turns, grabs at the broom, and began
to howl. “Aw...” I say to Marcie “he is just so scared...poor kitty.” She looks at me
and sets the broom down. She then moves closer to the corner of the water tank and
speaks soothingly to him in an attempt to get him to come to her. This does not work
either. He just sits there growling at her. Getting even more frustrated, Marcie
moves closer to the tank and begins to shake it.

“Wait” I say. Hoping that he will not rush me or try to escape now, I turn and run
to the closet. From the closet, I grab a litter pan, towel, and two dishes -- scattering a
few towels on the floor. “Dana...hurry up.” Moving even faster than I ever thought
possible, I go to the other side of the opening next to the surgery cages and fill the
litter pan and food dish. I then open one of the bottom cage doors, put the towel,
litter pan and food dish inside, moved to the sink, filled the water bowl and put that
in the cage next to the food dish. I sigh. “Ok ready,” I say while I try to block the
opening to the rest of the room by standing with my arms and legs spread out and
bent down a bit – hoping that I was not low enough for My Guy to take a chunk out
of my face. After Marcie begins to move the tank out from the wall, he runs out
toward me. I stand my ground and with a quick glance this way and that he scoots
into the now open bottom cage. Marcie drops on her knees and quickly shut the
door. He turns and spits at her spilling all his water onto his new towel. We laugh in
relief but do not try to refill his water. Marcie looks at me, “Well that was pretty
horrible for him...poor kitty he is going to be so traumatized from all this.”

A few minutes later, while I am cleaning the feces that My Guy left behind the
water tank and Marcie had gone to help prep surgeries, Pam walks in. She laughs
when she sees my crinkled up nose. He left quite a few deposits back there. I look
at her and say, “probably scared out of his wits...not a pleasant task but I don’t
blame him.” She looks in at My Guy and turns. I resume my “pleasant” task but
feel that it is justified on the part of the patient. I look up just as Pam reaches down
to open My Guy’s cage. “Uh...Pam...I wouldn’t do that if I were you.” I recounted
the chaos of a few minutes past as she stands with the water bowl in hand. “ahhh...”
she smiles “cats don’t scare me.” She opens his door all the while speaking
soothingly. He growls at her when she sets the water bowl down and picks up the
old one and she laughs “oh...you...you are all talk.” I stare at her as she shuts the
doors. She smiles at my amazement, “He is just upset...I would be too if I had to go
through what he just went through...poor kitty.”
Marcie, Pam, and I take measures to protect My Guy's social identity as an individual subject: “He is just upset.”

“He is probably just fine at home.”

“Awww... he is just so scared.”

“You have to get back in your cage.”

He is not categorized as a “problem,” nor is he objectified as an “it.” Despite engaging in practices associated with declawing an adult cat, we do not objectify My Guy even when his behavior is extremely resistant and we are upset.

I must note that Angie does refer to My Guy as “that cat” and as with the word “it,” the word “that” is an objectification. My Guy embarrassed Angie and she defends herself by objectifying him. However, this is a rare occurrence among staff members. In fact, when someone does use objectifying language to refer to a patient, other staff members usually sanction that offender. For example, despite my belief in animal subjectivity I sometimes called a patient an “it.” When I “slipped up” I was often quickly corrected. Participants also corrected each other.

Today I accidentally referred to misty as “it.” I made the mistake of asking, “what is wrong with it?” Marcie looks at me for a second, shakes her head and frowns. “Misty... is having trouble eating.”

I did it again. I referred to a patient as an “it” and this time I was directly sanctioned by Dr. Curtis. “We usually try to refer to our patients by name.” Of course, I quickly apologized.

Lisa asked Anne how much the patient weighs? Anne replied “It only weighs 4 pounds, can you believe it?” Lisa looked at her, then at me, then back at Anne “Four pounds? I would have thought that Fluffy weighed much more than that!”
Finally, My Guy is not labeled by us as “mean” or “aggressive” although his actions are highly resistant; he is simply scared. Staff members do not regularly apply “labels” to patients. Moreover, labels such as “aggressive” that are sometimes applied to patients in this setting are understood by staff participants as fleeting behaviors or emotional states that are contextually situated, not a part of that patient’s identity. Finally, Pam employs empathy to understand this individual’s behavior; “I would be too if I had to go through what he just went through...poor kitty.” My Guy is understandably afraid. In other words, he is not categorized, coded, or objectified in this context. His subject identity is, for the most part, preserved and protected.

Managing Tension

Staff participants in one way or another identify themselves not just as people who care for ‘other’ animals, but also care about them. Observing patients suffer particularly when a practice is not constructed as ideally in their best interest is upsetting. While it is recognized in any surgical procedure (such as neutering) that patients “do not like being in the cage” and “dislike getting shots,” when there is ideological consensus, staff participants can focus on the practice being in the patient’s best interest or the temporality of the emotional discomfort. Common comments to patients under ideological consensus by staff participants provide evidence of the above assertion:

“It is only for one day...then you get to go home.”

“I know...I know...but you go home today...and then you will be fine.”
"Oh, quit fussing in there...you are not being hurt.”

"It is ok baby...you will be ok...it has to get done.”

This focus, enabled by the ideological consensus of practices such as neutering, keeps tension derived from a patient’s emotional or physical discomfort for staff members easily at bay. However, when ideological consensus is absent, tension is not so easily discarded. Staff members have to employ further tension management strategies to reduce the tension that exists in the medical context of declawing.

According to staff participants, declawing “hurts them,” (Pam), “it is painful!” (Nell and Ezra), “leaves a wide gaping hole in their paws” (Victoria) and is “particularly hard on adults” (Dr. Curtis). Some staff members are still able to focus on the temporality of the suffering: “The pain is temporary. They won’t even attach that to you.” (Dr. X)

Some staff members deal with this increased tension by multiplying the amount of apologies offered to patients and more likely themselves. As I noted in the last chapter, apologies function to maintain social identities when a social infraction is taken on one subject to another. In other words, apologies help staff members continue to see themselves as “caring people,” “cat lovers,” or “empathetic” individuals when engaging in problematic practices or failing to engage in comforting a patient.

“I know… I know… I have to get these towels folded right now. I am so sorry” (Pam).

“You don’t like in there huh? I’m sorry but I got things to do right now.” (Anna) [Patient screams after getting a shot] “Oops I am sorry baby.” (Marcie)

“Oh a rear declaw huh? Poor kitty… sorry… people can be so mean can’t we?” (Pam)
"Oops didn’t mean to take so long...just couldn’t find the vein.” (Ezra)
[Looking down at an adult patient on his surgery table]“A rear declaw? I'm sorry. Oh you poor kitty.” (Dr. Curtis)

Apologizing can be used as a comforting technique and a way to empathize with the patients' feelings. However, it is also employed to relieve the emotional tension, the guilt, and to protect social identities as caring people while simultaneously engaging in a practice that is not ideally in the patient’s best interest.

**Temporary Disconnection**

As attentive observers, staff participants hear the patient’s howling and meowing from inside the cages and often define these sounds as calls for affection, comfort, and freedom. Nevertheless, when “work has to get done,” these screams sometimes get emotionally overwhelming particularly when the practice is not defined as “ideally” in their best interest. Some staff participants feel bad that they are unable to comfort a patient who is so unhappy and who is in for a surgical procedure that they believe will be particularly painful. The cries make some staff feel even worse. The constant yowling annoys others; it is hard to “concentrate” and “irritating.” Still others “worry that the clients will become upset.” When this type of tension arises, many staff members try to manage both their own feelings and the clients’ feelings by temporarily disconnecting the clients and themselves from the sounds and/or sites of patient’s emotional suffering.

Temporary disconnection as a tension management strategy is similar to the emotional management strategy employed by medical students in Smith &
Kleinman’s (1989) study referred to as “avoiding contact.” Medical students in their study covered certain body parts of patients and cadavers to “eliminate disturbing sites” and thereby avoid uncomfortable feelings that these parts sometimes caused (64). At the Loving Care Cat Hospital temporary disconnection is accomplished in a variety of ways: selective listening, leaving the room, and shutting the doors to the back room. Sometimes staff participants combine these strategies.

To illustrate the tension management strategy of temporary disconnection, I provide another story from my fieldnotes. This strategy is most associated with a busy clinic, which is associated with Doctor Curtis (pediatrician). In this context, a large number of patients are expressing their tension and simultaneously demanding affection. However, because there are many patients in the hospital, occupational tasks such as cleaning towels, filing and getting surgeries done, must be accomplished before leaving for the day. While this strategy is also employed with patients who are being neutered, it is most often noted when a large number of declaws are scheduled.

The back room is chaotic. Pam is moving quickly from one side of the room to the next; folding towels, washing litter pans, stopping for a second “Yes...I know...baby...” and then moving back to the washing machine. Marcie is coming in and out of the prep room to give patients their shots. Angie is walking back and forth between the reception desk and the surgery cages; checking patients in. “Come on Honey...get in the cage...please...” Honey responds “grrrrr...hsss.” Three of the kittens in the surgery cages are pushing their noses hard against the bars, trying to get out. One adult male is reaching out as far as he can with his paw, waving it around. A chorus of cats are howling, meowing, and screaming. One patient is repeatedly howling from the back cage “reooooow.” A small orange patient has her front paws on the cage door and is meowing; a long drawn out “meeeeeooow.” Sometimes right after Marcie sticks someone with a needle we can hear a high pitched sharp “meow.” Marcie answers: “oops sorry buddy or girl.” After other patients hear these short screams, they begin to join in “rowla,” and “yeooool.” The phone is ringing periodically and I can hear Lisa at the reception desk, “Hello Loving Care Cat Hospital, this is Lisa. Oh yes, I believe/Oops, could you hold on a second?... Hi and who do you have with you today?” Dr. Curtis comes into the room carrying an unconscious patient with bandaged paws on a surgical pad. When
Marcie sees him, she stops what she is doing and quickly moves to take the patient. He smiles at her, “Is the next patient ready?” She shakes her head, “nope...just going down now.” He nods and looks around the room. “My goodness.” Then he walks toward a patient who has her paw reached out between the bars “you don’t want to be in there much do you?” He gently grabs the end of the patient’s outstretched paw and shakes it as he speaks to her. “I think that she is ready now [referring to another patient],” says Marcie “I’ll just go prep her for you.” He nods and turns to follow her. He stops at the prep door and says to Pam as he points to the door to the reception area, “Hey, lots of clients out there right? Let’s keep that shut for a bit ok?” Pam turns, “Oh...sure thing.” I am alternating between checking patients in, following Marcie around and helping Pam to clean. The noise is bothering me. I want to help get stuff done around here, but at the same time I know that the patients want attention. I ask Marcie when I am following her how long it would be before all the patients waiting for surgery are anesthetized. She laughs, “yes sometimes the noise gets to me too...I feel so bad...you know...and especially for the declaws...but...well?” She shrugs and returns to her task of filling syringes. One of the patients begins to scream louder and louder. She is in for a declaw. I look at her and feel guilty that I really can’t wait until she is anesthetized while I realize that Marcie has not answered my question. I decide to do some filing in the other room.

I am in luck...the receptionist left a small stack of files from last night. I sigh, reach up to the top of the file cabinet, and grab the first one. Another patient must have joined in because now there is this much louder and more pitiful “yeeooowll.” It is even worse than the whole chorus is. I look over at the door. Someone has opened it again. Maybe if I concentrate...file one done. File two...done “yeeooowll!!!” File three done. About five minutes later, assuming that most of the patients had been anesthetized because it seems quieter...my body begins to relax. It is at this time that I turn to see a client looking around and then leaning inquisitively towards the back room. She looks worried. Lisa is sitting below her looking down at a chart. I look at her and smile. She smiles back, but hesitantly. Then she looks toward the back room again. I shrug, thinking that Lisa is taking care of her and turn to grab another file. I stop reaching in mid-air and swing around because I realize what she is doing. I suddenly begin to hear the “yeeooowll”ing again. I look at her, Lisa still reading, and she asks me “Is that my Jenni? It sure sounds like her.” Before I can answer, Lisa looks up “Oh, I didn’t even hear any meowing. I don’t notice it as much anymore. Nope that’s not her, that’s a patient in surgery.”

Selective hearing is one way that individual staff members manage the tension that is increased by patients screaming for help when one is simultaneously constrained to do so. Shutting the door to the back room helps keep clients from worrying about their cats. It is an emotion management strategy employed for the client. It also helps preserve an image of a caring, peaceful and pleasant atmosphere. When patients are on the surgery table, they are usually anesthetized. Dr. Curtis had been
working on a neuter/declaw at that moment; it could not have been a patient crying in surgery and Lisa knew this. Lisa was just about to go get Jenni from the back room, and she did not want the client to feel bad about leaving her here for a surgical procedure that is recognized as not ideally in her best interest – one that causes patients particular tension. She diverts the client’s attention to another room and another patient to reduce the client’s concern.

When I was doing my preliminary research and just sitting in the waiting room observing. I wondered why some patients were meowing so much. I also wondered how staff members could walk around, talking or filing as if these screams didn’t exist. Like the client in the above story, I looked at the door and wondered, “what are they doing to the patients?” I also questioned if staff members even cared that the patients were upset. After working there and then analyzing my field notes I learned that it wasn’t that the staff members at the hospital didn’t care, but that they did. Caring about the emotive needs of the patients within a context of getting the medical work done, particularly medical work that some of them personally did not agree with, causes tension in the lives of some of the participants. In order to maintain the atmosphere of the veterinary hospital, to continue to believe that one is an empathetic and caring individual concerned about the welfare of ‘other’ animals, and to continue to complete medical tasks, this tension has to be managed. Temporary disconnection is one way that this is accomplished.
Dispelling Blame

When it comes to declawing, dispelling blame helps many staff participants continue to participate in a practice that is not recognized as "ideal." As in Arluke & Sander's (1996) study of shelter workers' tension management strategies dealing with euthanasia, staff members' feelings of discomfort involved in playing a part in a patient's declawing can be turned toward the clients themselves. The clients are responsible for the patient suffering, not the staff. Rather than accept the responsibility for their own participation, staff members question the motives behind their choices, talk about "how mean," and "irresponsible" and "uncaring" those clients are. "How could they declaw a four year old cat!? How can they be so unfeeling?" (Anna)

"Why doesn't she just find another home for him?" (Dana)

"Why did they declaw an indoor/outdoor cat?" Her theory is that they must be "mean." (Marcie)

If the reader will recall, during My Guy's traumatic story, the staff members join together to discuss the motivations and cruelty of clients who are "mean" and "unfeeling." From these staff member's perspectives, clients who care more for their inanimate property than for their "loved companions" are responsible for this "cruel" practice. For Lisa, it reaffirms her belief that some "people think that animals are disposable items!"

After our experience with My Guy, some of us are standing in the prep room talking about how horrible it is that "someone could do this to him." This sparks a new discussion about furniture and declawing. Dr. Curtis tells us that when he and his wife had built their house, that practical flooring and furniture is built into the house
and that people ought to consider this before getting pets. Marcie agrees, adding that the flooring and furniture should either be able to be destroyed without concern, or are built strong enough to not be destroyed and are highly scratch resistant. Dr. Curtis adds that hardwood flooring throughout the whole house that is made out of wood that is scratch resistant would be ideal. Anna pokes her head into the prep room and similar to Angie had done earlier, imitated the client “Yes, but I really wanted new pine furniture!” We laugh and then shake our heads discussing how people can value their cats less than their furniture.

For people who believe in treating 'other' animals with respect and care, having an adult “companion” have a rear declaw because “they want new pine furniture” is a straight up disrespectful and uncaring thing to do. These clients must think of their “companions” as objects. This redirection makes our forcing him and our participation in the practice much easier to deal with because then we can partly believe that, like My Guy, we too are forced into it. Our ethical standards and social identities remain intact by using the client as the reason for the problem.

Further evidence of the use of this tension management strategy is that any confusion over who is responsible for a problematic medical practice is quickly corrected. In the field note excerpt below, it is an hour after Marcie and I scared My Guy into his cage. The client has come to pick him up. In this excerpt, the client asks us what we did to him to make him so upset.

Anna comes into the prep room and informs Marcie that the clients are here to pick up My Guy. Marcie tells her to bring the client to the back room and let her put My Guy into the carrier herself. Anna goes back into the reception area and Marcie and I go around the back way through the prep room into the back. Pam is there cleaning out some of the just emptied cages. Anna enters with a very tall woman who looks to be in her mid forties. The client walks indignantly into the room. From her pressed suit and direct and confident stride, I get the impression that she is an independent and financially secure woman. Next to her is a little girl (I would guess that she is about seven years old). The girl clings to her mother's skirt and looks around from underneath her long eyelashes, at the various staff members who now crowd the room in anticipation.

Marcie has taken a spot next to My Guy's cage. She points to My Guy’s cage that is still on the bottom row. The client looks at Marcie, then back towards Anna,
her brow furrowed and then she bends down in front of his cage. She fumbles for a
second with the latch and when she finally succeeds she opens the door with a bright
smile and gentle tone of voice “hi honey how are you doing?” My Guy greets her by
spitting at her; accompanied shortly there after with low growl. The client’s smile
drops and she backs up a bit, seemingly taken aback by My Guy’s behavior.

The client looks around the room and says, “he has never been like this before –
what did you guys do to him?!” Marcie immediately speaks up and speaks crisply,
“well, he will be more grumpy because of the rear declaw. It hurts you know...but
he was like this before we did the surgery...just not so bad.” The client reaches into
the cage and pulls him out of the cage. He visibly relaxes in her arms. The client
hugs him and then looks down at her daughter “do you want to say hi to your cat?”
The girl smiles up at him and then shyly grabs onto her mom’s leg. My Guy looks
down at her quietly from her mother’s arms. After a quiet moment, he seems to
recall where he is. He looks quickly around the room and then begins to growl at us
with his ears flat against his head. At that, the client bends down to put him in the
carrier that had been placed at her feet. He then begins to growl at her too and he
struggles – feet splayed – to keep him out of the carrier. After some struggle, the
client succeeds in getting him into the carrier and she looks in at him. He growls at
her from inside the carrier. The young girl looks in then and he growls at her too –
she looks confused but says nothing. When the client picks up the carrier to leave,
Marcie looks at the girl and says to her “now you be extra careful with My Guy’s
back feet ok? They will be really sore for awhile.” As the client reenters the
reception area she turns toward Anna and Marcie her face is red, her hands are
shaking and she says in a defensive tone of voice “are we allowed to come back
here?” Marcie looks surprised at the question and asks, “what do you mean?” The
client stars at her for a second, her eyes welling up with tears, “I mean, can we come
back here for vaccinations and checkups and stuff...are we allowed back?” Marcie
takes a step back looking quite surprised at the question and says “of course.”

Note that the client does not simply question why My Guy is upset; she asks what
“you did to him.” This question brings a quick response from Marcie; “well, he will
be more grumpy because of the rear declaw. It hurts you know.” Marcie wants to be
sure that the client assumes the moral responsibility for the problematic practice. She
reinforces this redirection by telling the child in front of the client that My Guy’s feet
are sore, “now you be extra careful with My Guy’s back feet ok? They will be really
sore for awhile.” Not only is Marcie redirecting the moral responsibility of the
patient’s suffering on the client, but she is also sanctioning the client for the behavior.

Finally, from my perspective, Marcie’s sanction is successful. By the end of the
encounter, the client appears to have accepted the responsibility and felt the sanction because she is notably upset and wonders if having engaged in such “cruel” behavior toward her companion, if she is “allowed” to come back.

Of course, one could infer from this encounter that the client is asking whether they can come back because she believes [given that staff members made her retrieve him from the back cages] that My Guy has caused problems in the hospital. While this is entirely possible, it does not negate the evidence that Marcie is dispelling the blame onto the client for the trauma that My Guy went through while in the hospital. The client did this to him, not us. This redirection protects staff members’ identities as caring individuals and enables them to continue to participate in it.

I have to point out that tension management strategies do not usually completely remove the tensions in the field, where a person becomes totally detached.\textsuperscript{217} Moreover, tensions can arise in organizations that just can not be managed by some people and this is the reason why some people leave a job. For instance, shelter workers in Arluke & Sander’s (1996) study that are expected to perform euthanasia on a regular basis sometimes “just get burned out.” Floor Instructors in Copp’s (1998) study who are in charge of developmentally disabled adults that consistently resist doing their work under conditions that seemed “beyond their control” would sometimes simply “lose control” and yell at their charges.

At the Loving Care Cat Hospital, staff participants are mostly successful in managing their emotions, just enough to ‘get the job done.’ I believe that this is

\textsuperscript{217}Copp 1998; Arluke & Sanders 1996; Smith & Klienman 1989
because they do not have to rely solely on individual tension management strategies. As Martha Copp (1998) suggests, “emotion management also fails when people lack social support” (326). Hochschild (1983) suggests that staff supervisors work to manage the emotions of those who work for them. As an effort to manage his employees’ emotions, Dr. Curtis provides his employees’ with professional resources to manage their emotions.

*Professional Resources for Tension Management*

As the co-owner of the hospital, Dr. Curtis has the greatest interest in maintaining the image of the hospital and making certain that work runs smoothly. Recognizing, either consciously or unconsciously that declawing presents tension for his staff members, Dr. Curtis provides them with professional resources to manage this tension. In her study of the emotion management strategies employed by floor instructors of a shelter for disabled adult employees, Martha Copp (1998) refers to these professional resources for tension management as “collective” and “preventative tension management strategies.” In other words, rather than “passively avoiding problems, the floor instructors tried to do so actively by performing preventative emotion management on their employees: they tried to manage how the employees felt...before they perceived any problems” (317). If the reader recalls, blowing in a patient’s face during blood work, is used as a preventative tension management strategy to control the possible feelings of clients before it happens. The preventative professional resource that I will discuss in this chapter is the use of
scripts to control possible tension of the staff members. There are two types of scripts relating to declawing that staff members are expected to use, short scripts and longer conversational scripts.

Two short scripts reinforce the individual management strategy of redirecting responsibility for declawing from staff member's participation to the clients and to the veterinarian himself. "We don't encourage it or discourage it" and "it is up to the owner to decide" are expected responses when a client asks a staff member if that staff member recommends the practice of declawing. Doctor Curtis states that the function of these scripts is to refrain from judging a client for their choices because he does not know the context of the situation at home. However, these scripts also function to enable staff members to redirect blame for any possible patient suffering.

Below is an excerpt from an informal chat that I had with Doctor Curtis about the details he gives to clients about declawing. Right after this short discussion, I contrast it with a staff member's comments about his short script. The point is that these scripts intended or not, allow staff members to redirect the moral responsibility for their participation in declawing onto the clients and the doctor.

“When I follow you into the exam room, I noticed that sometimes you describe the procedure to clients and sometimes you did not. Do you usually describe the procedure to the client when they ask about having a patient declawed?” Dr. Curtis responds, “Of course I do.”
“How do you describe the procedure?”
“I use the word amputation.”
“So you tell the client when they inform you that they want their cat declawed, that it is an amputation?”
“No. I tell a client who asks about the procedure that it is an amputation of the first digit of the toe – that we actually remove a bone.”
“But don’t you think that clients ought to know what the procedure is about?”
“Yes. But only if they ask me. You see I don’t want to encourage or discourage it because it really is up to the owner to decide.”
In the context of an interview, a staff participant discusses a short script "we don’t encourage it or discourage it."

"You know that we are not allowed to explain that it’s an amputation of the toe...people have no idea that it leaves a gaping wide hole...unless they ask specifically what the procedure entails, but no one asks...we simply have to say that we don’t encourage it or discourage it."

Another participant discusses how she is informally sanctioned for not following the script.

"I have tried to talk them [clients] out of this till I was told not to try to talk clients into or out of it...to not recommend it but also not to not recommend it. Supposedly, the clients are really supposed to come to that decision on their own...that it is really up to them and I can’t influence them in any way...but if I could I would because I don’t agree with it...they should know what it is about..."

Short scripts such as "we don’t discourage it or encourage it," and "it’s up to the client to decide," I believe are a part of the professional capital\(^\text{218}\) that Dr. Curtis acquired during veterinary education (veterinary medical socialization) rather than a personal emotional management technique. To provide evidence for my suspicion, I called other local clinics to see if their doctors provided similar scripts. I had an interview schedule on hand when I called these clinics (Appendix D). The fourth question on the interview list is "Do you recommend declawing?" Nine staff members out of 12 had either completely, or within longer answers, mentioned that declawing is a personal decision: "it’s really up to you, it’s about your personal

\(^{218}\text{In his study of Mortuary Science Students, Spencer Cahill (1999) argues that "professional socialization alters students' emotional habitus and thereby shapes the emotional capital they eventually bring to work" (113). In other words, students can acquire additional "emotional capital" during the process of medical socialization. This "emotional capital" is a type of professional resource learned during education to manage emotionally trying situations at work. His term is borrowed from Bourdieu (1979).}
preference” and “we don’t recommend or not recommend it, it’s your choice” or “we
don’t encourage or discourage it here.”

Leaning on the institutional and economic imperative “it is ultimately up to the
client to decide” can help staff members deal with the emotional tensions that might
arise had staff members continually question the “morality of our own acts and
feeling guilty” (Arluke & Sanders 1996:96) about it. Moreover, given that other
veterinarians use the same scripts, it might be safe to infer that Doctor Curtis acquired
this professional resource during veterinary socialization. This resource, I must note,
not only helps to manage staff member tension, but also socially constrains the staff
members from resisting the practice: maintaining the power imbalance between
“medical authority” and “non-medical authority.”

When staff members are confronted with clients who call up or come into the
office and ask about or more often schedule declawing, staff members are expected to
follow along a loose conversational script. I came to realize the conversational scripts
regarding declawing after listening to many one-sided phone conversations.

It is 9:00 am on a warm summer morning. Lisa is telling me about her children.
While she speaks about them her face has a soft, warm expression much like the
weather outside. The phone rings and she quickly picks it up “Loving Care Cat
Hospital this is Lisa [pause]. Yep [pause]. We extract the nail at the nail bed.
[pause]. It is 75 dollars, which includes the hospital stay [pause]. Ok...[she turns to
the computer]...when would you like to come in?...”

I walk out of the back room on my way to go home. I am in a hurry because I have
many field notes to transcribe today. I wave to Sally who is on the phone. She
smiles back and continues her conversation. “Well, it is really up to you to decide
[pause]. Kittens do bounce back from that surgery fairly quickly. If you are going to
get it done, we recommend that you get it done when you bring her in for her spay,
that way she doesn’t have to go through anesthesia twice [pause]. Yes, the earlier
you do it the better it is on her....” as I am walking away, I realize that she is
speaking about declawing.
As I am walking past Angie, the phone rings and I stop to listen. “Yes we do. seventy-five dollars. Well...it’s really up to you to decide. We don’t encourage it or discourage it...but it is better...if you are going to do it, when they are young cuz then they bounce back much quicker...mmmm...ok...”

Marcie walks into the back room carrying a rather small patient with bandaged paws on one of the soft surgical mats. She shifts her bundle gently into the crook of one arm to open one of the cages. Gingerly she sets down the soft gray bundle and arranges the body so that the patient’s now limp head is near the back wall and her white cased paws are not overlapping. The phone rings. Marcie, who was leaning slightly into the cage now straightens up. I stop folding the towel realizing that she needs one to cover the patient. The phone rings a second time. We both look over at it. I walk over and extend the warm mauve towel to her. The phone rings a third time and we look at each other for a split second and then simultaneously look at the open door to the reception area. No one is sitting there. I look at Marcie inquisitively and look at the phone. “That’s ok,” she says. “You cover Misty.” I breathe a sigh of relief as she turns to answer the phone because I am still so afraid to say the wrong thing. I listen to her side of the conversation as I place the towel over Misty paying particular care not to cover her head or her paws. “Yes, we do. [pause] Seventy-five [pause] we recommend doing it when you bring them in to be neutered [pause]. As early as three months do you plan on keeping them inside? It’s up to you, but usually the front claws are adequate [pause] and if you ever plan to let them go outside[/pause]. Ok, goodbye.” Marcie looks at me. “Thanks for answering the phone” I say, “I just don’t know yet what I am supposed to say.”

After months of listening to one-sided phone conversations, I began to notice that many of the phrases used to frame the practice of declawing were similar despite which staff member was speaking. After some time in the field, I could even guess what the topic of conversation was about even if I did not hear the word “declaw” or hear the procedure being described. Recognition that I was afraid to answer the phone out of fear that I might say the “wrong thing” clued me in that there must be a “right” way to answer client questions: there was a script.

To make certain, I call Angie to see how loose the script really is. I ask her if someone calls up and asks about declawing, what she says. She answers this question immediately. “We always start by telling the client that we offer the procedure and how much it is.” I ask her what she says when they ask if she would recommend the
procedure. “Oh, we don’t encourage it or discourage it...it is up to you to
decide...we are supposed to say that you know...”

Concerned that clients are really unaware of what the procedure entails because
they don’t get an information sheet describing the procedure until after it is done and
therefore can not provide informed consent, I ask “what do you actually say about
declawing when a client calls inquiring about declaws?”

“What do you mean?”
“About the procedure.”
“Well...they don’t ask often, but we say...that the claws are taken out at the nail
bed....if you think about it...it’s like removing the first knuckle of a human’s
finger.”
“So, that is what you say when a client calls up and asks about declawing?” I ask,
looking for confirmation.
“Yes...but...ehh...[short laugh]...actually I will only say that the claws are taken
out at the nail bed at first. Wait hold on for a second....” Angie puts me on hold for
a second. When she gets back on the phone she says “We next say that...the...nails
are...extracted...at the joint of the first knuckle.” She sounds like she is repeating
what someone else had just told her to say. I hear Lisa in the background “tell Dana
that we cut off their fingers...tell her that is what we say...[laughter].” My suspicion
is confirmed. “[Laugh] did you hear Lisa?” I laugh, “yes, should I say that?”
“No. I really just give them the first sentence unless, they ask
more questions.”
“You mean that when someone calls up asking about what the procedure is about,
you tell them ‘we take the claws out at the nail bed’ and you stop there?”
“Unless they ask for more details.”
“Do a lot of clients ask for more details?”
“Some do...though...not many. If they ask for more details then I tell them that
the nail is extracted at the joint at the first knuckle. And sometimes give them the
human analogy.”
“So, you make the analogy to the human amputation only sometimes?”
“Really, it depends on who I am speaking to and what they want to know about.”

These scripts enable the staff members to do two things. First, it helps staff
members from having to think about what to say each time they are presented with
the conflict of participating in practices or speaking to clients. Remember the staff
participants are aware of what the procedure really is and some are uncomfortable
with it. "Tell Dana that we cut off their fingers...tell her that is what we say." Lisa's joke is not only meant to tease me about my own concern for declawing, it is recognition that this is not an ideal caring practice. Moreover, it is a clear indication that there is a "wrong" way to answer client questions. The second thing that these scripts do is that they enable the staff participants to shift the blame for the practices not only onto the client, which was discussed earlier, but also onto the doctor.


In everyday life...some elements of conversation are pretty well scripted...we are so used to employing that it feels automatic...scripts can allow us a great deal of convenience; they constitute a taken-for-granted quality which, rather than creating our lines out of whole cloth, we borrow from a stock of well-worn scripts. (317)

They suggest that, at work, scripts are used "to control and limit employee autonomy...makes the job easier...and more predictable" (318). I would add that scripts can also provide employees a way to detach their personal selves from a professional role. They help employees maintain emotional control over otherwise tense or uncomfortable situations. In this way then, "we don't encourage it or discourage it" helps employees at the veterinary hospital from having to think about and possibly get upset about what to say every time a client brings up the topic of declawing. Any tension can be dispelled onto the owner of the hospital – the staff member is not choosing declawing – the doctor is. Moreover, since it is "ultimately up to the owner to decide" anyway, the tension can be redirected at them and their decisions. While scripts help staff member's redirect their tension outward, these

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scripts also maintain the property-owner status. Scripts are a part of the job that diminishes the staff members' ability to resist participation in "problematic practices."

**Resistance**

While the veterinarians have their own professional capital and provide staff members with extra professional resources such as scripts to manage their emotions; I found that the staff members with the least amount of professional capital in the veterinary hospital also used verbal resistance to manage their tensions. Pam's role as a cleaner gave her the least amount of status in the veterinary hospital. Having less occupational status (one form of professional capital), she is often observed verbally resisting more so than the other staff members. Whenever she would see that a patient was scheduled for a declaw she would comment on it. She would say things like, "oh you poor baby a declaw huh" or "not another declaw," or "she is going to get declawed how horrible...that is so mean." It is interesting that whenever she does this, she raises her voice just loud enough so that other staff members, including the doctors can hear her. Moreover, I note that it is only around patients that are scheduled to have a declaw, that she raises her voice while speaking to a patient. In other words, she is not only speaking to the patient in those cases, but rather telling other staff members that this practice is wrong. She is verbally resisting the practice of declawing.

Arluke & Sanders (1996) find that in their study of shelter workers, sometimes the
workers would resist the practice of euthanasia. However, this resistance, they observe, can not cause too much conflict for the other workers because then, new tensions – harmful feelings toward each other – might make participation in the practice even more difficult to handle and working at the place more emotionally uncomfortable. Causing those around her too much guilt might result in the reduction of the amicable atmosphere that functions as social support. Pam feels better about her participation in declawing, by indirectly resisting the practice.

As a new employee, Laura has not yet acquired enough professional capital to handle declawing and she too has the least occupational status in the field. She verbally resists in another way. She attempts to discourage the practice when clients ask about it. When she is sanctioned for doing this directly, she takes an indirect approach. While trying to find out precisely what the scripts are for declawing, I asked a friend of mine, another sociologist, to call the hospital using a similar script that I had employed with the other clinics. During the process of the phone call, Laura fails to follow the formal script; she bungles sections of it up. She has not learned the script well enough yet to lean on it as a professional resource for managing her tensions regarding declaw. Right before the end of the conversation Laura quickly tells my confederate; “if you really want to find out about declawing...check out this Website www.catsinternational.org.” The only article that this website provides to describe declawing, titled “The Truth about Declawing,” starts out like this:

Declawing is an inhumane, unnecessary procedure that has many alternatives. It is
never in the cat's best interest. With declawing, we are interfering with a species' nature because of our own whims, mis-conceptions, misinformation, and sometimes, laziness.\textsuperscript{219}

Both Laura and Pam are opposed to the practice of declawing. They also have the least amount of professional capital to draw upon to manage the emotions that are caused by participating in a practice that one does not believe in. Resistance then is another way that staff members can manage uncomfortable feelings and simultaneously maintain a self-identity as caring individuals.

All in all, the lack of ideological consensus about declawing leaves staff members unsure of the morality of their actions. This uncertainty increases the tension felt by staff members in human-feline encounters. In order to avoid the “burnout” that may arise had they continually questioned their actions, staff members engage in individual tension management strategies and draw from professional resources to manage these tensions so they can continue to ‘get the work done.’ As both Copp (1998) and Arluke & Sanders (1996) point out, paradoxically, relying on these strategies and resources to manage tensions actually helps support the current organization of the hospital – reproduces the practice.

\textbf{Discussion: Death or Declaw}

Out of 23 three recorded human-feline encounters within this ideological ambiguity of declawing, a significant majority of them involve tension experienced

by all participants. Patients are tenser without the client's presence, suggesting that social bonds exist for them outside of an ideological context. I observed only a slight increase in patient tension from neutering to declawing. This increase, although small is most likely because staff members themselves are experiencing more tension and 'other' animals are noted to be “tuned into the moods” of humans (Serpell 1986). Moreover, if the research that correlates greater pain during recovery from declawing is correct, the increased tension could most simply be a result of the increase in pain. For clients, the context of declawing appears to increase the tension experienced within the encounters simply because they are unsure about the consequences that this practice has for the patient’s behavior and feelings. However, clients and patients still express mutual affection when together.

For staff members, the lack of consensus brings a considerable degree of tension into the social encounters. The social status of the patient influences both the degree of tension and expression of affection experienced by staff and patients as staff feel more guilty about subjecting a patient whom they have “brought into the protective folds of civilization” to problematic and painful procedures. Indirectly, staff member’s and patient’s tension is further increased by the type of doctor involved in the encounters as Doctor Curtis attracts more surgical procedures and makes the hospital busier. Simultaneously, he also increases the likelihood that patients will receive affection when the hospital is not busy because staff members appear to model their affectionate displays accorded felines on the doctor’s behavior. The patient’s age also has an impact on the social encounters within the cat hospital.
However, the influence of age is largely due to the continuum of acceptance constructed by staff participants relating to the ideology of declawing. The older a patient is, the harder it is to accept this practice as serving their best interest even within the context of the situation.

Given the current structural relations between felines and humans within the United States, Doctor Curtis practices declawing because he feels that it is better than the alternatives. As both Dr. Curtis and Dr. X explain, declawing is the “better of two evils” in a society where human interest takes precedence (and rightly so in Dr. X’s opinion) over animal interest, as well as in a culture where cats are recognized as private property and sometimes regarded as disposal. Curious as to whether or not Dr. Curtis’ theory “death or declaw” could be evidenced. I conducted an Internet search\textsuperscript{220} of all “adoptable” cats from the greater surrounding area: I received a list of 900 cats. Out of 900, only 112 (12.4\%) were declawed. To control for the possibility that declawed cats simply are not put up for adoption (are euthanized or found), I called the local animal control office. I first asked if, from their perspective, they intake as many declawed cats as clawed cats. The answer came without hesitation “Oh we get way more that are not declawed...I think that we only get about a half dozen a month that are declawed.” I then asked the staff member what generally happens to the cats that enter the shelter who happen to be declawed.

Oh, they are usually adopted out quite quickly. People want cats who are already declawed...that way they don’t have to put any more money into getting it done. I really think that it is an advantage...at least in here...if a cat is declawed...because they are the ones that are adopted out first.

\textsuperscript{220} http://www.petfinders.com
The significance of this is that rather than a simple rationalization for a professional ethical decision that may conflict with personal ethical beliefs about an activity\textsuperscript{221} or a type of psychological armoring\textsuperscript{222} needed to conform to institutional constraints; this particular actor is balancing moral obligations within the structural walls. Moreover, he is doing so in a practical and contextual way. Declawing in this setting became a practice to serve the interest of the patient in a broader structural framework, which places animals as private property. Property, mind you, whose interests sometimes came second to other personal property. As one staff member sarcastically imitated a client to another staff member regarding the client's motivation to have an adult cat go through a rear declaw: "I have to have his back claws removed now. I just got new pine furniture."

Many feminist theorists\textsuperscript{223} suggest that in everyday relations, ethical decisions are not followed by some "transcendent moral principles that...govern [human] behavior" but rather are rooted in ways of relating that is contextual and narrative. Ethics in the everyday world are "sensitive to relationships" and are "open to the possibility of compromise and accommodation."\textsuperscript{224} In other words, relationships require a focus on obligation rather than abstract universal ideals. According to these theorists, in the real world practical ethical decisions are based on relational and contextual reality; it is a weighing out of interests and an attempt (not always a conscious one) at balancing the needs and wants of the various actors in the relations.

\textsuperscript{221} Rollin 1999, Goffmann 1970.
\textsuperscript{222} Eisler 1995; Arluke & Sanders 1996
\textsuperscript{224} Manning 1995/1996.
As my participants point out, one needs to take into account the contextual complexities of the issue in order to recommend policy or regulation of the practice. If declawing is outlawed to preserve an animals' “quality of life” then, many cats may indeed find themselves stressed within the home when their natural tendencies to scratch conflict with the human desire for order in the household. This conflict as the doctor suggests, may increase the likelihood of that cat’s chance of becoming a “disposable” member of human society and join the ranks of those already mass murdered for the convenience of human control. Moreover, regulation would further oppress the elderly and the sick (specifically those with HIV) who can not afford to put their lives at risk for the sake of preserving the fingers of their beloved animal. Would it be just to tell clients, who find themselves suddenly afflicted with a disease such as HIV or geriatric diabetes, who may have a loving relationship with a cat for years, that they now must find a new home for Fluffy? No. That would be oppressive not only to specific segments of human populations, but also those segments of the “companion animal” populations that are affiliated and may very well choose to be declawed over the alternatives. From the complexities of this research, however, I would recommend a regulation requiring veterinarians to explicitly state that an amputation is involved in this procedure. Along with this, a consent form (specifically outlining the procedure) releasing the veterinarian from the liability possible if the client later feels that “informed consent” of the procedure did not occur should be provided to each client who requests this procedure.
Despite the empirical evidence that many participants take the context into account when making professional ethical judgments about declawing, it remains that they do so mostly because the institution itself fails to provide a clear ideological framework from which to make those decisions. Without this institutional consensus that is found with other medical practices such as neutering, staff participants are left to make their own definitions of the situation. While they do create a local ideological structure\textsuperscript{225} to guide their behaviors (the continuum of acceptance), without the consensus that this practice is unilaterally in the patient's best interest greater tension is involved within the human-feline encounters for both staff members and clients. With the greater degree of tensions involved in the encounters, staff members need to engage in more tension management strategies in order to feel good about themselves while simultaneously practicing an ambiguous practice.

Paradoxically, these tension management strategies help to perpetuate the less than ideal practice that they believe causes them tension in the first place. The tension for the staff members, however, does not come from a practice that mutilates and controls the bodies and lives of felines because encounters within the context of neutering are not tense for staff members. The tension stems from the lack of consensus that the practice enjoys.

\textsuperscript{225} Arluke & Sanders (1996) also found that without a clear ideological framework set by the scientific
CHAPTER 7

EUTHANASIA

Coming to a Dead End

The ultimate control one individual or group can have over another individual or
group is the power over life and death. In the United States, humans have this control
over felines. With neutering, it is clear that the institution as well as the local
participants agree that humans have the right and obligation to control the feline
populations. Cutting off an individual’s reproductive functioning controls the
populations of feline life before it begins; the practice of euthanasia terminates an
individual’s life. According to Hannah (2000) “owners have a right to treat their own
animals, including the right to terminate the lives of those animals. This stems from
the fact that animals are property, regardless of court pronouncements that they may
be a special kind of property” (330). Owners, in this case are defined as anyone
(client, rescue organization, animal control agencies, research laboratory, and
veterinarians) who assumes the custody of an animal. In the United States in both
veterinary medicine and the legal institution, while “owners may treat their...animals
[by ending their lives], it must be done in a humane manner” (Hannah 2000:330).
For example, Hannah (2000) recounts a court case State v Andree (1998) in which the
defendant is determined guilty of animal cruelty for stabbing a kitten 9 times in order to end its life. Moreover, while humans have the right to end the lives of animals under their care using a humane method, not all humans can actually perform the termination. Had the defendant in the above case brought the kitten to a veterinarian to end its life, no legal question of cruelty would have ensued.

**Ideological Framework of Euthanasia**

As I pointed out in the conceptual framework, euthanasia in the veterinary institution is defined as providing a “good death” for an individual animal. A ‘good death’ is understood to be one that involves the least amount of physical pain and emotional suffering. As McMillan (2001) points out, the “official” position on the practice of euthanasia is “that it is our responsibility, as veterinarians and human beings, to ensure that when it becomes necessary to kill any animal for any reason, death should be induced as painlessly and as quickly as possible” (1204). There are explicit institutional guidelines on how an animal’s life is to be terminated. These guidelines, according to Sanders (1998), were first published by the American Veterinary Medical Association in 1963 and updated in 1972, 1978, 1986 and 1993. The discourse in these guidelines focus on the impact those specific methods of euthanasia have on the animals and the humans present.

\[^{226}\text{Rollin 1999; Sanders 1998; Elder, Wolch & Emel 1998.}\]

\[^{227}\text{See Elder, Wolch and Emel (1998) for an interesting discussion of human oppression and legitimate control over animal life in the United States using similar court cases involving other species.}\]
Primary criteria for the evaluation of euthanasia techniques are the physical pain and psychological distress experienced by the animal. Other criteria include the emotional effect on human who are present; the availability of appropriate drugs; and compatibility with the subsequent examination or use of the animal's body and tissues.

In other words, unlike in human medicine, "euthanasia in veterinary medicine bears no explicit requirement that it be in the recipient's interest or serve to alleviate suffering" (McMillan 2001:1204). What this means is that as long as the death is induced as painlessly and quickly as possible by a veterinarian or other qualified staff, the individuals in the local setting can determine when and why euthanasia is to be used. From the institutional framework,

it is regarded to be an act of euthanasia when a humane death is induced in healthy pet animals (so-called convenience euthanasia), animals with behavior problems, healthy surplus shelter animals, and puppies and kittens resulting from an ovariohysterectomy of a near-term pregnant female. (McMillan 2001:1204)

These guidelines do not provide an ideological framework for why and when the practice is to be used. Without a clear ideological framework on this issue instituted by the larger institution, the local veterinary medical practice is expected to create their own framework from which to guide their behaviors.

While staff participants did indeed construct an ideological framework from which to guide everyday life in the veterinary hospital, not all human participants agreed with the definition of a given situation, nor where to stand ideologically within this framework. While there is an ideological consensus in the veterinary institution and the local setting that when an animal is to be euthanized, it must be done as "painless and as quickly as possible," conflict arises from disagreement between
human participants about when and why to terminate a patient’s life. In this way then, conflict surrounds not whether humans are to control the lives and deaths of felines but under which circumstances this control is legitimate.

In this chapter, I present the loose ideological framework constructed by staff participants surrounding the practice of euthanasia, pointing the readers’ attention to the conflicting definitions members have regarding when the practice best services patient interest. In other words, the practice itself is not unilaterally defined as problematic nor serving the best interest of the patient. This ideological conflict has a profound impact on the human-feline encounters within the veterinary hospital. However, other social contexts such as the patient’s social status and age, presence of the client, type of veterinary doctor and the expressed economic ability of the client also impacts the interactional dynamics (particularly tension experienced by human participants) which define specific human-feline encounters. In this way then, it is not necessarily the practice of euthanasia that causes tension in the lives of human participants, but rather the ideological conflict about the practice and with that the practice within certain other social contexts. As such, I next outline the types of encounters experienced in the social context of ideological conflict surrounding euthanasia. These encounters, depending upon certain contexts, can be particularly tense for staff members. As with declawing, this tension has to be managed for staff participants to continue to engage in ending the lives of patients that ideally they are meant to save. Therefore, the final section of this chapter presents the types of
tension management employed by staff members to deal with tension in certain
contexts of bringing a life to a dead end.

_Ideological Conflict: When Does Euthanasia Serve Patient Interest?_

According to the owner of the Loving Care Cat Hospital euthanasia “is tough on a
case to case basis.” This is because, unlike neutering and preventative health,
whether or not this practice is in the best interest of the patient has to be figured out
case by case and weighed against human interest. To aid participants in case
determinations of euthanasia, the doctors appear to have constructed a local
ideological framework to weight out the competing interests. This ideological
framework, like declawing, appears to have a continuum of acceptance. Most
participants agree that when a patient is defined as suffering, euthanasia is in their
best interests. Likewise, many staff participants agree that if a patient is expected to
suffer in the future given their current condition, euthanasia is necessary to “preserve
the patient’s dignity.” The euthanasia of patients that need costly medical cures is
sometimes acceptable to some staff; however, that depends upon “how much a client
is trying.” Euthanasia of patients with defined “behavior problems” enjoys a
considerable disagreement among staff members and between clients and staff
because some staff members believe that medical and social alternatives to euthanasia
should be explored first. Finally, the euthanasia of healthy patients, regarded by the
institution and the staff members as “client convenience” euthanasia, is totally unacceptable by the staff. However, some clients request this service. Moreover, staff members disagree about what circumstance falls within this category.

Pain and Suffering

The most acceptable, even obligatory, situation where euthanasia is understood to serve patient interest is when the patient is defined as suffering. When I interviewed staff participants, all argue that if a patient is in pain or is understood to be suffering, euthanasia is the best course of action. The following responses provide evidence of such assertion:

“Well actually, I think that if the patient is suffering then it is the best thing to do, I mean...well...Nell’s eyes are watering...Nell go in the other room ok?...Nell just had to put her dog down cuz he had kidney failure...we took him home for one day...to spend the last day... but...it had to be done.” (Ezra)

“If they are suffering or in pain then how could you make them live that way? If that was my quality of life I wouldn’t want to go on. I think that it would be much better off the patient is euthanatized.” (Laura)

“Yes, then it’s really needed. If the animal has no quality of life then it is a good thing. I did it when my dog had epilepsy.” (Pam)

For other staff members, euthanasia of suffering patients is not only in their best interest, it is urgently necessary. In the field note excerpt below, Marcie impatiently waits for Doctor Curtis as she tends to a rescue kitten that is, from her perspective, suffering horribly from some unknown ailment. In this case, euthanasia does not present staff member tension; rather it relieves it.

228 Sanders (1999) also observes a similar framework in his study of a large multi-practice hospital
There was a small gray kitten here yesterday named Tess who had diarrhea and was shaking violently. Marcie attended to her all day. She tried to get her to eat, placed a heating pad in her cage, spoke to her, and carried her around for some time. She seemed to improve a bit and was sent home last night with medicine. However, the clients (foster parents for CAT) brought her back to the hospital at five o'clock this morning because she was unable to move.

When I arrive at nine o'clock Tess was far-gone. Her pupils are dilating in and out and her breathing is labored. I ask Marcie about her and she explains that the kitten is going to die and they can not figure out what is wrong with her. Marcie is very upset about watching Tess suffer. She spends some time at the cage petting and talking to Tess, "oh, you poor baby." She looks at me with a sad expression and tears in her eyes and says to me, "she is suffering, I want to euthanize her...I hope Dr. Curtis gets here soon." She carries Tess gently to the prep room and lays her out to check her breathing. "Lisa is he here yet?" she asks through the prep room door. She sighs and shakes her head. "Soon, he will be here soon."

The kitten is gasping for air but still alive when Dr. Curtis arrives. He listens to the kitten’s heart and tells Lisa to call the people who brought the kitten in to see what they want to do. It is a CAT kitten. He tells Lisa to tell them that it is probably congenital - failure to thrive. CAT tells them to go ahead and euthanize her as soon as possible. Marcie does not waste any time, as soon as Lisa hangs up and says to "go ahead," Marcie is ready with the injection. As they began the process, I asked questions about what they were doing. Marcie and Doctor Curtis explain to me that the injection is a very strong anesthetic. I note that the bottle has a poison label on it. The staff members weigh the patient and fill the needed amount per pound in a syringe. Then they inject the overdose of anesthetic into a vein if the patient is extremely sick and constructed as suffering. According to both Marcie and Dr. Curtis, the injection goes to the heart. First, it works as an anesthetic – relaxing the patient. Next it slowly stops the breathing and then it stops the heart.

While I watch, I think about what I would have done. I note that I would have at least waited a bit longer because, to me, Tess appears as if she is struggling to survive. On the other hand, I can also empathize with Marcie’s concern over Tess’ suffering; Marcie was the person who cared for Tess the prior day. When he was injecting Tess, Dr. Curtis pets her head and says softly, "you poor kitty." I stroke her too while she is going through the final process but am unable to speak for fear of crying. As the kitten stops breathing, Marcie sighs, "good, she is gone."

It is significant that Marcie’s and my definition of the patient’s behavior conflict. I believe that Tess is struggling to survive and that we have no right to interfere in her right to struggle. Marcie defines the kitten’s gasping and squirming as suffering and her obligation is to relieve that suffering using any method possible - including the method of euthanasia. The doctor and CAT client concur with her definition in this suggesting that this framework may not be a solely local construction but rather a part of medical socialization.
context, and their definitions of reality and construction of care organize the outcome of the situation – the death of the kitten. I must point out however that a later necropsy (which is an autopsy on a different species) confirms his diagnosis and that Tess would have struggled in vain. Despite this, the point remains that definitions of the situations (right or wrong) can conflict. Moreover, staff members such as Marcie and Doctor Curtis and clients such as CAT believe that control over another’s suffering, even through death can be legitimate and even urgent in some contexts.

According to Peter Hellyer (1998), a veterinary medical doctor and spokesperson for the American College of Veterinary Anesthesiologists, “Pain has been defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage” (628). Determinations of whether or not a patient is in pain or is suffering is not an easy thing to do because

Pain is a complex phenomenon involving pathophysiologic and psychologic components that are frequently difficult to recognize and interpret in animals. The term suffering is frequently used in conjunction with the term pain to imply conscious endurance of pain or distress. Suffering may refer to a wide range of intense and unpleasant subjective states that may be of physical or psychologic origin.” (628)

Because pain and suffering are subjective experiences, and feline patients can not verbally express these experiences, conflict can arise between human participants about whether or not a patient is experiencing pain and/or suffering and how much this pain and/or suffering conflicts with an animals’ quality of life. According to

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230 See also McMillan (2000) and Broom (1999) for a discussion of pain and suffering as subjective experiences that are difficult to determine in other animals.
veterinary doctors Rollin (1999) and Fogle (1983), there are numerous cases where a client’s and a veterinarian’s definition of patient’s behavior conflict. Sometimes, these clients are painted as “unwilling to let go” in the veterinary literature and veterinarians are urged to “help” the client empathize with the pain that the patient is going through.231

While I did not observe clients “unwilling to let go” when a patient was defined by staff members as “suffering” during the process of my research, staff participants suggested that sometimes this happens. For example, in the context of an informal chat with Lisa she explained “sometimes clients just don’t want to see the reality of the situation...you know? They don’t realize that euthanasia is for the good of the patient.” More frequently, I observed clients defining a patient as suffering and request euthanasia, and Doctor Curtis trying to help them to redefine the situation to prevent this decision. For example, in the fieldnote excerpt below Doctor Curtis uses his authority as a medical doctor to talk a client who is “prepared to do what is necessary” out of what both him and I believe to be a rash decision from a long night without sleep.

As Dr. Curtis and I walk into exam room one, we observe a distraught looking middle-aged white male client pacing back and forth alongside the exam room table near the client entrance. Sitting in the middle of the floor nearest the staff entrance to the exam room is a bony but pretty, 21-year-old female Calico. The client stops pacing and begins to explain the nature of the visit. Dr. Curtis bends down and pets the patient as the client speaks. “I really can’t stand it anymore...I guess what I am saying is that I am ready to do what needs to be done...I mean she was throwing up all night and I wondered if I ought to call in an emergency...then she had diarrhea all over my brand new carpet...and I am tired...and I had to go to work today and I worried that she was suffering and didn’t know what to do...Now, I am having someone else watch the store so that I could bring her in...[he takes a deep breath

and looks at the patient who is leaning into Dr. Curtis’ caress.” I am tired of all this...you know...she gets better...and I think we are fine...and now this. She had a good life and I love her a lot but I think that she is pretty much gone.” Dr. Curtis stands up and Nora [the patient] walks over to me and sits at my feet looking up. I kneel down to pet her. “Well, my friend I see that you are pretty upset, and I can count on one hand how many cats that I see that are this old. But she really seems to be in good shape now.” The client shakes his head, crosses his arms, and looks over at Nora who is purring as I pet her. “She was just so sick last night...I don’t think I can do this night after night...you know.” Dr. Curtis moves over and gently picks Nora up and places her on the exam table. The client makes no move to touch her. While the doctor examines her, Nora sits very still looking back and forth from him to me. He listens to her heart, looks into her mouth and ears feels her lymph nodes, and takes her temperature. She seems so alert, friendly and healthy that I am practically holding my breath while Dr. Curtis examines her. The client seems bent on euthanasia. He appears to have already made up his mind and has steel light himself. From her demeanor, age and his concern I am certain that the client was simply making a rash decision after a long night.

When the doctor is finished examining her, he lets her go and she jumps off the counter and heads straight to me. I bend down to stroke her while I listen to the client and Doctor discusses her fate. After the client recounts how she used to be so active and friendly and how she seems to get easily confused and sick now, he repeats, “I love her but I don’t think that I can handle too much more of this.” Dr. Curtis looks at him and states, “many older cats get sick now and then...and I think that we can control it somewhat with steroids.” The client looks doubtful, “yes but how often will we [he and the patient] have to go through this?” Dr. Curtis tells him frankly that he really does not know but, “well I believe that everyone, humans and animals ought to try steroids as an option for the elderly before they die. They work wonders. If it was me, well...I would like to have that option first.” The client looks at Nora and says, “well, maybe you’re right....maybe...but if I was throwing up all over and could not make it to the bathroom...I would want the option of a dignified death too...you know...but...[he looks at her again]...all right...lets try it.”

When Dr. Curtis and I return with the shot of steroids, the patient is at the door. We move into the room around Nora. Doctor Curtis stands there for a second with needle in hand. Nora appears not to notice us; she keeps staring at the staff entrance. The client laughs with Dr. Curtis at her confusion and says, “you see...confused.” Dr. Curtis looks at Nora, who is still staring intently at the door. Dr. Curtis speaks directly to Nora, “You have the wrong door [he chuckles] the door to home is the other way.” Then he gently picks her up and gives her the injection. She stays very still. The client keeps asking if he really thinks that this is the right decision, “she is really suffering though you should see her at home.” Dr. Curtis continues to reassure him that this is the right decision. “Well” says the client with a sigh as he picks Nora up and places her in the cat-carrier, “I was all prepared to do it today, but we will give this a shot and see what happens.” Dr. Curtis again reassures him “She may very well have a good couple of years left.”

From Doctor Curtis’ and my perspective, Nora does not appear to be suffering enough to justify the practice of euthanasia. The client, however, experiencing her behavior at home, believes that she is both “suffering and confused.” He suggests,
using empathy and an understanding of her normal behavioral repertoire, that both hers and his quality of life are at stake should he choose to postpone euthanasia. Arluke & Sanders (1996) argue that clients and veterinarians often work together to construct an understanding of the patient’s subjective states drawing from different resources. While this is true, sometimes these resources or differing perspectives can construct conflicting definitions of what the patient is experiencing and thus what the proper method of medical care should be.

In the above case, Doctor Curtis draws from his medical training to come up with an alternative definition of the patient’s subjective experience and thereby an alternative solution. He checks her temperature and listens to her heart to determine the physical location of the problem. Moreover, he utilizes the patient’s social cues such as leaning into his hands, to determine the subjective experience of pain [if she is in a lot of pain, from the medical perspective, she is less likely to be amenable to stroking]. He also draws from her social cues to recognize that he can pick her up and pet her. Finally, Doctor Curtis uses empathy to suggest which solution (steroids) might work to help relieve her physical symptoms (described by the client): “If I it was me.”

The client also uses empathy drawing from his personal experience with Nora, but provides a completely differing interpretation of reality: “...if I was throwing up all over and could not make it to the bathroom...I would want the option of a dignified death too.” The client also points to Nora’s confusion to promote the accuracy of his account of her subjective state: “You see...confused.” It is very important to note
here, that although the patient is a part of this construction, she has no power to define the ultimate definition of reality. Her only resource is the relational influence that she may have on human agents through social cues and possibly connections to them.

Before euthanasia is chosen as a medical option, clients and veterinarian must arrive at some sort of agreement of the definition of the situation. In other words, Doctor Curtis does not simply engage in the practice of euthanasia on client demand—he has to agree to do it. Sometimes these agreements are negotiated as above, other times these agreements are arrived at quickly. When the patient’s behavior indicates that he or she is in pain (such as difficulty breathing, defecating or urinating on self, shaking, howling or crying) and medical tests confirm the human participant’s observations that the patient is ill (such as low white blood count, high temperature, x-rays showing obstructions, blood work indicating presence of a deadly virus) human participants most often agree that the patient is suffering. Medical confirmation of patient suffering is an important element in the decision to euthanatize a patient. Without this confirmation, some clients and staff members are hesitant to arrive at this terminal decision.

While staff members and some clients sometimes disagree whether or not a patient is suffering enough to “let go,” most agree that euthanasia is an acceptable method providing that they can agree, usually confirmed by medical tests, that the patient’s quality of life is at stake. Given that a major goal of the institution and the local staff participants is to relieve feline suffering, euthanasia is most acceptable, even obligatory, when a feline is defined as being in serious agony and alternative medical
solutions can not be found. McMillan (2001) sums up the general institutional consensus regarding euthanasia in this situation:

“When other medical interventions are unsuccessful in alleviating this discomfort (i.e. drugs or surgical interventions) and the doctor is “unable to prevent discomfort from reaching the mind, we adopt a different approach altogether. We put the mind in a protected state—we interrupt consciousness. When this is done on a temporary basis, it is termed general anesthesia. When it is done on a permanent basis, it is called euthanasia. Euthanasia is the last effective tool we have, and use, to stop the discomfort.” (1205)

*Future Pain and Suffering*

Most staff members and CAT clients, also define euthanasia of medically defined “terminal patients” (who are expected to suffer and die in the future) as a legitimate reason for euthanasia. Evidence of this is that “strays” and “rescues” are automatically euthanized when they are diagnosed with a fatal illness such as Feline Leukemia Virus (FeLV) or Feline Immunodeficiency Virus (FIV). As Angie argues she would “probably do the same thing in this situation...especially if the cat has Feline Leukemia Virus or Feline Immune Virus [a shortened term for FIV].” Lisa believes that patients with terminal diseases such as FeLV “should be euthanized.” In fact, when a client questions the legitimacy of the immediate termination of a patient’s life some staff members define her as “strange.” In the excerpt below, this is even more “weird” because the client’s have brought in a cat who only days before was a “stray.”

“When I arrive this morning there is a woman and a man in the prep room taking pictures of a patient that is in the isolation closet. Around him are balloons and a variety of kitty toys. Confused because I have not yet seen clients bring balloons in for a patient, I ask Lisa what they are doing back there. Lisa shakes her head in
disgust and whispers to me “he has Felv and they don’t want to euthanize him. They are pretty weird – all goofy over the cat.”

“Oh. How long have they had him.” I ask.

“Oh no, it’s a stray, they just picked him up the other day.”

“He isn’t even their cat?” I ask surprised. Then I look into the prep room. The woman is crying and the man is speaking gently to the patient as he waves a toy around for the patient to play with. The patient stares at the man rather than the toy.

“Well” Lisa explains, “they would adopt him but they do not want to risk having their other cats catch it. They are looking into the Felv shelter though. They are upset about leaving him here and want to bring him home but don’t want to keep him locked up in the bathroom either and don’t want their other cats to catch it.”

After half an hour, the couple comes out into the waiting room and stands at the reception counter. A few minutes later, Doctor Curtis comes by and Lisa tells him that they want to speak with him before they leave. The male client sits down in one of the waiting chairs while Doctor Curtis and the female client have a long discussion about FeLV and adoption. They discuss the snap test, which is a local lab test that can quickly determine if a feline has FeLV. On rare occasions, this test can have a false positive. The woman informs Dr. Curtis that she knows that sometimes the test used in veterinary clinics can be wrong. He tells her that he does not think that it is false positive. She insists that he send the blood off to the lab and have the blood further analyzed [no matter the cost]. The client keeps asking him repeatedly “what are the chances that this lab test will come back negative?” Doctor Curtis explains that it is possible “but it is really a long shot.” She shakes her head “but it is possible right?” After a long discussion about the nature of the disease, the accuracy of the tests, the survival rate for felines with FeLV, and shelters that house FeLV cats, the Doctor excuses himself to return to his office. When he leaves the client looks at Lisa. Lisa quickly looks at her computer and starts fiddling with it to fake being occupied. I look at the client and she smiles at me with tears in her eyes, “I just don’t want to put him to sleep because he looks so healthy and happy. I would if he looked to be in pain. I would right away…but he looks so healthy I just refuse to cut his life short like that.”

When the couple leaves Lisa sighs and looks into the prep room from where she sits, then looks at me. “I guess that I can empathize with them looking at him and seeing him so healthy looking. But he is not even their cat and there really are plenty of cats out there...healthy ones...that need homes. Anyway, FeLV is terrible and he is going to suffer horribly...and it is expensive to keep him alive...it just is better to euthanatize him before it gets painful...you know? I just don’t understand it. They are pretty weird don’t you agree?”

Although I did not express this to Lisa, I did not agree with her about her assessment of these clients. Lisa’s confusion about the client’s motivations to get another test and look for alternative housing if that test also comes back positive, makes sense only from hers’ and other staff members’ perspectives. These staff members spend a considerable amount of time and energy investing in finding homes for strays and rescued cats and kittens. There are so many of them that they often
describe it as "overwhelming." It is "heart-breaking" seeing so many "healthy" felines end up "homeless" or sent to animal control agencies where many of them will come to a dead end. Given her moral crusade to bring as many felines as possible into the "loving care" of human society, focus on one feline who is doomed to die from a fatal virus is simply crazy. Moreover, this feline was a "stray" only two days prior. From her perspective, little time has been invested to yet create a strong client-patient bond. It is bizarre then that the clients are so emotionally attached to the patient. Finally, Lisa and the other staff members have a great deal of experience with the devastating effects that Feline Leukemia Virus (FeLV) has on feline’s quality of life. As a highly contagious virus, this patient is likely to infect other feline populations both vaccinated and non-vaccinated. As a "retrovirus" this

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232 FeLV "is mainly transmitted among cats by licking and mutual grooming..." (Hardy 1991:1283) although it can be transmitted through saliva left on food and in water if cats share bowls because it can live outside of the host for up to two hours (Hoover & Mullins 1991). Hoover & Mullins (1991) distinguish four possible categories of FeLV exposed cats. 1. Persistent viremia (positive snap & Lab) 30% of exposed cats get this and 95% of these cats die (from FeLV-related diseases such as Immunodeficiency syndrome, Lymphoma, Leukemia, opportunistic infections - as any retrovirus the body basically breaks down from attacks from diseases that body normally fights off) within three years. 2. Regressor (negative snap & Lab) 60% most often do not develop disease, but some have latent and may get a positive snap and may never develop disease. 3. Transient viremia (snap positive/lab negative or positive) "develops in a fraction (approximately 30-40%) of category 2 cats." Of type, 3 most do not develop disease later in life, although some do. Jarrett (1991) articulates it in simpler lay terms; "The outcome of exposure to FeLV is either establishment of persistent viremia, with consequent high risk of developing a FeLV-related disease, or recovery. In addition there is a third outcome, termed latency, which is a kind of delayed recovery. In this condition, cats make partial recovery so that virus is no longer detectable in the blood, but covert virus can be reactivated in the bone marrow" (1279-1280).

233 In both clinical studies (where cats are artificially exposed to the virus) (Charreyre & Pedersen 1991; Hoover et. al 1991) and field studies (where FeLV positive cats are housed with FeLV negative cats to see how many of the negatives turn positive) (Shibley, Tanner & Hanna 1991; Pollock & Scarlett 1990), vaccinations are not 100% effective in controlling the virus. Efficacy rates are reported to range from 85% to 95%. (Of course, whether or not an exposed cat develops FeLV also depends on a host of other complex factors (i.e. individual immune response, strain of virus, age of patient) (Rojko & Kociba 1991).

virus affects the body's immune system, disarming it and enabling FeLV-related
diseases such as lymphoma and leukemia to take control over the host. In addition,
the patient will be at higher risk to other viruses and diseases as the patient's immune
system breaks down.\textsuperscript{235} Patients usually succumb to the virus quickly and die within
two to three years after infection.\textsuperscript{236} As Ezra explains, it is “better that clients leave
the patient with some dignity and euthanize them before they begin to suffer terribly.”

From the client's perspective, this cat came to their door. The feline chose them to
provide for him and protect him. He appears healthy and could have been
misdiagnosed.\textsuperscript{237} The tests that are run in the veterinary hospital, which are called
“snap tests” sometimes come up “false-positive.”\textsuperscript{238} One might consider the
ramifications involved for all participants (client, staff, patient) of a veterinarian
suggesting euthanasia or even isolation of a cat that really does not have the virus.
The client’s hesitation to euthanize the patient is not because she is against
euthanasia; but rather, because she feels that she has no right to cut his life short
while he appears healthy and happy. “I just don’t want to put him to sleep because he
looks so healthy and happy. I would if he looked to be in pain. I would right

\textsuperscript{236} Hardy 1991; Hoover & Mullins 1991.
\textsuperscript{237} Empirical evidence supports this contention. In-house tests (known as ELISA or Snap tests) for
FeLV (it also tests for FIV which is a feline equivalent virus of the human HIV) are less accurate than
the lab test (known as IFA test). According to comparative analysis of false positives.
\textsuperscript{238} In a ten-year comparative study between ELISA (in-house snap) and IFA tests (reference test that is
the more accurate laboratory test) of 20,240 samples, Hardy & Zuckerman 1991 state that, “it is
apparent from this study that between 26 and 69\% of in-hospital positive ELISA results and 13\%
of negative in-hospital ELISA results are incorrect...our results indicate that many in-hospital positive
ELISA results are incorrect and support the recommendation that all positive ELISA results be
confirmed by IFA testing.” (1365). See also Jackson 1991 for 5-10\% false-positive and Hawks et al
1991 for a .3\% - 2.1\% false-positive using various controls such as technician error or inadequate
washing.
away...but he looks so healthy I just refuse to cut his life short like that.” This client feels responsible for the individual life that has come into her life-space rather than populations of cats whom she has never encountered. This responsibility, this feeling that cutting his life short while it may still be good because he may [in the future] experience suffering does not seem right to her. While she and the male partner may have developed a quick emotional bond with the patient, I believe that the strength of the emotional response (crying, seeking alternatives, bringing in toys to comfort) is to a life, under her care, that is threatened. Remove the signs of suffering and some human participants have a harder time defining euthanasia in the patient’s best interest.

For some staff and some clients, knowing that the patient is going to die soon anyway helps them to define euthanasia as an acceptable method of controlling patient suffering; even when that suffering is to occur at a later date. For example, when a mother and her kittens were brought in because the mother had a “protracted uterus” (meaning it was outside of her body) I noticed during the commotion that one of the kittens’ intestines was hanging outside of his body.

“Um Marcie, I think one kitten has his guts hanging out.” Marcie looks in the box, “oh no, poor guy, is he alive?” I look in and my heart sinks “yes, he is even trying to crawl around.” Marcie shakes her head “Oh, poor guy, we are going to have to euthanize him.” I look in at him and then at her “can’t you just put them back in him?” She shakes her head “no, we can’t.” When Doctor Curtis arrives, he looks in at the kittens before surgery on the mom. I am standing above the box, trying to comfort the kittens. “Aw, poor guy, if the clients let us we will have to euthanatize

[239] Cats with FeLV that are “healthy” live on average 2 to 3 years. Longer when living in isolation because germs are not as easily transmitted as they are from cat to cat. According to Doctor Susan Cotter (1991), “with good medical care and attention, viremic cats may enjoy good quality of life for several years.”
that one kitten.” I ask him a similar question that I asked Marcie earlier, “Why? Can’t you save him?” He looks at me with an amused expression and then looks sadly at the kitten, “no, Dana, even if we could detangle and place the intestines and liver back in, they would get infected because they have been exposed to such bacteria.”

After the clients had given their approval to terminate the kitten’s life as quickly as possible, I explain to Doctor Curtis and Marcie that if the kitten were mine, I would want him to try to save the kitten. Both Doctor Curtis and Marcie are surprised and suggest that I am not considering that he will suffer even if he lives beyond the surgery. “He will have trouble for the rest of his life,” explains Doctor Curtis. Marcie adds, “yes, and then he will die anyway. We don’t like to see patients suffer...he really is better off being euthanatized.” In other words, it is in his best interest to not suffer and because of this, they and the clients believe that euthanasia is the only alternative. I, on the other hand, question whether humans have the right to terminate a life, when they actually do not know what might happen to him in the future. Anyway, I question whether some suffering is preferable to a patient to death.

In Need of Costly Cures

Euthanasia is also sometimes acceptable if the patient is not medically defined as terminal, but is rather sick or physically injured and needs extensive and costly medical cures. In the context of interviews, staff participants argue:

“I have experience with this too and I can best describe my stance telling you about my experience...I had a bottle baby that was less than 2 years old. She was very human oriented. But she got a spinal injury and afterwards lost control of bowels and bladder. This happened to happen at the same time, by the way, as the death of my father and my daughter’s 10th birthday. So you can imagine the stress and timing - So, I told my daughter - she was considered my daughter’s cat – that I would give her two months to see how she is doing. We spent a considerable
amount of money on her...drugs...chiropractor. After the first visit to the chiropractor, she actually got a bit better...but then the second visit and she got worse. I figured that it was really not fair to her to be in a cage...cuz of her bowel and bladder problem it was not fair to us...I was not having her going around the house. So, in that type of situation, I am all for it. Give the medical options a chance at first, but if the cat fails to respond in a decent amount of time...well...one should not spend their life savings on an animal needing critical care.”

“If the cat can’t move around or is in pain or can’t control themselves like their bladder and is going on themselves then there really is not much other choice but to.”

“I think that I understand. But it depends really on how sick the cat really is. I mean if its just that a patient has an upper respiratory and the client doesn’t have the money to pay for it to get help and wants to do it then its really not ok – but it is their decision. If its really just the money then no, I guess that I don’t agree with it, though I am not in that situation...I would never be in that situation...but I guess if ya got kids and tons of bills and can’t afford it...It’s really up to them to decide.”

Note that felines are defined as suffering a diminished quality of life when they can no longer control their bowels and bladder. Lisa’s cat is restricted to a cage so that she does not “go around the house” so the cat suffers from the restriction of movement, to protect order and cleanliness in the house for the humans. In addition, Laura argues that felines are actually suffering when they lose control and “go on themselves.” Euthanasia, in these cases, is not an immediate solution. Humans are expected to try other alternatives first. However, there is a financial limit to the degree of medical care that one human individual or family can provide a feline. The interest in an animal’s life has to be balanced against human cost. For euthanasia to be legitimately practiced from these staff members’ perspectives, this cost must be somewhat relatively substantial. As Tannenbaum (1993) asserts,
One central fact underlies all interactions between people and animals: deeply ingrained in any society is a fundamental belief that both people and animals have legitimate interests worthy of human concern, that human and animal interests sometimes conflict, and that people must sometimes weigh the strength of these interests and decide how they should be reconciled. (144)

This, I must point out, is not simply an individual weighing of interests or determination of the value of ‘other’ animal life. Rather, it is a balancing act within structural walls. In this case, a constraint is placed on individual human agents within a capitalist social structure where animals are regarded as property and veterinarians are expected to and need to charge for their services.

Clients that work hard to balance these interests before choosing euthanasia are sometimes regarded as almost heroic because staff members believe that many people out there don’t even try to weight out competing obligations. For example, when I ask Ezra if her stance on euthanasia has changed since working at the hospital she explains that she has developed greater empathy for clients’ who “keep trying” despite the difficulties that these medical problems can cause.

“I guess that I have changed since working here...you know with chronic urinary problems I have more sympathy.” I asked who does she have more sympathy for “oh, for the client’s perspective. For instance, there were these clients that came in here, they had a three-year-old child and a cat going all over the place. It must be hard for them...and frustrating...but they keep trying...I could understand more in their situation. Actually [tone of voice change with word actually – slightly higher and clearer] I am really proud of them...a lot of people would have given up already, they are hanging in there longer than many others would...” (Ezra)

She suggests that in everyday life, the decision to euthanize a patient is not always an easy one, but is often a situational balancing of interests.
Behavioral Problems

According to Doctor Curtis, "aside from being sick...having no quality of life, the second biggest reason [for euthanasia] is definitely behavior problems." In fact, across veterinary hospitals in the United States, "it has been estimated that between 35 and 50% of the companion animals that veterinarians euthanize are killed because of aggressive or destructive behavior (Schwabe 1984)" (Tannenbaum 1993:150).

Staff members are more divided when it comes to euthanasia of patients who are labeled to have "behavioral problems" such as human-directed "inappropriate aggression" (aggression without apparent provocation) or peeing outside of the litter pan. This is mainly because of disagreement over the reason that the patient is exhibiting these behaviors in the first place and the conflicting definitions of the situation. Doctor Curtis somewhat agrees with and engages in the euthanasia of patients with behavioral problems because he simply does not define patients with behavioral problems as "healthy." When I ask Doctor Curtis "how many healthy patients do you estimate that you euthanize per month or year" he replies, "totally healthy? None...but I would say I do about 6 to 10 per year because of behavioral problems."

Some staff members agree that euthanasia is acceptable for "aggressive cats." Doctor X, for example, not only regards this practice as an acceptable method to stop this "problem," but also recommends it.

"...if it is a behavior problem, especially inappropriate aggression and the client has kids then I have absolutely no problem with it, I would recommend it because you really have to set your priorities straight...you know...you can't have a cat around that is hurting people and putting your children at risk!"
Both Ezra and Victoria agree with Doctor X.

"In this situation there really is no other option. Yes. You can’t ask anyone to risk themselves over it." (Ezra)
"This is a good thing. It is the best option for these patients." (Victoria)

While some staff members believe that euthanasia is an appropriate method of eliminating “owner directed aggression” by patients, others suggest that clients should try alternatives first.

"With aggressive patients, I am more apt to suggest to the client to try behavior modification first or send them to a barn before this." (Lisa)
"Well, I would start by trying to help the clients out with other options first. First, I would tell them that they have other options and most clients try them. Like they post their cat on the board and try to find the cat another home. I try to help them as much as possible first with other options." (Angie)
"I think that we can work with them first. Anyway, why are they aggressive? Whose fault is this?" (Laura)

Pam believes that euthanasia outside of a patient being very sick is simply unacceptable. People, from her perspective just don’t understand that an animal’s life, just like another person’s life is a “life time commitment.”

"With all the other circumstances, I don’t know how ya’d get rid of it, ya know? People don’t realize the life time commitment that they are taking on whether animal’s life or people’s life. Don’t know howedja educate people bout this?"

When it comes to the euthanasia of patients that have been brought in because they are described by clients as “peeing outside of the litter box,” conflict about the legitimacy of the practice among staff members and between clients and staff members is even more pronounced. Some clients believe that this is a perfectly
acceptable method of controlling a “behavior problem” even when this “problem” has a medical reason and an alternative medical solution.

“We actually get this often. We try not to do this but it is done...you know...a client came in not long ago wanting to do this...said he was sick of ‘it’[sarcastic tone of voice with emphasis on ‘it’] peeing around the house and wanted to put him down and we tried to talk him into letting us keep the cat and find him a home...we had to get permission to keep him [cat] alive! Can you believe it? But we did...we kept him here. The cat had a bladder infection...we took care of him for two weeks took care of his bladder infection, and found him a really nice home with this lady and now they are both really happy and he hasn’t peed outside of his litter box once...he had a bladder infection and he was going to get euthanatized for it and now he is happy with this new home...that one worked out well...I am so glad that it worked out ya know? It happens all the time...quite a lot...and some just get euthanized...that’s not fair.” (Laura)

In the case that Laura describes above, Doctor Curtis tries to convince the client that the patient’s behavior could be a result of a medical problem. In this case, the client wants nothing to do with alternative medical solutions. He wants to be rid of the responsibility of this cat. Fortunately, for the patient as well as for staff members, Doctor Curtis provides another solution: relinquishment of the patient. In addition, the client, while accepting euthanasia as a solution to this “problem,” is amenable to another alternative providing he no longer has the responsibility to care for the patient. Not all hospitals will offer this solution and many cats like the one above will be euthanized for “peeing outside the litter pan” whether or not the cause is medical or social. Some clients will also not hear of the “relinquishment” alternative because, as Doctor Curtis points out to me in an informal chat, “they believe that the patient would not be happier anywhere else. They believe that the patient is better off dead.” Moreover, the death of a patient for some clients, according to Doctor Curtis,
"reduces any worry or concern that they may have for the patient...out there...possibly cold and starving. This way they don’t have to worry about them anymore."

Doctor Curtis empathizes with many of these clients because he believes that in most cases clients have struggled with this decision and have put up with this problem for a considerable amount of time. When I ask him how he feels about euthanasia of cats who pee outside of their litter box with no known medical cause, Doctor Curtis explains that it is a hard decision for most clients and that usually the behavior has lasted for some time.

"Usually, with these clients and patients, I have a long history...many pages of notes where we tried many things to stop the behavior and then by then I usually have sympathy for the people as well as the cat, but then, you know, I understand...if they really tried various things...You know sometimes people feel guilty about this, like their veterinarian will be disappointed or judge them...and then they don’t want to face their veterinarian and they will go to another clinic to have it done. When this happens here and a new client comes in wanting this done, I usually talk to them for awhile and suggest that they go back to their veterinarian explaining that if the veterinarian was anything like me that they would understand and not judge them for the hard decision."

Ezra, argues that alternatives such as letting a cat outside, might be less acceptable than euthanasia because the older the patient, the less able the patient will be able to defend him or herself against what might be out there in nature. Victoria points out that it should never be the first option, but you can not expect felines without claws to "defend themselves out there."

"In this case it depends really on the age of the cat...if it’s older then you just can’t put it outside...you know...it won’t survive. For younger cats anti-anxiety drugs may help." (Ezra)

"With this situation I have a problem with it...it should not be the first option. We do it but we are reluctant to do it. A lot of people just make them an outdoor cat. Now if they are front declawed this is possible to do because cats can still defend themselves, you know they use their front claws as a warning. But if they have their back claws removed too then they really can’t be put outside, they use their back claws..."
claws to defend themselves with...you can't put them out defenseless and what are you going to do?" (Victoria)

On the other hand, Lisa believes euthanasia of patients in this case is totally unacceptable. When clients do request this, she believes that they are regarding the patient as disposable property. “Cats are not disposable items. I strongly believe that. People ought not to be allowed to do this!” Laura and Angie agree with Lisa. “If they are healthy, there are other ways to deal with the situation.”

“I don’t agree with this.” In other words, there is simply no other way to define the situation in these cases. Euthanasia of patients who are “peeing outside of the litter box” is simply wrong; this circumstance from their perspective and from the perspective of those who disagree with euthanasia of “aggressive patients” ought to be placed under the circumstance regarded by the larger veterinary medical institution as “client convenience” euthanasia.

Client Convenience

When I asked staff members to describe their stance on “client convenience” euthanasia, all staff members, including both veterinarians take a strong position: they all disagree with it.

“Well, for euthanasia...it depends on what the situation is really. I mean...if it is for owner convenience only...then yuck, I don’t like that...I don’t do that. I really don’t have to deal with that situation anyway as I am not here that much.” (Dr. X) “We don’t do that here!” (Dr. Curtis) “I don’t agree with that at all!” (Angie) “People request this all the time...you know? It is wrong and should never be allowed in any hospital.”
Institutionally, it is up to the veterinarian to decide if they wish to practice “convenience euthanasia,” and many provide that service to clients. However, the acceptance of euthanasia under this circumstance is slowly diminishing.

Balancing competing animal interests can be even more difficult and controversial when substantial proportions of society disagree about the importance of animal interests – or indeed, about what should be recognized as a legitimate animal interest at all. For example, some veterinarians will euthanize a companion animal if the client requests it, even if the animal is healthy and capable of providing companionship to someone else. Underlying such behavior is a value judgment that whatever interest animals might have in living is not strong enough to prevent their owners from having them killed out of convenience or even caprice. Today, an increasing proportion of veterinarians view such ‘convenience euthanasia’ as unethical (Parachini 1989), but the controversy is by no means settled. The debate revolves largely around the issue of what is to count as an animal interest and how much weight it deserves. (Tannenbaum 1993:145)

The doctor/owner of the Loving Care Cat Hospital claims that he does not “provide this service to the clients.”

He does not resist the institutional acceptance of this practice either. Most staff members believe that if a client wants to “get rid of” a patient in this way, that they will simply find someone else to provide that service for them. Moreover, the institutional and cultural ideology regarding any care for feline patients is that it “is ultimately up to owner to care for animals.” I once asked Dr. Curtis if he would “save” a patient by telling the client that he would do it and when the client leaves, rather than euthanize, find a home for the patient. During the process of my research, I observed that this had been done at another clinic in the community.

A young white male came in while I am standing next to Anna behind the reception desk. He carries a large male black cat named Mocha. Mocha has his paws around the client’s neck and is rubbing the man’s face. The man rocks Mocha back and forth and smiles at me (as if to say ‘isn’t he great?’) while he waits for another client to finish paying her bill. When the man is speaking with Anna, he tells her the name
of Mocha's former veterinarian so that she can call and retrieve Mocha's medical records. Anna asks the client to wait while she calls the other clinic to have them faxed over. When Anna hangs up the phone after speaking for a few minutes to the other veterinary clinic she motions for me to move closer. I do and she whispers in my ear, "Mocha was euthanized." I look at her and then at him holding the patient and whisper back, "He is coming to euthanize that cat?" She laughs at my confusion and then explains what she learned during the phone call. "No. He saved him from being killed! Isn't that awesome? The patient was described as aggressive can you believe that?!!" I smile at her and then look at the client and patient who are snuggling each other and say to her, "cool!!"

Dr. Curtis explains that he will never do this. He tells me that while he does attempt to convince clients to "relinquish" ownership to him in these circumstances, he will not deceive a client. He offers a moral story that a woman in veterinary school told him about her experience:

"Would you ever save a patient from euthanasia if the client insisted on it and would not take no for an answer, knowing that he or she would go do it somewhere else?"

"No, I would not do it. Never have done it and never will."

"Why not?" I ask.

"Well, it is because of experience really. When I was in veterinary school there was this woman and she had told me about this experience...a really bizarre story really. This guy came in to her clinic and wanted her to euthanize this healthy husky puppy who happened to have a short nose. She told him that she would find a home for the puppy but he didn’t want the dog around he said...wanted him to be euthanized. She knew that if she didn’t do it that he would just go somewhere else. And the puppy was healthy and she felt bad for him and so she told the man that she would do it and he paid for it and left. Then, she didn’t do it. She decided to call the Husky Rescue and she told them the story and described the dog. Well, the guy that asked her to do it was actually on the board of the "Husky Rescue" and he knew it was him she was talking about, and knew that it was his dog that she was talking about. He was on the board – bizarre but these things can happen. Anyway, she got busted...a big part of it was because she accepted money for it...for the procedure. And it wasn’t that she wanted or needed the money or anything she just wanted to save the puppy...you know."

I say, "well she had to take money for it, right, if she told him she would do it, because otherwise he would know that she wasn’t really going to do it?"

"Exactly! And it was weird, him being on the board of the rescue but these things happen... It is illegal. And I would not ever do it. Besides I don’t mislead my clients. I don’t ever do that because then you have that reputation. I would just turn them away. If a client walked in here with a perfectly healthy cat and wanted me to euthanize, I wouldn’t do it. No, I would never do it. I would first offer up other viable options and I would not recommend it and then if they still wanted to I just would not offer it. I don’t have to do it, you know, I am not legally bound to do it."
The moral of the story is that resistance in this way could cost him his reputation and even worse, his license to practice medicine. Legally, if an “owner” wishes to take it up in court that the veterinarian charged for a service that he or she did not provide that veterinarian could be severely sanctioned. Fear of very real medical and legal institutional sanctions limits his ability to resist. While the structures here do not determine his action in that he does not simply say no to a client but tries hard to creatively provide alternatives to euthanasia, these structures have a powerful influence on how he behaves in the face of “unjust” encounters.

While Doctor Curtis and Doctor X both argue that they do not engage in euthanasia for client convenience, some staff members believe that they do. For example, when I ask one staff member what her thoughts on “client convenience” euthanasia is she had this to say:

“This actually happens quite a lot here. People come in and they are tired of their cat or they got new carpeting and just don’t want it anymore...happened actually two or three times already since I have been here [she has been there for a couple of months]. Quite a few come in wanting to euthanatize to get rid of...you know they [animal] don’t choose you – they have no choice – once you take them then it’s your responsibility...they don’t choose why should they suffer because you just got new carpeting!? You know I think that people should have to do jail time if they do this. We need stronger regulations about this sort of thing. It’s horrible. I really don’t think that this is fair at all and people should not be allowed to do this at all!”

Two other staff members also suggest that the Loving Care Cat Hospital does engage in “client convenience” euthanasia. For example, when I ask one staff member during an informal chat about her stance on the practice, she appears to concur with the staff member above as she tells me that it should be “against the law to kill patients simply because clients wish it done.” As we continued to talk about this, I
asked her if she would continue to work here if “client convenience” euthanasia would be practiced at this hospital. She looks at me for a few minutes and answers in a whisper,

“oh, but it is done here. And I want this on the record.... Write this in your book. I get very angry with him [Doctor Curtis] and tell him flat out that what he is doing is wrong and immoral. Sometimes I think that he empathizes with the clients too much and does not really look at what they are asking him to do.”

On another occasion, a staff member pulls me aside to recount a story of a “client convenience” euthanasia that she had recently “taken part in.” She claims that although she usually just walks out, on this occasion, she did it, and swore that she never would again.

I believe that from Doctor Curtis’ definition of “client convenience” euthanasia, he does not practice it in his clinic. From his perspective “client convenience” entails clients who bring in healthy and affectionate felines who do not engage in any “problematic behavior” such as “owner directed aggression” or “peeing outside of the litter box” and who have worked unsuccessfully to “control or eliminate such behavior” to be euthanized. These clients feel no responsibility toward the patient and would rather see them dead because they interfere in their daily lives. These clients come in to the hospital and say that they simply no longer want “Fluffy” because of what the patient is rather than what the patient does.

On the other hand, some staff members believe that “client convenience” euthanasia is practiced at the hospital because of a conflicting definition of this situation. For them “client convenience” euthanasia includes clients who may or may
not have worked with the patient to “control or eliminate behaviors” that may interfere in their lives, but refuse to take responsibility to search out alternative solutions. For some staff members, there are alternative solutions to aggressive behaviors and to peeing outside of the litter box. For these staff members, as Marcie suggests, “I am sure that the patient would rather be outside taking their chances or in another home than dead!”

In the local setting, euthanasia is employed on a regular basis. It is understood by all staff members as ending the life of a patient *humanely* and in this sense, conforms to the institutional definition. Clients request euthanasia for a variety of reasons and not all of them to relieve a patient’s suffering. Sometimes it is requested simply because a client no longer wishes to keep a healthy patient. Other times this practice is requested because clients no longer wish to, or is overwhelmed and unable to, handle the behavior of a feline under their care. Given the range of requests for euthanasia, it is safe to infer that clients are not in consensus about when euthanasia serves the interest of the patients. Some clients do not believe that any patient interest, including life, should come above their own interest of order in the household. Others work hard to negotiate the household terms before attending to their interest in order, by finally sentencing the offender to death. Still others, such as Mocha’s man, saves patients from their death sentences, in this way insisting that a feline’s life outweigh any “problem,” (including aggressive behavior) that humans must contend with.
Bringing Feline Lives to a Dead End

Human-feline encounters associated with euthanasia are notably both affectionate and tense. However, all members of the encounters do not experience tension, and affection is not always reciprocated. For staff members, the experience of affection and tension in human-feline encounters appears to be highly influenced by the ideological consensus or conflict regarding whether or not the practice is defined by staff members and clients as in the patient’s best interest. For example, in the situation where a patient is defined by human participants as severely suffering, staff members are notably affectionate and lack a significant degree of tension. If the reader recalls, in the case of euthanasia of the rescue kitten named Tess, while Marcie does express tension from the suffering of the patient, once euthanasia is decided and being enacted, Marcie’s tension diminishes. Moreover, while Doctor Curtis expresses concern over the patient—“poor kitty”—he experiences very little tension. Both Doctor Curtis and Marcie express affection toward the patient despite the lack of reciprocal affection offered by Tess.

These encounters conform to the institutional guidelines regarding the practice. According to the American Veterinary Medical Association, euthanasia is to be practiced humanely. Social guidelines for the experience of affection and tension within an encounter are included in the institutional definition of ‘humane.’ According the 2000 American Veterinary Medical Association Panel on Euthanasia Report, a humane death means that the veterinarian is to structure the encounter in
such a way that it does not cause the patient more fear or pain than is necessary to accomplish the goal. This is an important point because it attests to the institutional recognition of the emotional needs of an ‘other’ animal. In other words, the institution recognizes that suffering not only includes physical states such as pain, thirst, hunger and disease, but also emotional aspects such as “fear, anxiety, loneliness, grief, frustration, anger and boredom” (McMillan 2001:1723).

When a patient is killed, it is to be done in as quiet, relaxed and stress free environment as possible. The patient is ideally rendered unconscious before the lethal injection is administered. For felines the general procedure is to inject a lethal dose of anesthetic intraperitonially (in the abdomen) or intravenously (in the vein). According to Dr. Curtis the former is used “if it is a sick pet because it is less dramatic. But if [they] need to do it fast, then [they] do it intravenously.” The less dramatic approach is intended to protect the patient from the awareness of death. However, the other purpose of these guidelines is to protect a client or staff from the emotional stress that may occur if the patient begins to violently shake as the poison hits their system, or if the patient collapses entirely (from animate to inanimate in a matter of seconds). As two veterinarians argue,

“We teach that no conscious animal should be euthanatized by intracardiac injection. A struggling and frightened animal, stressed from repeated unsuccessful intracardiac injection attempts between the ribs, is totally unacceptable.”

“An excitement phase is aesthetically unpleasant to the personnel.”

—

243 Grier 1991:1103
244 Seif 1991:1102

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In other words, the encounters are ideally structured to be tension free and affectionate. In these encounters, patients' will not have their faces blown into to force them to be quiet while removing blood nor will they be “poled” to receive the anesthetic that stops their bodies from functioning. These actions would directly challenge the definition of a humane death. From the perspective of the institution, for a humane euthanasia, there must be a pleasant and stress free atmosphere to diminish the fear of the patient. Euthanasia will ideally appear as if the patient is falling asleep to control the definition of the situation for clients and staff as in the patient’s best interest.245

*Pediatrician*

If the veterinarian present in the context of euthanasia of “suffering” patients is Doctor Curtis (the pediatrician), human-feline encounters are notably affectionate despite the lack of reciprocation by the patient. Staff members, clients, and doctor express this affection through gentle moves, soothing caresses, and soft whispers of empathy such as “I am so sorry buddy” and “it is ok...it will be over soon” or “poor baby.” While tension exists for staff members and clients as they experience the behavioral manifestations of the patient (defined as obvious suffering), this tension is a slow and melancholic acceptance of the “necessity” to end a patient’s life. In other

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words, in these cases, euthanasia itself does not cause the tension, the patient’s suffering does. This finding is significant because it challenges the assumption that euthanasia universally presents tension in the lives of those humans present. I provide the encounter below to provide evidence that it is not the death of a patient that causes tension in this context, but rather the suffering. Moreover, it helps provide evidence that encounters with “suffering patients” with Doctor Curtis are melancholic and affectionate. Once staff members agree that a patient is beyond medical care, there is a general sad acceptance of the necessity to end a life. The patient, in this case, despite being highly contagious is treated with the utmost affection and kindness.

I come in today and some of the staff members are trying to save a kitten diagnosed with distemper. The kitten “Charlie” is unvaccinated. Doctor Curtis and other staff members pay a great deal of attention to him; constantly speaking in soft soothing tones, stroking him and moving very gently around him. Although I feel bad that he is in such pain and note that it is important to comfort him through affection as other staff members are doing, I do not touch him. Distemper is very contagious and can live outside of the host body for a long time. I can’t risk bringing it home on my clothes and spreading the disease to my own cats. I did speak softly to Charlie while Marcie holds him and rocks him. Doctor Curtis and Marcie bring him into the prep room and try to give him fluids. “We have to get some fluids into him...Marcie hold him up for me...gentle...ok.....it is ok there...come on honey...” The patient whines and tries to squiggle out of Marcie’s grasp as Dr. Curtis tries to place a needle in Charlie’s throat. I ask Doctor Curtis what he is doing. He explains that he can not place Charlie on an IV because he is so little and it would explode his veins. After two unsuccessful attempts, Doctor Curtis puts the needle down and says while shaking his head, “this kitten is just not going to make it.” Marcie wraps Charlie in a blanket and then holds him close to her chest. “I can’t force him to keep taking liquids...I don’t want to stress him...scare him...We are going to have to euthanize him [he looks at Marcie] go ask Lisa to call the client and explain the situation.” 

The client (a CAT representative) arrives shortly after the phone call. I can see that she is visibly shaking. Doctor Curtis enters the reception area to greet her. He is holding the patient like a baby wrapped in a blanket against his chest. “How is he?” Asks the client as she moves into the reception area and looks down at the patient. Doctor Curtis rocks him back and forth, as he speaks to the client. “Not good. His condition is worse: I would suggest that we intervene via euthanasia.” She nods “I agree. He should be put to sleep to end his pain....[she stops and looks at the doctor with a gasp] What about my other rescues?” The client and doctor discuss the distemper virus and how it seems to have spread lately. He laments that the kittens
are not vaccinated and the client’s eyes begin to water. He then quickly points out that the virus is hard to kill. He explains that the vaccines for distemper have to keep changing to keep up with the “hardy virus” because it has such a long “shelf-life” and “it produces many strains.” She nods and looks at the patient, “the best thing to do, I agree, is to put it out of its misery.” Doctor Curtis nods and looks down “well, actually, I think that he may have already just passed in my arms.” He carries the patient into the prep room and slowly unwraps the blanket from around his body. He listens with his stethoscope to the patient’s chest. After a few minutes, Doctor Curtis lets out a deep sigh. “Yep, he’s gone.” Marcie sighs and nods. Doctor Curtis leaves to inform the client. As soon as Doctor Curtis leaves the prep room, Marcie turns and leaves the prep room. Nell stands by the body. When Marcie returns a few seconds later she is carrying a black plastic bag. She holds the bag open while Nell quickly lifts up the patient and puts him into the bag. Marcie ties the bag shut and puts the bundle into the freezer. Nell goes to the sink and washes her hands. I ask Marcie “what happens to it now?” She explains to me that animal control picks “it” up and disposes of the body. Burns “it.”

Although I pointed out earlier that patients are rarely “objectified” in the Loving Care Cat Hospital, here is one interesting case when one is. It is important to note the variable change of reference (from “he” to “it”) employed by individuals as we talk about the patient. The client uses the referent “he” when she walks into the hospital, “how is he?” He continues to be a subject as she makes the decision to “put him to sleep.” Her referent changes, however, after she has already made the decision, and indicates that the doctor should not wait any longer to “put it out of its misery.” This is often discussed in sociological research as a “distancing technique.” The analysis might suggest that the emotional impact of her decision is lessened by his objectification.246 The use of this technique by the client lends credit to empirical research suggesting that humans often objectify ‘other’ animals to distance themselves – to block “sympathetic opposition.”247 -- from ‘other’ animal’s suffering

246 She also uses the euphemism “to put to sleep” which Arluke & Sanders’ (1996) suggests is another distancing technique.
when engaging in “problematic practices.” As Iris Murdoch (1971) suggests, “the more...[it is] seen that another...has needs and wishes as demanding as one’s own, the harder it becomes to treat a person as a thing” (66). In this way then, the client objectifies the kitten to kill “it.” It is important to point out though that the analysis of such behavior usually refer to people within social institutions set up to “exploit animals” rather than care for their physical and emotional needs. The client does not “objectify” or “distance herself” from the patient’s suffering, she focuses on it to make the decision to euthanize. Moreover, the objectification comes after she has already made the decision. It might be safe to infer then, that objectification is not solely employed to engage in “problematic practices” but also employed by some participants to psychologically armor (Eisler 1986) the self from what McMillan (2001) refers to as the “unintended consequence” of euthanasia; the impending death of a subject. The objectification in this case is used to diminish the emotional impact during the grieving process rather than prior to it.

Individuals have different ways to deal with the impact that death has on their psyche. Marcie and I refer to the patient as an “it” after the patient has stopped breathing. In essence then, we reinforce our definition of the patient as a “subject” while alive. He is no longer a subject after he dies. However, anecdotal evidence suggests, that humans in the United States do not refer to a human body in a casket as an “it.” In this way then, the bouncing between subject and object when referring to “other” animals is just a cultural manifestation of the ambiguous place that felines

have in American society; somewhere between personal property and loving companion.

It is interesting that Doctor Curtis, never employs this objectification, “...he may have already just passed...” However, the subject is no longer here, “yep, he is gone.” In other words, he is somewhere else...not in his body. He does not refer to the body, however, as an “it.” Possibly, death, especially one that results in the necessary termination of suffering, is not as problematic to him because he has spent a considerable amount of time during his veterinary education experiencing it; so he simply does not need to engage in this “distancing technique.” Regardless, this lends itself to further empirical investigation. What further conditions (outside of the emotional consequences of death) are more or less likely, in caring institutions, to promote the objectification of beings that participants once considered subjects?

Patient Age and Social Status

It is significant in these cases, to point out that both patients (Tess and Charlie) are rescue kittens. In the context of the euthanasia of a companion kitten, the encounter is notably similar for staff members and clients. The staff members offer affection toward the kitten, and while the client is disappointed and saddened by the loss of life, little observable tension is derived from the euthanasia. For example, when the clients are informed that the doctor suggests the euthanasia of one of their kittens (the kitten with his “guts hanging out”), the clients respond, “of course, right away...poor

\[249\] Arluke & Sanders (1996) argue that the focus on an ‘other’ animals’ suffering, by shelter workers,
little kitty...he must be in pain.” When Marcie is informed that it is ok to go ahead with the euthanasia of the kitten while Doctor Curtis tries to “save the momma,” she wastes no time. Below is an excerpt from my autoethnographic field notes about this euthanasia. Note the difference in expressions by Marcie and myself. Remember that I do not define this as an automatic euthanasia while she does.

As Marcie prepared the “solution,” I pet the tiny kitten’s head and whispered to him “I am sorry....I am so sorry.” I felt so bad for him. He seemed to be struggling so hard to stay alive that it felt unfair and cruel to take away his right to struggle. They don’t know that he might not live a decent quality of life. Anyway, maybe he would rather live a poor quality of life than die before he even gets to touch his own mother. I fed him before Marcie was told that she could euthanize and he ate, despite “his condition.” He was trying so hard to hold his head up too. I felt like crying as Marcie moved over to inject him with the anesthetic, “he is so small, just a little bit is all he needs...[she looks at me and seems to notice that I am upset]...he is in pain Dana... “Aren’t you little guy? I am so sorry it had to be like this, baby.” She injects him and strokes his face gently as he stops breathing. When I looked at Marcie, she seemed relieved.

None of the staff members or the clients are particularly upset about the euthanasia of the kitten. In fact, when Anna enters a few minutes after the above encounter, she asks if the kitten has been “put down” yet. When I nod, she says, “good” and returns to her prior task of answering client questions in the reception room. In any case, the euthanasia of both companion and rescue kittens that are suffering are associated with encounters that have only a slight degree of tension (brought on by the patient’s suffering and not the death of the patient).

Because of the similarity of these three encounters, one might infer that because CAT clients are preparing to adopt the kitten out, that they hesitate to bond with a patient. Moreover, the younger the patient, the less time that either types of clients is a tension management strategy used to engage in the practice of euthanasia.
have to develop a bond with the patient. In their empirical review of 132 case histories of clients who had been referred to social workers by their veterinarians, Quackenbush and Glickman (1983) observe that “pet-owners” are significantly more likely to attend social work intervention for their grief over the loss of an older companion. In their discussion they suggest:

Another important dimension of the human-companion animal relationship is the age of the animal at death, or, more specifically the length of time the owner and the pet have been together. The longer a person and a companion live together, the more likely it is that their relationship and interdependency will grow stronger and deeper.

This lack of bond, developed through time, then may be a factor involved in the relative lack of tension that clients’ experience within encounters involving the death of kittens. In fact, the euthanasia of companion adults is associated with high tense encounters for many clients. Sometimes this tension reaches beyond the grave.

I am sitting behind the reception desk speaking with Victoria when an older woman walks through the front doors carrying a carrier. She smiles at us and silently sets the carrier down on the floor. She opens the door, “come on out, you.” As the woman stands up, she holds a lean orange cat against her chest. The cat reaches up and paws at the necklace dangling from the client’s neck. It is a slow day, so rather than ask the opening question, Victoria punches in the client’s name [which she apparently knows from memory] on the computer. I look at Victoria and ask, “I thought that the patient’s name is the name in the computer.” Victoria nods “well, yes...but you can access it this way too...see here [she points to the screen] the patient’s name is right here.” Victoria looks up at the client with a grin “So, Misses is here for a checkup?” The client’s face looks stricken and then it turns red. Suddenly, the client bursts into tears and she puts her face in the cat’s fur. Victoria looks again at the chart, seeking for answers as the client looks up again and speaks through her sobs, “No...this is a...new member...of the...family.” The client’s voice gets quieter and she says in a barely audible voice “Misses was put to sleep six months ago.” Victoria apologizes and mentions that she sees it on the chart now. The woman sniffs and holds the cat in her arms tighter; the cat begins to purr and she smiles at him or her. “I know, I just can’t bear it...you know...she was so old and sick...you know and I tried everything to keep her comfortable and happy...and then she was dying.... And I just seem to burst into tears whenever I think about her or hear her name.”
While the loss of a companion can be considerably stressful for some clients who are considering the euthanasia of their loved ones, encounters associated with Doctor X appears to exacerbate that tension. In the field note excerpt below, I point to the extreme worry that the male client experiences as he waits for a "second opinion" on the fate of his cat, Fluffy. This concern appears to be aggravated by Doctor X's silence or lack of social support. The client's former veterinarian suggested that they euthanize her because she appears so sick. Rather than follow up with the former veterinarian to confirm her diagnosis of terminal illness with medical testing, the clients decide to come to another clinic, hoping that the doctor will arrive at a differing definition of Fluffy's behavior.

Doctor X stops at the door of exam room one and picks up the chart. He looks over the chart and I walk over. He nods at me and mumbles something into the chart before he enters the room. I follow and take my usual placement in the room: against the right wall. Both of the adult clients look at me puzzled for a second and then they smile. I smile back. The child is standing between the legs of the adult female and trying desperately to reach the patient despite the frequent slaps to hand by the female client. The man looks over at the child, then at the woman and then at the patient. He moves in closer to the patient who is sitting quietly on the exam table with wide eyes and seems to pet the patient for her. When the man's hand touches the patient, she twitches her back then looks in the direction of the touch. She sniffs the man's hand and turns her head up to look at his face.

Meanwhile Dr. X is examining the chart without speaking. His only indication that he recognizes the client's presence is a nod as he enters the room. For what seems to me to be a long time, the doctor looks at the chart while the woman and the child struggle over the child's outstretched hands toward the patient. The man shifts his weight back and forth while stroking the docile but wide-eyed patient. We all jump slightly \[including the patient\] to attention when Dr. X finally speaks.

"Well, it says here that you are coming in for a second opinion. That she is not eating too much and has changed her behavior and seems to be having trouble breathing?"

The man begins to speak and is interrupted by the female client. "That's right. She used to like to hang out around us more...but lately all she does is hide out in the basement.../don't do that and sit still \[to child\]/ ...and she is not playing or licking the other cats anymore...she just stays away from everyone now." The woman looks
at the patient who does not look in her direction at all but rather watches the face of
the doctor while leaning into the male client’s hand as he strokes her.

The man speaks up once the woman stops speaking, “and we can hear that she is
having trouble breathing.” The doctor looks at the patient but does not touch her.
He looks at the woman “could be an upper respiratory...let me see.” He slowly
reaches toward the patient who sits immobile but cringes as Doctor X touches her.
The man continues to pet Fluffy and begins to speak incessantly while the doctor
feels the patient’s lymph nodes and looks in her ears and eyes – the male client talks
about the change in behavior – repeating what the woman had just stated. The male
client also talks about the other cats and how long that they have had this one and
how she had gotten along so well with the other cats and how he is so worried about
her that he just had to get another opinion “we can’t just...you know...[in a
whisper]...let her go without a good reason.” He spoke so fast all the while stroking
the patient and looking at various individuals in the room. Once in awhile he would
stop and look at the woman and wait until she indicated agreement either by nodding
or saying “yes” or “mmhmm.”

After Doctor X completes his look over of the patient while intermittently
offering eye contact to the male client, he stares at the patient for a few seconds and
pulls on his stethoscope. He waits stethoscope in hand not giving the male client any
eye contact, presumably for the client to stop speaking. Once the client realizes that
the doctor is no longer looking at him at all, the client directs his conversation to me.
Doctor X begins to listen to the patient’s lungs. He stops after a few seconds, sighs
and looks at the client who is speaking to me and petting Fluffy. Doctor X, sighs
again and moves the patient slightly away from the man. The client lets his hand
drop and moves closer to me to tell me about how much he loves his cat, how she is
a “part of the family” and he hopes that she is ok. The doctor lets out a loud sigh and
looks at the man for a second before returning the stethoscope to Fluffy’s chest.
Fluffy begins to shake violently and she looks at the client before trying to inch her
way away from the doctor toward the male client. Doctor X brings her closer to him
again and looks at the client with an even louder sigh.

The client, finally understanding the doctor’s nonverbal clues to be quiet, stops
talking in mid-sentence. For a minute there is a heavy silence in the room [the child
has given up and is now sitting still on the woman’s lap]. The male client continues
to look at the patient, then at the doctor and then at me. He appears to be holding his
words on the edge of a cliff, and before the doctor is done listening, can not hang on
to them anymore. He returns to his constant and rapid speaking. Doctor X ignores
him and I notice a slight grimace on his face when the man begins to speak again.

I am certain that the doctor is concerned about the patient by the extra long
examination and furrowed forehead. He slowly puts his stethoscope down and backs
away from the patient, which indicates to the client that he is through with the
examination. The male client immediately moves closer to the patient who moves
her body as close to the client as possible but continues to watch the doctor.

Doctor X picks up the chart and looks at it for a few minutes saying absolutely
nothing. The clients are now both shifting uncomfortably and looking at me with an
obvious question in their expressions. The man begins to speak again...this time
about how good the patient was in the car and how she used to make them laugh
when she was younger and how the patient would “snuggle up with [him] when [he] was upset. After speaking for a few minutes — he stops abruptly and looks at the
doctor. Doctor X looks up finally and asks a simple question. The question makes
my stomach drop. “I see she has not been vaccinated against Feline Leukemia Virus.
Has she been tested for Feline Leukemia Virus?” The male client’s face drops and
begins to turn red and he grabs on to Fluffy. The woman answers, “No, the other vet
said that because her mom was tested and was negative that there was no need and/"
The man interrupts "and we don’t let her outside so she can’t have it you know…it can’t be that."

Doctor X looks at the patient who is looking from the man to the doctor as she leans even closer into the client’s body and then looks up into the man’s eyes and meows in a raspy voice. “Well, I would suggest getting an x-ray of the lungs to see why she is having such difficulty with her breathing and running a blood test to rule out feline leukemia virus.” Despite that, the doctor is looking at the man, the woman answers. “Yes, do what you need to do to find out what it is. We can come back…right? We have to drop [child’s name] off at school.” The male client’s face has now turned a deep shade of red and he continues to look down at the patient his eyes blinking rather fast. Doctor X nods and informs them that he will send someone in to get the patient and that they could come back later.

When we walk out, I look over at Dr. X and note that his face is furrowed. “I couldn’t listen to her heart when he was talking -- I was getting pretty frustrated.” I smile and say, “I bet! He sure talked a lot didn’t he?” Dr. X sighs and then smiles at me for a second. Then his smile drops as he states, “I can’t believe people sometime! And that doctor ought to know better really. [Then in a more sarcastic tone of voice] No need to test her because her mother was negative when they tested her! The doctor should have known better and they have other non vaccinated cats at home….” He shakes his head and walks away.

In this encounter, the human participants are notably tense and reciprocal affection is noted between the patient and the male client. Note too that, similar to preventative health, Doctor X is focusing on the medical problem of the patient. The clients are considerably tense. Their tension is most likely due to a combination of factors. First, there appears to be a strong bond between the male client and the patient. The male client is concerned about the loss of that bond through the loss of his loved one. Doctor X makes little attempt to control the client’s tension. His focus is on the medical case before him. The lack of social support by the doctor appears to increase the male client’s tension, evidenced by the client’s increased rocking and incessant talking to fill the uncomfortable silence. The client’s talking, during the examination frustrates Doctor X. The client is hindering his ability to do his job. In other words, his tension is derived from the client’s failure to comply. If the reader recalls the case under the context of preventative health, while Doctor X is more distant and
experiences tension himself, he has little impact on the degree of tension for clients. Within the context of uncertainty over the fate of a loved one, however, his lack of support has a significant impact on the degree of tension experienced by the clients.

Dr. X is not only associated with a higher degree of client expressed tension in the context of uncertain fate, but also patient tension. Similar to the above encounter with Fluffy, in the context of determining the health status of a young kitten, for example, Doctor X’s lack of social support increases the degree of tension of both patient and client.

As we enter the exam room, Dr. X and I encounter a young Hispanic female who is smiling as she watches a kitten wander curiously around the room. The kitten named Blue, approaches me with his tail up and leans against my leg. I bend down to pet him. He then approaches Dr. X. Dr. X looks down at him but does not touch him. The kitten scoots back over to the client who is still sitting on the bench and jumps into her lap. He rubs against her chin and she laughs and pats his head. Meanwhile Dr. X is examining the patient chart in silence. Blue jumps down again to sniff the corner. Dr. X clears his throat and the client’s smile fades. He asks her some questions about the purpose of their visit. She explains that he is losing weight and not playing or cuddling as much as, he used to and she just wanted to check him out. Dr. X nods and looks at the patient. The client looks over at the patient as well. Blue comes over to me and I pick him up and place him on the table and smile at the client. The woman stands up then, and holds Blue.

As Doctor X approaches Blue in silence, Blue cringes and then backs up into the client’s waist which she has leaning against the counter. As Doctor X feels Blue’s lymph nodes and checks in his ears, he asks the client if she has noted any vomiting or diarrhea. The client explains that no she had not but “come to think about it, he is not eating and drinking as much as, he used to and she just wanted to check him out.” Dr. X nods “It might be the flu, but I don’t see any sniffling or runny nose, so I am not certain.” She nods and holds Blue tighter as he is trying harder to get away from Dr. X. Dr. X stops examining Blue and Blue moves closer to the client looking up at the Dr. with wide eyes. “Where did you get him?” The doctor asks the client.

“From animal control.” She states.

“How long ago did you bring him home.” She explains with a breathier voice that it has been a couple of weeks. Doctor X nods and stares at the patient silently for a minute without touching him. The client begins to look from Dr. X to me. Then Doctor X reaches for Blue, picks him up, and feels his abdomen. Blue struggles, and begins to meow as Dr. X turns him around and looks at his anus. Dr. X remains silent as he does this and the patient struggles harder and tries to reach for the client. The client shifts back and forth and starts to look worriedly at the patient and at Dr. X. After a few minutes of silence the client asks him, “why do you want to know where I got him from?”
Doctor X looks up and states plainly, “well, animal control has had an outbreak of distemper and I am concerned about the fact that he is losing weight when he should be gaining...and his behavior change is different. It is possible that he has distemper. But we have not finished running the fecal yet and he could simply have worms.” The client looks confused and a bit more anxious. Dr X does not explain what distemper is. After he silently finishes the patient’s exam, he excuses himself, explaining that he has to check the status of the fecal.

When we return to the exam room, I note that the client’s eyes are red as she snuggles with the kitten on her lap. When the patient sees us, he jumps down from the client’s lap and hides on the left side of her feet. She looks up at Dr X expectantly. “Well,” he says, “it is not worms.” Her hopeful expression falls and Dr. X quickly states, “He could just have a slight flu is all – lets hope for that.” She nods and looks down. Dr. X looks at the chart as he asks the client, “is your other cat vaccinated for distemper? We ought to be on the safe side just in case. I think it says here that he is overdue.” The client looks up sharply and then says, “Yes, he is. What is this distemper?” She asks hesitantly.

“It is a virus,” is all that he says.

“Yes,” she says, “but is it deadly?”

Dr. X looks at her with a blank expression, “Yes it is. And contagious.” The client quickly looks down at the patient, at me, and then at Dr. X before her eyes drop to the floor. Her face begins to turn red and I can see tears falling down her cheeks. “I have to bring in Henry right away don’t I? Do I have to keep them separate?”

In both of these encounters, the male client with Fluffy and the female client with Blue become increasingly tense as the encounters unfold. Note too that both patients’ tension also increases. Granted, the tension in these specific encounters could be a result of the client’s concern over the patients. The patient’s tension could also be a result of the increased tension that the client experiences. Interviews of “pet-owners” conducted in a veterinary hospital suggest that many “pets” appear to recognize when their companion human is upset (Belk 1996).²⁵⁰ Note too that the client in Fluffy’s case, points out that in the past she would “snuggle up to me when I was upset” indicating that she has an awareness of his moods.

²⁵⁰ See also Sanders (1993) and Alger & Alger (1997) for similar accounts.
In sharp contrast, Dr. Curtis’ role is more often associated with lighter and all around affectionate encounters—even when the topic of conversation is the possible death of a loved one.

Dr. Curtis and I walk into exam room one and greet the middle-aged white female client and her 14-year-old female “companion,” Maxine, who is sitting quietly in the middle of the exam table while the client absently stroked her neck. After initial greetings, the client explains that Maxine had been “letting herself go.” She is grooming less and is getting “up” in age. The client whispers to Dr. Curtis, “not that I want to...you know...but...when is it appropriate to let her go...I don’t want her to suffer...you know...be in pain...[then she raised her voice again to a normal tone] and she is having trouble getting enough food...she lets the other cats bully her...they keep eating it all...[she looks down at Maxine]...Mom had to move your food bowl into the bathroom didn’t I? You like to eat alone now don’t you, so you could eat in peace.” When the client addresses her, Maxine looks up with her ears forward and purrs a bit. Dr. Curtis says, “Well, let me take a look.” He speaks to Maxine while he looks into her mouth, “that’s a good kitty” and feels her lymph nodes, “what a nice kitty.” Then he pets her for a second before listening to her heart with his stethoscope. Maxine sits still while he examines her and purrs when he pets her. The client is quiet as Doctor Curtis listens to Maxine’s heart. After he is done he pats Maxine on the head. He looks at the client and smiles. “Well, her heart sounds good.” The client smiles and they begin to talk about old cat antics before returning to discuss other symptoms....

Doctor Curtis’ role, as pediatrician, tends to put many clients and patients at ease. Many clients appreciate direct communication with the patient as well as themselves, and patients appear to be calmed by it as well. It is not my intention to assert that one role is “better” than the other role is. Nor is my point that Dr. X cares any less about patients or clients than Doctor Curtis does. In fact, from working with Dr. X, it becomes clear that as he stares at the patient he is concentrating on the medical problem, trying to find solutions, rather than divide his concentration between the medical problem and the comfort of the other members of the encounters. It is simply that, in many encounters, the mechanical role is more often associated with tension in ambiguous situations such as euthanasia.
Once the socially defined ambiguous situation is gone, once consensus about euthanasia is reached between client and doctor about the “only” course of treatment (euthanasia), the encounter with Dr. X continues to be tense but the client’s tension changes in type from nervousness to grief. Staff members, however, lack a significant degree of tension. In the encounter described below, Fluffy’s family is to find out that the medical tests confirm that she has FeLV. In this encounter, I play a less observational role in the client’s absence. The lack of affection offered by staff members is so significant in this case that I offer the patient affection where I can – including attending Fluffy’s death.

Fluffy is scared and it is made worse by client’s absence. When Fluffy is brought to the prep room, she begins to cry and shake violently as the staff members methodically take her x-rays, remove blood, and shut her into the isolation closet without any affectionate displays. Her test is found positive. I stand in front of the isolation closet as Ezra tells me the results. My stomach drops as I listen to Fluffy howl....

...Nell pokes her head around the door to let Dr. X know that the clients “are waiting in exam room number one.” Dr. X asks her if she told them about the test results. “No way” says Nell. Dr. X tells her that she can tell them if she wants -- not to try to hide it from them or anything. “That’s ok.” She says, “they are already in the room.” He sighs and finishes up the last declaw. I stay very close to him because I don’t want to miss this consultation. He asks if I am ready. I take a deep breath and say “yep.”

He walks briskly into the room. Fluffy is already in the room with the clients. The child is not with them. Fluffy is in the man’s arms and he is quietly speaking to her. She is looking up at him. When we close the door behind us, the man gently places the patient on the exam table and looks over at the doctor. The male client is silent, which is a sudden change from last visit. The female client is sitting in the same spot as before watching the man. She slowly looks at the doctor too. “Well, I am sorry to say that her test is positive, she has feline leukemia virus. From her x-rays, she also appears to have a rather large growth in her lungs which accounts for her trouble breathing.” While he says this he looks back and forth between the two clients, he does not look at the patient at all. The man’s face drops and then begins to turn red, he looks down at the patient, and she looks up at him and meows. The woman says “well, we kind of expected something like this, didn’t we?” She looks at the man who is now stroking the patient while his face is becoming progressively more ashen. He nods mutely. I am holding back tears now, determined to focus on the research aspect of the interaction so I do not miss anything. Doctor X shifts back
and forth silently for a second. The patient meows at the man and then pushes her face into the crook of his arm. He sniffs.

The doctor says, “well, do you want to see the x-rays of her lungs? It will help you make a more informed decision of what to do next.” The woman says immediately, “yes, we want to see them.” The man says nothing and picks up the patient, holding her very close and she rubs her head against his chin. Doctor X opens the door to the back room and leads the clients out. We are silent as we take the couple steps to look at the x-ray board that already has two x-rays hanging on the front. The doctor turns on the light. The woman stands in the middle with the doctor on her left and the man holding the snuggling patient on her right. I take a place on the far right -- next to the man and Fluffy. The doctor explains to the clients as he points to the x-rays “Do you see this area right here? These are her lungs. And this large dark mass, this is the growth that is obstructing her breathing.” The woman nods and says “mhmm” while the man clutches the patient tighter and looks down at her. The doctor continues, “as you can see from this area right here [pointing to a much smaller lighter area on the x-ray] this is the part of the lungs that she is using...not much.” He waits for a second.

The woman looks at the man. “Well, it’s your cat what do you want to do?” The man looks down at the patient who meows up at him. His body starts to tremble and he puts his now very red face in the patient’s fur. I can see that his eyes are watering. I am trying desperately not to cry. Doctor X looks at the man, shifts from side to side, looks at the woman then back at the x-ray. He says “I can give her a shot of steroids...you know to make her have a better quality of life for a few days...and you can bring her home and say your good-byes if you would like. I think that would be a good idea.” I wonder if the doctor is thinking, as I am, about the child who tried hard to pet the patient and was not allowed to by the female client. The woman looks at the x-rays and then at the man.

“No, I think that we already did that, we sort of thought it might come to this before we came here...and... Well...I really don’t want to further expose the other cats to it by bringing her home...I think that we will just [she stops abruptly and she looks at the man who is still clutching tightly to the patient but is now staring at the x-rays] it is really up to you it is your cat...want to bring her home for a few days or do you just want to put her down now?” He says nothing. The doctor looks at the woman and says “do you want to stay or...well...do you want the body?” I notice that the man’s body has begun to shake a bit more with the word body. The patient meows and looks around at the word body. The doctor shifts uncomfortably and moves in the direction of the exam room. We all follow silently. After taking our positions, the woman now standing next to the bench, the man in the middle of the counter, me at the wall and the doctor in his position on the opposite side of the counter. “Well, what we will do is give her an injection that will make it like she is just falling asleep then, we will give her the other one and she won’t even realize what is happening. Then we will bring her out to you, unless you want to stay?” The woman looks at the man. “I really don’t want to see it. I have seen this kind of thing before and it really is not something that I want to see again.” She looks at the man who has set the patient down on the exam table and has begun to stroke her head with both hands. “You don’t want to be there do you?” He again says nothing and she looks at the patient who has begun to tremble looking up at the male client’s face. The patient meows and moves as close as possible to the male client. His eyes began to water and he puts his face very close to hers. The woman reaches over and pats the top of Fluffy’s head, grabs her chin, and forces fluffly to look at her face “you have been a good kitty.” The patient moves away from her as soon as she lets go and pushes herself closer to the man’s arm. The man looks down and says, “I love you. I am soo sorry, Fluffy. [then more choked up] Good-bye.” I was so
engrossed in the patient-client interaction that I had not even noticed that the doctor had gone out to get the injection and had already come back in. “Do you need a few more minutes?” he asks. The man shakes his head while stroking the patient, his eyes watering. “Ok, then you can wait outside and I will bring her out when we are done.” Fluffy looks around wildly for a second then looks back at the man and howls. The woman grabs the man’s shirt and he turns and begins to walk out. He stops and takes one last look over his shoulder before he leaves the room. The woman closes the door.

I am getting the feeling that I am in some surreal drama. I feel sick to my stomach and am glad that I had not had to go through this experience too often. I feel that it is my obligation to the patient to “be there for her” since the clients would not be. I feel anger toward the woman because I have the impression that she is the authority in the family and that the man really does not have much say in the matter. I wonder if he wanted to be here. I hope at this point that Dr. X will allow me to help. I move toward the patient and hold her in place. She doesn’t seem to be trying too hard to go anywhere. She looks alertly around the room while I stroke her head and look into her eyes. I guess that the other staff members are probably more than willing to let me hold the patient while the doctor does the injection because I do not notice them come in and “take over” like they have in the past — with other procedures. I watch as the doctor picks up the syringe and think how strange it is that in a second this alert and alive being will be dead. I stroke Fluffy’s head without a word.

The doctor injects her as I hold her in place all the time watching her eyes very carefully. I expect her, like other patients I have watched being euthanized by Dr. Curtis, to slowly stop moving while her eyes dim. I expect her to fall unconscious before dying. My expectations are wrong in this instance. One second Fluffy is looking around alert and the next her body just deflates like a balloon is popped. She is dead almost as soon as the syringe is fully depressed. I feel sick. It is so unreal — unexplainable. I look quickly at Dr. X who has his stethoscope already in his ears, listening for a heartbeat. I wait while he listens. “Gone.” He says. “How come it happened so quickly…was she that sick… was it because her lungs were so full?” He shrugs. “I must of hit a vein.” At that he turns and walks out. Nell comes in with a box. I look at the stiffening body that was alive, animate only two minutes before, and walk away.

I walk out to the reception area and watch Nell bring the box holding the now deceased Fluffy inside of it. The man’s eyes are swollen and he takes a deep breath when she hands him the box. He begins to cry. Doctor X is standing behind the counter. He says, “I am sorry” when he looks at the man. The woman nods at the doctor, thanks him and leads the male client, carrying the box, out the door to their car. I notice that the man’s shoulders are shaking when he waits for the woman to unlock the rear car door. The clinic is eerily silent.

This encounter is extremely significant in a number of ways. First, Fluffy’s tension increases significantly without the presence of the male client. Moreover, she appears to only reciprocate affection toward the man; lending credit to an assertion made by Lagoni, Butler, and Hetts (1994) and empirically supported by Voith (1981)
and Serpell (1986) that sometimes, individual animals will become attached to individual humans. This attachment can cause tension in the lives of animals in the absence of those whom they are attached to.

Separation anxiety occurs when social animals are involuntarily separated from the individuals to whom they are attached. During the separation, they show signs of separation distress. This distress is, in fact, one sort of evidence that an attachment exists.

It is obvious to me that Fluffy and the male client are attached or what other researchers refer to as "bonded." While Doctor X's presence fails to reduce tension (even appears to increase it) in human-feline encounters within the context of ideological ambiguity, it is the social bond between Fluffy and the male client that fosters his grief and her fear. For me, I had no bond with the patient. My tension was derived from the lack of affectionate displays by the staff members – in part influenced by the role that the doctor played. If the reader recalls, the same staff members were considerably affectionate toward patients slated to be euthanized in the presence of Dr. Curtis.

Also, note the lack of question regarding whether or not Fluffy would die at home naturally or be euthanized by Dr. X. Doctor X used the x-rays to help the clients "make a more informed decision" about what to do next and even offers to provide steroids to help Fluffy with a "better quality of life," if they do bring her home. However, he appeared to assume that the clients would bring the patient back, after they have "said their good-byes." The assumption remains that a patient is better off dead at the hands of humans than spending her last days suffering from the elements.
of disease. The female client noted this and decided, understandably so, that her other cats should not be “further exposed to the virus.” However, although she asked the male client what he wanted to do—“it is your cat”—it seems to me that she had already made the choice for him and Fluffy.

Finally, I wish to point out that the manner in which the patient died is highly significant. In all the other euthanasia that I attended during the process of this research, as well as the four personal euthanasiass (two cats, one dog, one horse) throughout my adulthood, the patients appeared as if they were falling asleep. Their body becomes droopy, their eyes heavy and slowly they stop breathing. Fluffy’s euthanasia was particularly dramatic, because the medical masking technique was absent. Without this masking, the power and control over life and death that humans use over other animals becomes glaringly evident. Masking the reality of this control serves two functions. One, it “protects” the clients and staff members from the emotional impact, not just of death, but one that is controlled and served to others “in their own good.” Two, it protects human’s ability to control and dominate other species without question, because it is done in a “humane” way.

When Practice Ideology Conflicts

The institutional ideology of euthanasia is powerful; many human participants believe that control over the deaths of felines, as long as it is done humanely, is needed to preserve a patient’s quality of life. However, when euthanasia is practiced for reasons outside of this ideological box, control over the lives of felines becomes
too obvious. As I stated earlier, many staff members and clients disagree about when euthanasia is legitimate. In my opinion, these participants are struggling with the everyday awareness that they have the power over feline life. Similar to the context of declawing, encounters within the context of ideological conflict over the practice of euthanasia are associated with a higher degree of tension for staff members. This degree of tension depends highly on where along the ideological continuum the euthanasia falls.

Economic Ability to Pay

When the fate of a sick patient is uncertain, and clients are trying hard to “pay the bill” before making the terminal decision, staff members empathize with both patient and client and express affection toward the patient and experience some tension. The patient is sometimes both affectionate and tense depending upon how they feel and the presence of the client. Clients in these situations are typically both affectionate and highly tense. Tension increases for both clients and staff members when the cost of the medical bills constrain the human participants to balance their obligations in the interest of “saving” the patient’s life.

I now turn to another story. Niko’s story best exemplifies how the caring practices and relations in the field are affected by the economic context of the veterinary hospital. This story reveals the reality that human and ‘other’ animal relations exist within an economic structure that materially constrain and enable participants to creatively navigate social action within that structure. The structure pushes
veterinarians (many of which really want to provide the very best care to patients) to charge for their services. As such, this social context has a profound impact on the everyday encounters between humans and felines. Sometimes clients need to make difficult and emotional decisions – decisions that would not exist had the health care been available to them without cost. This necessity belies the economic structural inequality existing between clients (some clients can afford to provide the “best care” and some simply can not) as well as between patients. In the end, however, the patient loses out. In an institutional and economic structure that accords less value to ‘other’ animals – they are animals – why ought they have the right to health care?

A patient is brought in today because he is acting lethargic. According to the client (a very pretty well dressed young white woman), Niko [patient’s name] was gone for ten days and came back acting sick and exhausted. She looks concerned, but smiles as she leaves him Dr. Curtis’ “loving care.” She pats Niko on the head and tells him that she will “be back tomorrow.” When Dr. Curtis brings Niko into the prep room he says to Marcie, Nell and me, “Niko is usually a very temperamental cat...very wiry and active too...now look at him...” Niko is barely able to move as Dr. Curtis puts him in the cage. Dr. Curtis addresses Marcie who is standing at the prep counter filling syringes. “I can’t figure out what is wrong with him. It could be a neurological infection, rabies, distemper or body trauma...the blood work came back normal and his breathing and heartbeat are ok...no signs of fractured bones...” He tells me that they are going to send some more blood to the laboratory to check for other ailments. They put Niko on an IV, give him antibiotics, and decide to monitor his condition. Dr. Curtis looks in at Niko, laying still in the cage, “Ok, Niko...I am going to do my very best to figure out what is wrong with you.” Then he looks at Marcie and states, “my goal for today is to save Niko.”

In this encounter, the client is relaxed and places Niko in Dr. Curtis’ “loving hands.” She trusts that he will come to a medical determination of Niko’s condition quickly and draw from his medical knowledge to help him to get better. Dr. Curtis’ is affectionate to Niko and pronounces that his goal is to “save him.” Outside of ending suffering, saving lives is the veterinary institution’s main goals.
The next day, Niko is doing a bit better and the staff members take him off the IV. Niko still cannot sit up however. He tips over or sways when the staff comes by and sits him up. Marcie stands by Niko’s cage and stares at him with a worried expression. She opens the door and strokes him “poor baby...what is wrong with you?” Victoria comes in soon after and she and Marcie discuss his condition in worried tones. When Dr. Curtis enters, Marcie, Victoria, Lisa and I are standing in the prep room looking in at Niko who is looking at us as he lays there in his cage. The prep room, when Dr. Curtis enters is heavy silence. Dr. Curtis looks at us and shakes his head. He opens Niko’s cage and speaks soothingly to him as he examines him. We all watch. Dr. Curtis looks at us staring at him and tries to get Niko to stand up again. Niko sways for a bit and then lies back down with a plop. Dr. Curtis looks at us again and then back at Niko and says, “looks like you had a few too many there buddy.” The silence is broken and the room fills with laughter. We shake our heads smiling as we return to our tasks.

Dr. Curtis is concerned about Niko, but he is also concerned about his staff members’ emotional states. In this encounter, he works to manage his staff’s tension through laughter. This tension management strategy is also evidenced in other public arenas. Laughter helps alleviate anxious situations and can help members redefine a problematic situation into one more readily handled. This tension management strategy also enables members to “acknowledge a problem and relieve tension without having to confess weakness” (Smith & Kleinman 1989:63). It is a way to admit to each other that yes, this situation is troublesome and we don’t have a medical solution and we all want to “save” Niko, but maybe we can agree to set this aside for the moment and get other work accomplished.

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251 See for example, Cahill & Eggleston (1994) for an analysis of laughter as one type of emotion work strategy employed by Wheelchair users. Another good analysis of laughter as a tension management strategy is Smith & Kleinman’s (1989) analysis of how medical students manage problematic emotions as they deal with patients that they find in one way or another disconcerting.

252 Goffman 1956; Coser 1959.

253 Cahill & Eggleston (1994) find that Wheelchair users sometimes employ laughter to reduce other people’s anxiety about their situation. Laughter is also employed to reduce embarrassing situations in public to redefine a situation, to prevent selves from being socially hurt and to relieve self-consciousness.
Niko's family arrives later that day. The woman has brought her one-year-old son and five-year-old daughter with her to “visit Niko.” When the little boy walks through the waiting room entrance he immediately begins calling “Niko...Niko...where are you Nikoooooo.” All the staff members look touched. I am trying hard not to cry because it is obvious that this family really loves Niko. From the prep room Marcie calls out “hey look, he hears you and recognizes your voices...he is trying to sit up.” Marcie informs the woman that he is doing much better today. The client holds the children up to the cage to see and pet Niko. The boy pets Niko vigorously and accidentally pokes him in the eye. The client laughs and says, “Oops...Niko just like being at home huh?” The client explains to the children that “Niko is on a little vacation – he needs his rest.” Woman caresses Niko and with a choked voice says to him, “hurry up and get better my little boy (he is a huge cat) your sister misses your baths that you give to her.” She looks at Marcie. “She is just wandering around the house crying...looking for him.”

The human-feline bond is evident to the staff members in this encounter. The awareness of this bond increases the empathy that staff members have for both client and patient. In an article describing her case history investigation of attachment between humans and “their pets,” Victoria Voith (1983) poses the question most debated in human-animal attachment research: “Is attachment a motivational entity or a set of specific behaviors?” I agree with Voith’s (1983) conclusion that although attachment is evidenced by behaviors, it is a motivational entity. In the encounter described above. Niko’s attachment to his family, evidenced by his behavior of trying to sit up, motivates him to engage in this behavior. Voith (1983) also describes consequences of the human-animal bond. In the encounter described above, this bond can simultaneously increase the interactional dynamics of both tension and affection.

The third day of Niko’s hospitalization, I note that every staff member heads straight toward Niko’s cage when they arrive: each staff member checking on him in their own way...talking to him, petting him, trying to stand him up, examining him. It is obvious from their actions that he is on their minds. I overhear Marcie and Dr. Curtis speaking about Niko’s condition. Marcie tells him that she had stayed up real late and researched symptoms similar to Niko’s. “I was just desperately trying to figure out what was wrong with him,” says Marcie. “Me too” Dr. Curtis replies. “Thanks” he adds “I have a few of them [books] on my desk too.”
For staff members, saving the lives of patients moves beyond a nine-to-five occupation. This encounter provides evidence that concern over their patients and the tension that this creates can bleed outside of the encounter itself. The urgency to determine a solution or at least an answer to his medical condition is not derived only from concern over the patient. Staff members are aware that their time is limited by the economic position of the client.

Later that day the client comes in to check on Niko. After her visit with Niko, she asks Lisa, “what is my running bill? I need to know if I have to get a job or not.” Lisa informs her that it is $281.00. The woman looks very upset. “How much is it to board him like this every day?” she asks. Lisa tells her $25. “Oh” she says with a frown. Then she adds, “well we will be back to check on him…and speak to the doctor at 3:00.”

The staff members are aware of what the client is debating. They know that she is weighting financial obligations against Niko’s interest in life. For many clients this weighting is not an easy thing to do. It is highly emotional and complicates the already present tension or grief over the concern of a loved one.

The next day Niko is much worse. Dr. Curtis is very concerned and he mentions that the clients are not going to “wait much longer.” He says to the staff members in the room that he is hoping for a dramatic change in Niko’s condition. When Niko’s family comes in to the hospital later that day, the client says to Lisa, “we belong to Niko.” The client looks very distraught. It is obvious by her red face and swollen eyes that she has been crying. The client goes straight to Niko’s cage and begins to speak to him as she strokes him, “I love you Niko…we love you so much.” Niko’s tail appears like it is wagging, not twitching like when a cat is frustrated or irritated but slowly moving back and forth. While he does not focus too well on the client because of his medical condition, he keeps his face turned toward her as she speaks. After her visit with Niko, the client gets up, and looks at me with tears in her eyes. “What do we do? How long can we all do this? How long do you wait?” I can tell that she is searching for an answer from me. I shrug my shoulders, look at Niko, and smile sympathetically. “I don’t know.” I say, “You should speak to Dr. Curtis about that.”

The combination of the financial burden and the emotional cost of seeing Niko in...
such a medical state become too much for the client to bear. As in other encounters, where medical conditions and finances must be weighed, the encounter while mutually affectionate is also emotionally trying for clients who express an attachment to their feline companion. Staff members feel the emotional turmoil of this position and while they stand back to allow the other members of the encounter to express mutual affection, they are close by, ready to attend to any question that the client might have.

When I enter the hospital the next morning, Lisa tells me that Niko’s family is coming in today and they expect her to “give the order” to euthanize him. Lisa explains that she feels bad for both patient and client in this position. Dr. Curtis is examining him, as I enter the prep room. He looks at me and tells me that he wishes that the client would wait for test results that are supposed to come in that afternoon. “I would feel better about the euthanasia if tests come back FLP positive because then there is nothing else you really can do.” Staff members take turns attending to Niko (petting him, speaking to him, and trying to adjust him to make him more comfortable) until the client arrives an hour later.

When the client comes in she is silently crying and trying desperately to hold the tears back. Her eyes are red and swollen. When I ask her if she is ok, she explains that she is “hanging in there.” She also informs me [as she looks down at her son] that it’s her son’s second birthday, and at least that is “a nice distraction.” I bring her and her son back to Niko. The client and child speak to and caress Niko for twenty minutes. She takes a picture of him “to remember him as he was on his last day of life.” Every present staff member takes turns speaking to her. Dr. Curtis is concerned about her son watching, “will he understand?” The client looks at him confused for a second and then says “oh, no we are not staying. We are just here to say goodbye.” Marcie is in the prep room too and she watches the client with Niko for a bit before she states, “You know...he is doing a bit better today.” The woman nods and looks in Niko’s eyes for a long time. She kisses Niko on the head and then chokes out, “I love you Niko. I am sorry. Good-bye.”

When the client walks out of the prep room, away from Niko, she is barely managing to hold back her tears. She looks at Lisa, who hands her a tissue and says “I took his collar... [she holds it up and gulps]...I hope that is ok?” Lisa nods and tells her hesitantly, “I can see how upset you are...we will bill you through the mail ok?” Dr. Curtis comes out from his office [where he retreated during the encounter] as the client is on her way out. She sees him and says, “I’m so sorry. I just can’t watch it.” He nods. “Don’t worry we all care about Niko here...he is in good hands and will be treated kindly.” The client nods and looks down at the collar. “I am sorry...I just can’t...” she stops speaking to hold back her sobs. Dr. Curtis says, “You know...a lot of people wouldn’t have gone to this point.” The boy, that had been standing quietly at her side at that moment yelled toward the door “Bye
Nikoooo.” With that, the client can not hold back her tears, she looks at us standing there for a second and then pulls the child out of the hospital door.

After this encounter, the staff members are silent. No one seems at all happy about the situation – or relieved. I believe that the staff thought that she should wait a bit longer but also understood her need to get it done quickly. After a few moments of silence, Niko begins to meow. These meows become progressively louder and longer and he tries to get up (which is not usual). I look in at him from where I am standing. Marcie looks at him, then at me, then back at him, “Are you looking for your Momma? Are you wondering where they are huh? Poor baby.”

While encounters in the context of euthanasia in socially defined “clear cases” are affectionate and lack a significant degree of tension when Doctor Curtis is present, tension, for staff members is pronounced when participants disagree about whether or not the practice serves patient interest. In the context of ideological ambiguity, most staff members and some clients find euthanasia problematic. This tension is pronounced in the context of limited financial ability. Staff members prefer that clients’ wait for medical confirmation of suffering, to terminate the lives of their loved ones simply because then they can define the euthanasia as in the patient’s best interest. As doctor Curtis states, “I would feel better about the euthanasia if tests come back FLP positive because then there is nothing else you really can do.” While he would feel better had the test results confirmed an imminent death, he would have provided the service to the client before the results came in (had she chosen to stay) because he recognizes that she will not be able to provide costly medical solutions to “save” Niko anyway.
The social consequences of the economic context of the veterinary hospital are profound. In this case, Niko lost his life. The capitalist economic system and the dominant cultural category – legal status – of animals cause individuals in everyday human-feline encounters a considerable amount of tension. Not only are the clients psychologically oppressed, so too are the rest of the staff (including the veterinarian in this case) who recognize the constraints of the structure and simultaneously recognize ‘other’ animals as subjects.

Breaking the Bonds

As I brought up earlier in this chapter, some clients request euthanasia for reasons outside of medical complications. Often a bond between patient and client in these encounters is not evident or has diminished enough that clients are willing to break them permanently – by bringing their companions lives to a dead end. These encounters tend to be associated with a considerable degree of tension either by patient or staff member. However, clients are expressing very little tension. Affectionate displays between patient and client are absent in encounters in this context. Most often staff members try to make up for the lack of affection accorded patients by clients by giving the patients affection. Sometimes the patients reciprocate this affection, when they do; the patient’s affection appears to increase the tension felt by staff members.

In the encounter below, the patient is extremely tense. She reciprocates Dr. Curtis’ affectionate displays. The client expresses little tension or affection and
makes it clear that no bond exists between her and the patient. From her perspective, the patient’s behavioral problem is causing her too much trouble in other relationships and she wants this trouble to end.

Doctor Curtis and I enter exam room two to find a middle-aged white female standing alone at the exam counter. We look around for a patient as we enter and see only a cat carrier with no cat inside sitting on the bench. Dr. Curtis smiles at the client and she smiles back. “So you have brought in Serenity because she is not using the litter box?” The woman nods and explains that “she pees right outside of her litter pan. So, it is not that she can’t make it...you know?” He nods and they talk for a while about the home environment and the history of this behavior. Dr. Curtis indicates that it sounds like a behavioral manifestation of anxiety. The client tells him that she is wondering what he can do to “fix it fast.” She explains that the landlord will not let her sign a new lease if she does not “fix the problem in one way or another.” As Dr. Curtis speaks to the client, he continues to look around subtly for the patient. The woman says that she is “ready to euthanize her.” At the word “euthanize” we hear a long pitiful meow from behind the carrier. Hearing that, Dr. Curtis looks quickly over at the carrier and says “awwww.” The client appears not to notice the cry and continues to look at doctor Curtis. She begins to talk about her “hopes” that Dr. Curtis will fix it quickly, and if not, then “permanently.” Dr. Curtis asks the client at this point, “well, can I see her? Let me take a look at her. We can run another urinalysis to see if there is a medical problem. Otherwise, you know there is the options of anxiety drugs...”

The woman lifts the patient up from behind the carrier and plops her down then backs up. The patient, a beautiful long hair large female, is shaking violently, but docile on the counter. Doctor Curtis speaks to her soothingly as he examines her. She appears to relax as he caresses her, her shaking stops and she leans into his hands. As he feels her lymph nodes, the patient looks at the client, but the client neither touches nor looks at Serenity. The woman continues to talk about how Serenity has “interrupted” her “quality of life at home” and “is not worth it.” After the exam, Doctor Curtis continues to stroke Serenity as him and the client talk about behavioral modification options. She continues to emphasize her desire to “put her down.” As soon as the doctor says, if “I have to intervene via euthanasia for this problem I will...but I would highly recommend looking at other options first.” Serenity howls. The client shakes her head at the howl and frowns at Dr. Curtis as she grabs Serenity out from under his caress and off the table to put her in her carrier. When she closes the door of the carrier she turns toward us and says, “well my daughter and I are not averse to putting her down. It’s the men that we have to convince.” At that, she smiles and laughs about how men can be so silly sometimes.

In this encounter, Dr. Curtis’ suggestion to consider alternatives before using the last behavioral intervention at his disposal (euthanasia) is considered by the client. This is most likely due to the influence other members of her family remain “unconvinced”
that the patient’s behavior warrants the end of her life and the termination of a bond that may exist with them. Doctor Curtis’ suggests however, that he is willing to use this option. No doubt because he defines patients with these problems as not entirely healthy. Moreover, he focuses on the uncertainty of her emotional quality of life in a home where some of the humans wish to “get rid of her” because of the natural way that she manifests her anxiety.

Not all clients are amenable to alternatives to euthanasia. This ideological conflict between staff members and clients and staff members and the veterinary doctor who makes the decision to provide euthanasia in uncertain circumstances presents a considerable degree of tension among staff members. In the field note, excerpt below, Marcie tells me the story of what she felt is “client convenience” euthanasia. In the context of ideological conflict about the practice of euthanasia of “affectionate” felines, encounters are associated with a high degree of tension for staff members even when the feline expresses little tension.

Today I came in and Marcie told me about what happened after I had left. It was the last appointment of the day. A large male cat was scheduled for a check-up. He was brought in by a woman who had lived with the patient for six years. He had been urinating all over the house for some time now and Marcie said sarcastically “she just could not handle it anymore.” After looking at him and testing the urine, Dr. Curtis told the client that it was a chronic urine problem and that he ought to be treated. The woman, Marcie explained, told Dr. Curtis that she had done this treatment repeatedly to no effect and that she wanted the patient euthanized. Dr. Curtis had tried to “talk her out of it.” He had told her about a farmhouse that he knew of where she could drop him off. Marcie explained, “since he was fixed and had all of his claws he could live outdoors.” The woman was dead set against this, she had told him that the patient was a “homebody” and would not fare well outside. She also said that he was afraid of outside and that she wanted him euthanized today and that was that. Dr. Curtis agreed reluctantly and she paid her bill and left him there. Marcie said that her and Nell “had to do the euthanasia.” She was very upset she said. “It really made me mad. I mean I am sure that he would prefer to live outdoors than being dead! How could she be so unfeeling after spending so much time with him...and
Dana he was so sweet and healthy.” At that point Marcie was getting choked up. “He was so friendly. And when we went into the room to do it...he just snuggled up to us and then he rubbed Nell’s face...oh that did it...we were really upset! But I am so mad right now...we were really angry...and we had to do it...and I can’t believe that she did this to him...you know?”

Being told that you are to kill a cat that looks and acts loving and healthy, knowing that there is an alternative and that it had been offered to the client and she still refused, is a horrible thing to go through. It is traumatic. From Marcie’s perspective, the client is unfeeling and irresponsible. From Nell’s perspective, she took the life of someone who trusted her. In a letter to the editor, veterinary medical doctor, Donald Seif (1991) remarks that “any human being asked to kill healthy animals, because of man’s irresponsibility, will harbor stress” (1102). While it depends upon the perspective taken by staff members, it also depends upon the social context whether or not this request will be carried out. In a social structure, where animals are the property of humans, euthanasia, controlling feline life, is made possible.

Tension Management Strategies

In Arluke & Sanders’ (1996) analysis of how shelter workers manage tensions involved with human-animal encounters involving euthanasia, they make the assumption that euthanasia itself inevitably presents feelings of guilt and other “uncomfortable feelings.” In a later extension of this research, Frommer & Arluke (1999) begin their study of “blame-displacing strategies” with the “finding that the prospect of euthanasia creates guilty feelings for both surrenderers and shelter
workers" (1). My findings suggest that the assumption that euthanasia inevitably presents tension in human-feline encounters is problematic. Not all individuals feel guilty or uncomfortable with bringing feline lives to a dead end. Moreover, whether the act of euthanasia presents tension for humans involved in these encounters, depends upon the context of the situation.

**Focusing on Suffering**

Arluke & Sanders (1996) found that one tension management strategy employed by shelter workers in their study to “deal with killing animals under their care” was to focus on the animals’ suffering. In their words, “workers could also take the animals’ welfare into consideration, rather than focus on their own feelings, by seeing their death as the alleviation of suffering” (91). The workers explained that this strategy was easier to use when the “animals...were sick or old...” (91).

While focusing on the alleviation of suffering is also used by my staff participants, I am not convinced that it is a “tension management” strategy used to deal with the death of animals under their care. The deaths of many staff-defined “suffering” patients appear to come as a relief more than something that causes tension. The suffering itself is what staff members’ report that they have difficulty dealing with. Whether or not euthanasia presents uncomfortable feelings depends upon the context of the situation. When medical tests and patient’s behavior conflict, then focusing on suffering enables participants to kill felines that are expected to suffer in the future. As staff members suggest, “when they look healthy, it is harder...but if you know that
they are going to die, well than it makes it easier." In this case, staff members engage in this type of tension management strategy – the focus on future suffering – the preservation of a patient’s quality of life through death.

"It’s all her fault."

Similar to the context of ideological conflict about declawing, staff members are able to engage in euthanasia that they do not agree with, and simultaneously preserve their self-identities as people who “save lives” rather than “take lives,” by blaming others. Blame-displacing strategies are common strategies used in everyday life to deal with feelings of guilt or disjunction between individual behavior and personal perception of one’s self-identity. This strategy works to reduce the emotional and social damage that might be derived from engaging in behavior that one is not reconciled with or one believes that others do not accept. “It is all her fault,” for example, is used as a “blame management strategy” by rapists to control the definition that others may have on their behavior (Scully & Marolla, 1984).254 In other words, sociologists have noted that often people want others to see them and want to see themselves in a favorable way and use these strategies not only as tension management, but also as damage control for self-identities.255

When it comes to the euthanasia of a patient that the staff member believes is not ideal, particularly when the staff member defines the euthanasia as a situation of

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254 See also McGraw 1991 for this strategy employed by legislators and Henslin 1970 with suicide survivors.

255 Arluke & Hafferty 1996; Tavuchis 1991; Hewitt & Stokes 1975; Scott & Lyman 1968; Sykes & Matza 1957; Mills 1940.
“client convenience,” blame displacing strategies to manage tension and to manage other member’s perception of personal action is common. If the reader will recall, for example, when Marcie is involved in the euthanasia of a patient that she defines as healthy, she asks “How could she be so unfeeling...” and states “and we had to do it...and I can’t believe that she did this to him...” In an informal chat, Nell had complained about the patient as well. “Some people just don’t care...you know?” In other words, to deal with the emotional trauma of killing someone – even with kindness – that one disagrees with it helps to redirect the blame. Both Marcie and Nell use their anger at the client and possibly Doctor Curtis (“we had to do it.”) for not refusing or for asking them to do this “horrible” task. While all of their tensions were not relieved through dispelling blame, and this is why I believe that Marcie told me this story through tears, enough was so that they could inject him and take away his life. And enough tension is relieved to continue to do it again as long as the client and the doctor are defined as responsible.

Relinquishing Tension

Dr. Curtis helps his staff members redirect their emotions by offering clients the option of “relinquishment” (signing over property rights of patient) and working with the CAT organization to find these patients a new home. Dr. Curtis recognizes that many of his staff members become emotionally upset with the practice of euthanasia in certain contexts, and especially when a patient “could have been saved.” To help reduce their tensions in these encounters as well as to best service patient interest, Dr.
Curtis usually does everything he can do to convince clients not to make that decision if he believes death can be avoided. This not only makes him feel better, it also makes his staff members feel better. Recall Laura’s story of a patient that had a urinary tract infection that could be cured medically but the client signed over, at Doctor Curtis’ urging, “relinquishment:”

“And he was going to get euthanatized for it and now he is happy with this new home…that one worked out well…I am so glad that it worked out ya know?”

Focusing on all they could do to change the patient’s outcome of some situations helped staff members and the Doctor to relieve the tension that arises in their participation of other euthanasia. Like with Arluke & Sanders’ (1996) shelter workers, staff members at the Loving Care Cat Hospital protect their own identities as caring individuals by focusing on providing new homes for some of the patients. Arluke and Sanders (1996) argue, “rather than chewing over the morality of their own participation in euthanasia, they become part of a serious campaign…in defense of helpless animals and against the formidable foe of the pet owner” (98).

Discussion: Coming to a Dead End

Bringing feline lives to a dead end is a common practice in veterinary institutions across the United States. Lagoni, Butler, and Hetts 1994 estimate that two and a half million companion animals are put to death intentionally by veterinarians each year. Hart & Hart (1987) found that 66 percent of companion animal deaths, cited by
veterinarians, are the result of euthanasia. More recent studies\(^{256}\) indicate that on average, veterinarians perform 8 to 11 euthanasia's per month (Stephens & Hill 1996). Another study that combined both the actual engagement of euthanasia and discussions involving euthanasia indicates that these comprise a total of "3 percent of total patient contacts [encounters]" (369) across 23 private clinical practices across four western states (McCulloch & Bustad 1983).

Research also indicates that for humans, euthanasia can be an emotionally trying event. Sometimes encounters within the context of euthanasia can also impact other social institutions as some clients who "put to death" members of "their family" reportedly experience similar grief experiences as the deaths of other members of their family. These similar experiences, reported by empirical studies include a temporary inability to cope with everyday life such as going to work, school, or the maintenance of health or other personal relationships.\(^{257}\) Obviously for animals, encounters with euthanasia are particularly devastating.

Given that it is empirically verified that encounters involving euthanasia are experienced by participants on a regular basis and that it can be emotionally and socially trying, it is important to understand the nature of such encounters and how the social context influences them. To my knowledge, while studies have examined the impact of the social context of the grieving process after a companion has been

\(^{256}\) Hart, Hart & Mader 1990; Sanders 1994.
\(^{257}\) Lagoni, Butler & Hetts 1994; Gage & Holcomb 1991; Cowles 1985; Quackenbush 1985; Stewart 1983.
killed, many research involves the impact of the social context on the actual encounter. From post-encounter studies, research indicates that the human-animal bond is likely to influence the encounter. Many clients are expected to experience a significant degree of tension and possibly accord the animal member a great deal of affection – given that the bond is present. Staff members, as observers to the bond related grief, are expected to be emotionally impacted by this client-patient bond; most often increasing the tension that they reportedly feel because of encountering death of a patient itself.

My findings lend credit to the social impact that the human-animal bond can have on human-feline encounters within the context of euthanasia. Many clients, who are reportedly or observationally attached to their feline companions, express a great deal of tension within encounters involving euthanasia. Moreover, some of these clients express a considerable degree of affection toward the patient – affection that is reciprocated by the patient – as they are trying to make their decision. However, the bond does little to keep the client member present during the actual euthanasia. Although, staff participants report that clients sometimes choose to stay to “be there” for their “loved one” through the passage, no client opted to stay during the process of my research. The lack of observation of encounters involving actual euthanasia is unfortunate, and warrants further exploration. How might the context of client

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258 Lagoni, Butler & Hetts 1994, for example, while focusing on the impact that the bond has on grieving, death and euthanasia, suggests that other social factors or “circumstances” might “complicate” grief for humans (i.e. social support for grieving, presence at the euthanasia, and the role that the veterinarian plays during and after euthanasia itself).


presence during the actual euthanasia influence the degree of tension or expression of affection by staff members and patient?

Further support for the impact that the human-animal bond has on human-feline encounters includes clients who indicate a lack of bond with the patient. Encounters in this context involve less tension for clients. A decision to kill their companion comes easier given that they are less emotionally invested in the patient. In these cases, sometimes the patient is notably tense and sometimes they lack a significant degree of tension. However, affectionate interaction between these patients and staff members are noted and reciprocated. In addition, affectionate interaction by staff members appears to reduce the degree of tension that patients express in the absence of social bonds with clients. What this tells us about the impact that the human-animal bond has on the patient’s experience of encounters, is inconclusive and warrants further investigation. However, my findings suggest that attachment for clients can increase the tension that a patient feels in their absence, as the cases of both Fluffy and Niko indicate. This finding may have broader implications in the sense that when their human companion leaves them alone at home, they may be likely to “act out” this tension in human defined “unacceptable” manners such as peeing outside of the litter box or acting in aggressive ways – which are two reasons why clients request euthanasia.²⁶¹

As I explored the impact that a patient’s social status and age has on the human-feline encounters within the context of euthanasia, I found that less tension
(experienced by human participants) was involved with the euthanasia of both rescues and kittens. Indirectly this lends even more evidence that the human-animal bond has an impact on everyday encounters. In other words, as less time is invested developing a bond because of the age of the patient, there is less of an emotional impact resulting from the possibility or actuality of their death. However, I must point out that if it is the lack of a developed bond that influences the encounter, then one might expect affection to be relatively lacking particularly when the patient is not expressing any themselves. Actually, some of the most affectionate encounters (displayed by staff members and clients) were those encounters with kittens and rescues – even with a rescue kitten that is highly contagious.262

While the human-animal bond may influence the human-feline encounters within the veterinary hospital, other social contexts appear to influence the encounters within the context of euthanasia. One such social context involves the client’s economic ability to pay for medical alternatives. Making the decision to kill under economic constraints creates added tension in both the client’s and the staff members’ experience within those encounters. These encounters are notably both affectionate and tense as the humans struggle to balance the interests between themselves and their economic position and the patient’s life. The impact that the economic context has on the patient is obviously life and death.

261 A case history study conducted by Voith (1981) suggests the human-animal bond can be paradoxical in the sense that the bond felt by companion animals can lead to the “behavioral problems” that clients cite as reasons for breaking those bonds through euthanasia.
262 Recall that the rescue kitten positively diagnosed with distemper is treated with a great deal of affection by staff members while Fluffy (a companion adult) whose virus is less contagious is placed in isolation and not touched by staff members.
The role that the doctor plays also influences the interactional dynamics that define human-feline encounters. The mechanic role is more often associated with tension for both client and patient as neither client nor patient is comforted by the mechanical model of veterinary medicine within the context of euthanasia. Staff members are notably less affectionate to patients who are doomed for euthanasia within the context of the mechanical model, lending further support for an earlier assertion that the person in authority has an impact on the behaviors that employees employ toward ‘other’ animals.

For staff members, the ideological construction has a profound influence on the experiences of affection and tension that defines the encounters. Because of the lack of ideological consensus and the particularly terminal result of this practice, human-feline encounters within the context of euthanasia tend to depend significantly on the reason that euthanasia is being requested – the categories within which the patient’s euthanasia falls. The larger veterinary institution is consistent with their aim to end feline suffering. As such, the humans in the local hospital experience less tension when a patient is defined as suffering. Encounters within this context [euthanasia of a patient defined as physically suffering] lack a significant degree of tension for human participants because of the tension that patients are experiencing which is assumed to derive from their medical condition. Most often, the human participants, in this context are displaying a significant degree of affection toward the patient. Patients, on the other hand, are most often displaying very little affection. This is no doubt because they are either focusing their attention on “struggling to survive” or they are
"writhing in pain." In either case, the institutional mandate of euthanasia is to "kill with kindness." Staff participants are expected to give patients as much comfort as possible in the last minutes. In other words, the institutional definition of euthanasia helps to guide the actual encounters. If the human members agree about the legitimacy of euthanasia, they are more apt to engage in killing with little question and even, as in Marcie's and Tess's case, with urgency. On the other hand, disagreement over the legitimacy of the practice creates tension within the encounter and members are more hesitant to kill, even with kindness. Despite the hesitancy and the ideological conflict, some participants kill even when they disagree.

Doctor Curtis' social position as the owner of the hospital and the institutional definition of euthanasia enables him to make case by case determinations. As doctor Curtis points out, "this is not an easy thing to do." When I asked him during an informal chat whether he is getting used to the deaths of feline patients he replies, "No, I am not becoming desensitized to this at all, you know I really have more empathy for both the client and the cat, and it is still really tough for me." Moreover, when I asked him what he does and how he feels when a cat with a bladder infection whom is medically treatable is brought in by clients to be euthanized he replies, "A blocked cat? Well...I believe we should always try...you know deciding on this...what to do...is a tough thing. I mean it's playing God in a way. I like to try all that is possible with the client before that decision is made." Note that he is uncomfortable with making such decisions and how he subtly changes the definition of the situation presented to him. "A blocked cat" is a more serious medical
condition than a cat with a treatable urinary tract infection. For doctor Curtis, he is “playing God” and it is uncomfortable, yet he does kill cats whom are medically treatable, if the client decides that this is the only acceptable alternative. In other words, ultimately the legal status of animals as private property has an influence on both the doctor’s decisions to end a life as well as the everyday human-feline encounters.

For other staff members they kill not because they are weighting human and animal interest in a contextual way under the social structures, but rather because their social position disallows much resistance. The doctor and ultimately the client make these decisions and resisting too often will jeopardize their job. However, being able to diffuse responsibility for their actual participation through blame-displacing strategies enables them to continue to participate despite the tension that is involved in the encounter under ideological conflict. In this way then, like with declawing, tension management strategies paradoxically enables staff members to go against their own ideological standpoints. However, although they engage in bringing feline lives to a dead end, these encounters are not unilateral encounters. Tension and affection within the context of euthanasia experienced by all participants is contextually contingent. When an institution defines a practice as legitimate, human members are more likely to do so – even when that means the death of a subject. As they define the encounter as less problematic, the encounter lacks a significant degree of tension for them. The encounters within ideological conflict where humans experience tension from their actions – tension that has the possibility
to promote resistance – is managed by defining the practice as someone else’s fault. The broader social significance of this finding is that the lives and deaths of animals as well as their experiences within an encounter, is highly dependent on the human definition of the situation.
CHAPTER 8

DISCUSSION

*Interspecies Encounters in Context: A Balance of Interests*

This inductive exploratory analysis of field notes derived from observations in a veterinary hospital and a qualitative context analysis of the last ten years of the *Journal of the Veterinary Medical Association* demonstrates that human-feline encounters within the hospital are a product of multiple interacting social and social-psychological factors. This study has clearly drawn out the impact that human social constructs such as cultural ideology, social status, and roles have on everyday encounters. The local and extra-local social constructs that we build to guide our actions toward 'other' animals have real-life emotional and social consequences not only on each other, but also those animals that we bring into the domestic realm. Moreover, many of these constructs such as medical ideology and feline social status interact with each other to produce significantly different social experiences for both feline and human. However, taken alone these constructs do not tell the whole story, as felines act and react according to the relationships they have with humans and according to their own definitions of the situation.

In this paper, I have drawn out specific practice ideologies and have shown that these ideological constructs are grounded in assumptions about nature, felines, and
human obligations toward preserving feline interests. I have shown how some of these practice ideologies enjoy a consensus among the humans and how that consensus is maintained. Consensus is maintained through various means of social control: social sanctions (positive and negative) for clients and the physical control over the patient's expressions of tension. I have also shown that human tension is minimal in the face of ideological consensus and that social encounters with felines can be affectionate in this context. However, human consensus does not necessarily mean that felines are protected from pain and suffering at the hands of humans; only that humans are enabled by this consensus to be free of the emotional consequences of the patient's tension.

I have also shown that when a larger institution fails to provide a clear ideological framework for specific medical situations that the local community constructs a framework from the ground up, based on the balancing of human and animal interests from everyday experiences. These locally constructed frameworks are more fragile and often meet with human conflicting definitions. The major sources of conflict are whether the practice services a patient's interest and if the patient's interest no longer takes precedence to human interest given their failure (intentional or not) to meet human defined social expectations. For humans, the consequence of this conflict is that they look to others (including felines) to structure their actions toward felines. For felines, the consequence is that they have more influence on the human's experiences within the encounter. Despite the fragility of these local frameworks, they too influence the social encounters by enabling humans to define some situations
as more problematic than others. Finally, I have shown how staff members draw from tension management strategies to enable them to participate in actions toward felines that they believe is wrong and still retain their self-identities as people who work for animal interest.

More generally, I argue that while the encounters are influenced by an individual human agent's perception of 'other' animals, this definition is often grounded in cultural ideologies, which are made explicit through the analysis of specific practices. Also two feline social statuses can influence the encounters simultaneously – we can draw from our construct of animal as subject at the same time we are limited or enabled by the larger status as object. Human action toward 'other' animals is guided by (both enabled and constrained) cultural ideology. However, there is a limit to the influence of human constructs on the actual social encounters with other animals. 'Other' animals themselves can challenge our definitions of the situation – they can force us to see the constructions that delude us, make us complicit, alienate us from them. Sometimes when they challenge our ideas about things, we work to maintain our constructions; other times we struggle with the consequences of our actions on their lives. Sometimes, 'other' animals, through their actions can support our definitions of the situation – they can enable us to feel good about ourselves and our actions. While humans through our socially constructed contexts can have control over the lives and social experiences of 'other' animals, we do not have complete control over the encounters themselves.
Feline Subjectification

Many human participants in the Loving Care Cat Hospital define felines as individual subjects. In other words, staff members and a majority of clients conceptualize feline patients as feeling and thinking beings deserving respect for their quality of life. As I indicate throughout my finding chapters, both staff members and clients describe cats as having emotional lives. Felines are frequently reported as being happy, angry, bored, sad, lonely, and scared. 263

Not only do human participants express the belief that felines feel, but they also indicate that patients have wishes, preferences, desires and needs. In various field note excerpts, I show how patients are understood by the human participants as “wanting to get out of the cage,” as having preferences for specific toys or food, desiring comfort and attention, and “not wanting to go to the vet.” Moreover, these felines make these wishes clear to many clients: “I can’t keep it [food] from him when he asks for it.” Felines are also described as cognitive beings that have at least some ability to communicate both their thoughts and feelings to humans. For example, when Mrs. Flannigan came to pick up Honey after her surgery she asks Lisa if Honey has eaten. After confirmation, the client explains why she is concerned:

Well...that is good. I felt so bad the other night. Honey looked at me and then at the empty food bowl and then back at me....she wondered where her food was and wanted me to know that there was nothing in it....she wanted to know why the bowl was not full. I felt so bad.

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Wondering why is a cognitive excursion. These thoughts are communicated to the client through both her nonverbal (looking at her empty food bowl) and verbal (meowing) actions.

Many human participants also indicate that they believe that cats anticipate events and manipulate action in an attempt to control that event. Similar to Alger & Alger's (1999) findings, patients are described as anticipating a trip to the veterinarian and engaging in actions to stop that trip from occurring. If the reader recalls, in chapter five, I present an encounter in which the client describes how his two cats Manny and Sammy anticipate the trip to the veterinarian. During this encounter, the client explains to Doctor Curtis how one patient will “sleep in the carrier if he let him.” However, the minute the carrier is to be used to go to the veterinarian that patient disappears. “Sammy was all excited for awhile like ‘hey cool’ then he realized where we were going...Manny, however, knew right when I brought out the carrier what was going on. He ran and hid.” These finding are consistent with other empirical research on human’s accounts of the emotional and cognitive lives of their companions or ‘other’ animals under their care.

Not only do many human participants express the belief that felines are subjects, some human participants (particularly staff members) work to preserve these subject identities even in the tensest moments. Staff members correct each other and subtly sanction clients when they refer to a patient as an “it.” They regularly refer to

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263 For further reading on the emotional lives of ‘other’ animals, see Masson & McCarthy (1995) and Page (1999) and felines specifically see Masson 2002.
patients as “who” as indicated with the general greeting “so who do you have with you?” Moreover, even patients such as My Guy (chapter seven) who are treated with forceful tactics to comply with medical practices are defended as subjects whose behavior is contextually situated.

In his study of human-canine interaction in various public settings, Sanders (1999) extends the symbolic Interactionist perspective of “aligning actions” to suggest that humans generally assume responsibility for their canine companion’s behavior. When a dog behaves in a socially defined “problematic” way, the “owners” who are “with” the dog – are partners in social action – will excuse the canine’s behavior to protect their own human social identities as competent social actors. Parents also excuse the socially defined norm violations of their children (Cahill 1987). There are various techniques that human participants are expected to employ to re-establish their social identities in the face of disrupted social interaction or norm violations by their social partners. Many of these strategies are the same techniques that individuals use to provide justifications or accounts of their own behaviors in the face of social judgment.266 During my fieldwork, some clients did engage in such “excusing” behavior. Clients sometimes apologized for or offered excuses for the patient peeing on the floor, growling or biting a staff member, or struggling to get away from the doctor.

“I am sorry...you know she doesn’t behave this way at home.”

266 For further analysis and enumeration of these various techniques used to restore social identities within human interaction see: Mills 1940; Blum & McHugh 1971; Perinbanayagam 1977; Hewitt & Stokes 1975; Stokes & Hewitt 1976; Scott & Lymann 1968.
“She is really just scared here...she didn’t mean to scratch you.”

“He is still just a kitten...you know...he hasn’t learned to sit still yet.”

In this way, these behaviors may indicate, as Sanders (1999) analysis suggests, that the client is asking the other human member or members of the encounters to forgive their social partner’s behavior; in a way saying, “hey, I am not an irresponsible pet owner...it is just that...”

While some members engage in this behavior to preserve their own social identities as responsible caretakers, I would add that human members do not confine this behavior between themselves and as only human identity preservation tactics. If the reader will recall, Marcie apologizes to Bark for “making him mad” and then adds, “it had to be done.” In this way, she makes herself feel better about her actions; she is protecting her own self, as a person who comforts and protects animals—not hurts them. However, I suspect that Marcie and other staff members are also engaged in defining the patient as a social agent – a subject – who participates in these social expectations. Staff members excuse their behaviors not just for themselves or other humans to “save face,” but to the feline participants who are regarded as feeling and thinking social actors. It is another manner in which human participants construct other animals as subjects from which to guide their further social interactions.

Finally, I wish to point out that clients are not alone in their use of what other sociological analysts refer to as “excusing tactics” for perceived misbehaviors of those around them. If the reader recalls above, many staff members defined My Guy’s behavior as “understandably afraid” in this context. Clinton Sander’s (1999)
refers to this rather commonly employed excusing tactic as "situating." Sanders
(1999) argues that situating is used regularly by clients for their companions because
these companions represent an extended self. While his analysis makes sense, doctor
Curtis also regularly employs this situating tactic for a patient's client-defined
misbehavior. Sometimes clients will get upset or embarrassed that their cat is hissing
or growling and will look at the doctor and say "he is not mean at home" or will look
at the patient and say "don't be mean." Doctor Curtis will regularly reply to these
statements by moving the "vocabulary of motive" (Mills 1940) from being "mean" to
being "in pain." He is informing the client that he recognizes that the patient is not a
"mean cat" but rather that this patient's behavior is normal under the circumstances of
being in pain. In other words, staff members who are not 'with' the patients also use
these excusing tactics. I argue then that staff member's participation and expansion
of client's excuse tactics, are used not only to help the client amend their own
perceived tear in social identity; but are also employed to protect the patient's social
identity as a subject who is behaving normally given the circumstances.

Stewardship Ideology

Because feline patients are socially defined subjects, they also deserve respect for
their quality of life. From the perspective of the American Veterinary Medical
Institution as well as many human participants, this feline quality of life is rightfully
defined and defended by humans because these subjects really don't know what is
good for them. A good quality of life for felines depends upon human control. In other words, 'other' animals are subjects, but subjects that rely on the "compassionate control" of human society. I found that the animal subject as it is locally defined and encountered is both similar and different from the sociologically defined subject as presented by Arluke & Sanders (1996) and Alger & Alger (1999). This feline subject is similar to humans in the sense that he or she is recognized as an individual being with certain rights to be free from suffering. This subject is also defined by human participants as having a degree of agency in the sense that they are frequently described as influencing human action including feelings, thoughts, and behavior. However, this subject is different from the human subject in the sense that felines are never expected to become autonomous agents — but are, rather domestic subjects whose well-being depends on human responsibility.

There are various ways that humans are expected to preserve feline well being. In the veterinary institution, this preservation is maintained by common medical practices including preventative health, neutering, declawing, and euthanasia. Each practice has an attendant ideological framework that is constructed around the aforementioned ideas about feline subjectivity and the management of their quality of life. "Humane" clients are expected to protect and control the felines under their care. Protecting felines from the vagaries of nature preserves patients' quality of life. Disease, parasites, dirt, and fat are to be controlled to protect feline interest. This is accomplished through, vaccinations, a clean environment, and a controlled diet. Neutering is the most legitimate solution to the growing feline population problem.

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Felines "out there" will suffer. Other solutions to feline suffering, such as feeding, providing temporary housing and leaving the control over reproduction to individual human initiative or felines subjects themselves is simply inadequate and actually contributes to the problem. Permanently removing feline’s ability to reproduce is the most “humane” weapon in the battle to reduce the number of felines that are left to fend for themselves. If people care about cats in general then they will do all they can to help – including taking responsibility for strays. Declawing preserves a patient’s quality of life as their natural instincts of scratching can ‘offend’ the humans who care for them. Felines are expected to follow human rules of order and control; those who can not are better off surgically altered than discarded or pushed out of the domestic realm. Finally, humans have the rights to control feline quality of life even in death. Death for felines is better than suffering under a poor quality of life. This poor quality of life could include physical, emotional and social suffering. Humans preserve the feline’s quality of life through a quiet and stress free (“humane”) death.

These practice ideologies reveal underlying assumptions about the nature of nature and humans’ relationship to it. One such assumption that I think is important to address here that is most evident in the ideological frameworks of preventative health and neutering is that nature is chaotic and dangerous; thereby it needs to be controlled. According to both Merchant’s (1987) and Birke’s (1994) analysis of scientific ideologies, this is a common assumption—especially within the “orderly” medical discourse. Parasites and disease are insidiously out there and wreak havoc on the lives of those “poor abandoned cats.” Dirt is constructed as a contributing factor
to hosting disease and parasites, and is especially abhorred by staff members despite their medical knowledge that, "you can have a clean house and have fleas" (Victoria). For CAT clients, rescues have to be cleaned and inspected even before they move in social status – they are strays until they are “cleaned up.”

The staff members’ disgusted reactions to dirt and fleas I find particularly interesting. According to Mary Douglas (1966), dirt in the human mind symbolizes disorder, because it is “all the rejected elements of ordered systems” (35). For staff members and CAT clients, I think that this dirt is “out of place” because their definition of subjectivity requires inclusion within civil human society, which is paradigmatically “cultured” and ordered, not chaotic, messy, or dirty. According to Sabloff (2001) in order for ‘other’ animals to participate in the “domestic realm” and be included as “kin” as “family members,” the nature of animals must be “rejected for the pattern of animal as human kin to be sustained and reproduced” (76). They need to be “rescued” from the wild. This is where, I believe that the labels “companion,” “rescue,” and “stray” come from. Their label or rather social status is described in relation to human control and distance from nature.

While staff members and CAT client’s reactions to dirt and parasites are telling, even more interesting, however, are the client’s expressions of guilt and embarrassment when the “uncleanness” of their companions is brought to their attention. Bakhtin (1965/1984) argues that people in modern civilization prize individualism and social hierarchy. Those with power and money have the distinct advantage of being able to separate themselves from environmental determinations.
and bodily concerns. The “elite” do not have to get dirty, can afford to have higher standards of cleanliness, and wear clothing that is impractical. In other words, they are not bound by nature but rather they rise “above it.” To distinguish themselves, he argues, from “common folk,” one must separate from bodily functions and be especially clean. Likewise, their cat’s bugs and dirt can embarrass participant because a “pet” may be an extension of a social identity (Belk 1996) – those whom we relate to and live with. If one is responsible for a patient and they get dirty, then the logic extends that one can not control nature.

A related assumption to the control over nature then is for felines to be accepted into the “civil society” their own nature also needs to be controlled. Their bodies and behavior must be manipulated to conform to and fit into the human social structure. I find it extremely interesting that to provide for an individual animal’s welfare that has been brought inside a home that people often consider it paramount to separate them from the rest of the natural world – to, in a sense, civilize them. They need to be neutered, cleaned up, vaccinated against disease, defecate in the proper place, and to control their aggression.

In her ethnography of various settings analyzing the various metaphorical relations with ‘other’ animals, Sabloff (2001) entered frequent discussion groups dealing with human-animal relationships. Her participants point out in a conversation this interesting relationship some humans have with domestic animals:

One woman said: ‘It’s interesting what we do to animals, to domestic animals, to make them domestic. You’ve go to neuter them, you have to declaw them; perverting very basic drives. You’re disarming them. You’re making them less of what they are, less animal.’ Added another: ‘More civilized.’ A third participant
countered: 'What do we do to babies? What do we do with human beings? It's the same thing.' In the kinship metaphor that organizes human-animal relations in the domestic domain, it appears that what is most actively suppressed is an acknowledgement of the animal in pets and in human beings. (72)

To provide for individual feline welfare, their nature must be severed from them as many humans in modern civilization severe themselves from nature. They are constructed as "family members" and as subjects to help structure the encounter. As shown in a great deal of encounters, common kinship references were often used to describe a relationship between a client and patient. This metaphor (Momma, Mom, Dad, Baby) not only describes a relation, but also helps to structure human-feline encounters as intimate and a part of the domestic realm; deserving of affection.267 In the human mind, the kinship metaphor brings felines into 'civil society' and reinforces the assumption that humans must 'protect' them as they do their children. However, these feline subjects are qualitatively different from human children. Human children are socialized to eventually be autonomous agents. Feline subjects are not socialized toward autonomy but rather toward dependency (dependent agents).

A final assumption that is prominent in the practice ideologies is that the larger human public fails to care for 'other' animals. The larger public is irresponsible, unfeeling and thinks of 'other' animals as disposable items. This public does not recognize the dangers that felines face 'out there.' It is important then to point out that for most human participants, but especially staff members, another danger of 'being out there' includes the danger of being susceptible to abusive and unfeeling
humans. I am reminded of stories told by both clients and staff members of cats who were shot because they transgressed the lines of private property. Also, the larger public is not only abusive but is unaware of or are unwilling to live with "natural" feline behaviors—such as clawing furniture or spraying when they are not neutered. Because of this public attitude toward 'other' animals they fail to see that neutering and vaccinating is in the patient's best interest, they abuse them when they claw on furniture, and they discard them when they no longer "fit their lifestyles." Here I remember how I felt when I saw a cat sitting on the empty cement slab of my mobile home park on my way to the hospital. When I shared what I saw with staff members that morning, they nodded sadly and Marcie stated, "the people probably let the poor cat outside the day before they moved the trailer and then when they could not find her, they shrugged their shoulders and left. People do that all the time...and the poor cat is waiting for them to come home." This feeling, that other people "do not care," I believe actually ties people together in their ideological constructions; it is powerful and has an impact on everyday interspecies encounters.

_Ideological Consensus and Conflict: In whose interest?_

While each practice appears to have its own ideological framework, all medical practices follow from the institutional mandate of the Veterinary Oath. This oath combined with the patient's social status as private property and the economic position of the hospital (fee for service) places all veterinarians and their staff

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267 Sabloff 2001; Arluke & Sanders 1996.
members in a position requiring them to balance feline and human needs. In an article titled "Stress and burnout in the profession Part 1: Veterinary Practitioners dragged through traumatic times," written by Paul Zuziak, Dr. Cecilia Soares a private veterinary practitioner, consultant and instructor at the University of California-Davis lists three main conflicting interests that can arise in the field. "The veterinarian needs to charge for services rendered; the owner has the right to decide what will happen to the animal; and, as an advocate for animal welfare, the veterinarian must speak for the animal" (523).

From my analysis of the last eleven years of the *Journal of the American Veterinary Medical Association* (JAVMA), caring for 'other' animals is constructed as the protection from disease and relief of suffering for the benefit of society. This is clearly evidenced in the Veterinarian's Oath. Frequently, during the graduation ceremony at veterinary universities a graduate will be expected to recite the Veterinarian's Oath, thereby making a promise to uphold the values of the veterinary profession. The Veterinarian's Oath was first adopted in 1954 by the *American Veterinary Medical Association* (Osborne 1991). The Oath has not changed much since then. Minor word changes were made in 1969 (Osborne 1991) and again in 1999. In 1999, for example only two words were changed from the 1969 oath: from *livestock* to *animal* and from *continued* to *continual*. The Oath that is now recited by graduates is similar to the one recited in 1969:

> Being admitted to the profession of veterinary medicine, I solemnly swear to use my scientific knowledge and skills for the benefit of society through the protection of animal health, the relief of animal suffering, the conservation of livestock [animal]
resources, the promotion of public health, and the advancement of medical knowledge.

I will practice my profession conscientiously, with dignity, and in keeping with the principles of veterinary medical ethics.

I accept as a lifelong obligation, the continued [continual] improvement of my professional knowledge and competence.\textsuperscript{268}

The principles of veterinary medical ethics are, as I pointed out in chapter two, strongly grounded in animal welfare. In short, animal welfare recognizes as do human participants in the field, that ‘other’ animals are subjects deserving some degree of respect for their quality of life, but subjects that can be used, manipulated, and controlled for human benefit. As long as human and animal interests are not conflicting, the animal’s interest must be served. Human interest from the larger institutional standpoint takes precedence over animals’ interest.

This interest is intricately connected to the ideology surrounding a specific practice. According to Tannenbaum (1999), ideological consensus and conflict within the veterinary hospital largely centers on the human question of whose interest is served. As I pointed out in chapters five and six, sometimes, as with the practices of preventative health and neutering, the practice is understood to service both client and patient interest. However, with declawing and euthanasia, “whose interest is served” is questionable and lacks a significant degree of consensus both within the field and in the larger veterinary institution. When the institution clearly outlines how the patient’s interest is served, it is generally accepted as ‘in the best interest’ of the

patient and is a black and white issue; either the patient is cared for properly or not. However, when the institution fails to provide a clear framework for the local setting, staff members create their own framework to guide their everyday encounters and not all staff members agree on where to stand within that framework. As chapters seven and eight clearly demonstrate, the practice ideology is splintered to negotiate the context of the situation, and client’s motivations are questioned as to whether they are caring for the patient in the patient’s best interest.

**Ideological Impact**

The practice ideologies and their underlying assumptions as well as the ideological consensus/conflict is a large part of the social context that structures human-feline encounters defined for the purpose of this research by the presence and absences of affection and tension. In chapter five, I outline the preventative health ideological framework and show how staff members clearly define vaccinations, cleanliness, and dietary management as proper care for feline patients. Most clients agree with this definition of proper care, although they sometimes struggle with varying definitions of a patient’s need when it comes to food. Doctor Curtis recognizes this struggle and uses his pediatric role to compare a patient’s dietary needs to a human child’s dietary needs. “You wouldn’t just let your children have anything that they wish to eat would you?” On the other hand, he will sometimes contrast interaction between child and feline. “Often people just can’t say no to their cats like they can their children.” In either case, he is drawing from the kinship metaphor to remind the clients that they
have a responsibility to their cat similar to the responsibility that they have for their children, proper and controlled care for their own good. In the face of his lectures, clients do not defend their alternative definition, but rather accept that they are not doing the right thing by their cat and offer an excuse for their behavior; “I can’t help it.” These excuses lay the blame on the client’s failure to comply with the social expectation to control the patient’s weight on the feline subject or on to their feelings of empathy “I feel so mean.” In either case, excuses sustain the definition of the client’s behavior “of giving in to a patient’s wishes” to eat when they want as improper care (Hewitt 1997). Consensus then, for preventative health is revealed and maintained through social sanctions such as medically instructive talk as well as offering extra-service to gold star clients by staff members. It is also maintained by a cohesive feeling of moral righteousness by clients.

As human participants define preventative health as something that is equally in both client and patient interest, the social encounters with felines are most often mutually affectionate and lack observable tension. Humans are joined together to provide the care that a subject under their responsibility deserves. As such, they feel good about and believe in the morality of their actions toward felines and the encounters reflect this. Felines also lack a significant degree of tension. Their lack of tension, I believe is not due directly to the ideological consensus, but the present human’s lack of tension combined with their simultaneous affectionate displays. While sometimes the patient may be scared, the overwhelming lightness experienced
by the humans combined with their comforting strokes and soothing words may indicate to the patient that “everything is ok.”

Affectionate displays, as I have pointed out throughout my findings chapters, are often believed by participants to have a comforting effect on the patients. Patients appear, from my observations (recall how the patient in the last chapter that was ignored by her companion but affectionately interacted with by the doctor relaxed as he stroked her), to find assurance in the human displays of affection – and frequently seek it when they are scared. These observations support the theory posed by Voith (1981) and the empirical evidence offered by Katcher (1981) that affectionate displays can be comforting to animals as well as humans. I want to note here that many patients do something else rather significant; they look toward the client when the doctor approaches them. ‘Other’ animals, and in this case felines, watch human companions to, in their own way, define the situation. People who work with ‘other’ animals on a regular basis regularly report this observation that ‘other’ animals are carefully watching the present human’s expressions.269 In other words, felines are engaged in a type of emotional social referencing that helps them determine if their human companion defines the situation as dangerous or not. In this way then, affectionate displays and a lack of tension in the faces of their human companions may indeed have a calming effect on the feline patient.

269 For examples and discussions regarding the observations or social referencing that ‘other’ animals use in their social encounters with humans see such works as Midgley 1999; Page 1999; Hearne 1987; Goodall 1986.
If the reader recalls, the client that brought Fluffy in to discuss and engage in the practice of euthanasia remarked that she was empathetic to his moods. In the context of various medical exams, other clients provided similar accounts to Doctor Curtis:

"He just knows when I am upset."

"I am trying not to get too nervous, because I know that that will make her more nervous."

"We just love each other you know? When good things happen, we enjoy them together and when bad things happen we comfort each other. We sort of know what each other is feeling...Don't we honey? It is probably because it is a one woman one cat household...." Both Alger & Alger (1998) and Belk (1996) describe similar accounts derived from interviews with “pet owners” and Katcher (1981) claims that “over 80 percent” of his interview participants “thought their pets were sensitive to their feelings.” Of course, respondents’ statements about whether or not their “pets” are sensitive their moods enough to influence their behaviors does not tell us whether they actually are – or even definitively that people actually believe that it is true.

Aaron Honori Katcher (1981) argues that “[t]o what degree animals are empathetic, to what degree their behavior changes with the mood of their owner, is an important research question in its own right” (56). I agree. My own research on the social encounters between humans and felines, suggests that the moods felt by human participants, although not just the human companions, has an impact on the degree to

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270 See also Fox 1975.

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which they express affection as well as tension. However, an ethnographic analysis (and a sociological one at that) of one specific setting, where ‘other’ animals “may not be themselves,” is not enough to support this contention of feline empathy. I would suggest an interdisciplinary connection between cat ethnology and human ethnography in the home environment to more adequately understand the impact that human feelings and moods have on ‘other’ animal feelings and moods.

In chapter six, I outline the neuter ideology and provide evidence that neutering is actually a socially defined solution to a socially constructed problem. Consensus, I believe is largely maintained in the local setting by the feelings of working together (clients and staff) to solve a problem. When Doctor Curtis had his own “Spay-Day,” many clients from CAT and staff members volunteered their time on a Saturday to “help out.” All of the cages were filled and the floors were lined with carriers full of patients either recovering or awaiting the removal of their reproductive organs. Many of the patients were trembling or crying out for attention. Their cries are completely ignored. Unlike regular workdays, the staff is unconcerned about keeping the patients quiet to control client tension. Unlike, the cries of patients who are to be declawed, these patients did not need our attention. Rather, the goal was to complete all the neuters as quickly and as efficiently as possible. Despite the large amount of patients, more than I had ever seen in one afternoon, people were joyfully working together to get things done. Below is an excerpt from my auto-ethnographic field notes that describe the feelings that I had about helping out on that day.
I just went in today to volunteer my time for the free spay-day at the hospital. It was so much fun. The atmosphere of the hospital all day was even more cooperative and pleasant than during everyday workdays. I can’t believe how many patients that they had, and some staff told me that they had “hoped” for more. The patients were not so happy, but I don’t think that staff was concerned about that; the patients were getting more care than they would have had if the hospital did not have this day. It was a bit surreal, to be honest. On the one hand, I felt so good about myself for being part of this crusade. I also felt proud of the staff for working extra with no pay in order to, as Doctor Curtis said today, “put something back into the community.” On the other hand, when I stepped back a bit and watched them, considering the patients, it felt like an assembly line of domination and control. No person really questioned the rightness of all this – it is just assumed.

In the local setting, the consensus is that neutering ultimately preserves feline interest. This consensus enables human participants to ignore the feline cries for affection, to distance themselves from the Thou, in order to “get the job” of control accomplished.

Neutering also preserves human interest. Neutered animals are believed to be more docile and manageable companions – more controllable. According to Tuan (1984), pets might be lavished with affection in the United States, but they simultaneously “exist for human pleasure and convenience” (88). Sexually intact animals are a nuisance. These animals freely reproducing outside the home poses the “problems of zoonotic diseases, garbage scattering, fecal deposits, and urine volume, mak[ing] animal control the number one complaint by citizens” (Beaver 1991:1241). Inside the home, they are “smelly” and “dirty.” Tuan (1984) presents a survey conducted on a sample population in the Twin Cities area in Minnesota in which participants argue that “female pets ought to be spayed because their blood is ‘messy,’ ‘annoying to see,’ ‘dirty,’ and will stain carpets and furniture. Castrated male pets, they say have the advantage of being more docile and less smelly” (88).
In an article discussing the cultural attitude of human stewardship toward wildlife (specifically condors), Charles Bergman (1999) points out that “it is hard not to conclude there is something convenient for us in this arrangement” (251). This convenience, he argues is “complete control over the creatures” (251). Both Bergman (1999) and Cooper (1999) argue that social practices involving “stewardship ideologies” toward other subjects, be they other creatures or other humans, are ultimately in the interest of the more powerful group; even as they are directed to protect the interests of those others. The result of relationships formed under these ideologies is to prevent the “I” from encountering the Thou. Moreover, this relationship leaves the “I” incomplete. As Martin Buber (1971) suggests, “this is part of the basic truth of the human world: only It can be put in order. Only as things cease to our You and become our It do they become subject to coordination. The You knows no system of coordinates” (81)

We might argue from this stewardship ideology that humans are twisting ‘other’ animals into cultural inventions through the “complete control” over their lives and as we do this, we are losing parts of ourselves as nature. Indeed, I believe that this is exactly what Paul Shepard (1993) argues in his article “On Animal Friends.”

From this metonymic stew of the animal as friend and object emerges the paradox that primal peoples kept their distance from animals – except for their in-taking as food and prototypes—and could therefore love them as sacred beings and respect them as ‘peoples’ while we, with animals in our laps and our mechanized slaughterhouses, are less sure who they are and therefore who we are. (289)

He suggests that domestic animals actually disconnect us from nature because of the “God-like” human control over their lives. As we make others such as felines it,
through our controlling actions, we also transform ourselves into objects of control. Only by seeing others in their entirety can we see ourselves in ours. By domination of nature, we dominate ourselves – we limit our ability to encounter each other. Ideological consensus then, helps us to forget, ignore, and collude in control over other subjects; making it possible to ignore their cries. The everyday social encounters between us are impacted in the sense that humans can experience little tension despite the fear and pain of those we are connected to even as we define them as subjects; maybe even because they are defined as subjects anthropocentrically – on human terms (Michael 1996).

It is possible that lacking consensus, this power over ‘other’ animal’s lives (including how we define them) becomes more salient – more obvious. For some people, the salience of this power over other subjects or living beings is scary, because deep down is the ultimate recognition that we are losing ourselves in the process. Possibly, for many people, there is a limit to the control over nature that they can be comfortably tolerated. Some people might argue that the unquestioned control and manipulation over animal bodies (in the form of preventative health and neutering) is actually a manifestation of their object status in the United States. This may in part be true, however this control and manipulation is not unilaterally unquestioned – it is not complete control, or we would not see ideological conflict and negotiations among humans within the practices of declawing and euthanasia. After exploring the practice ideologies that exist in the veterinary hospital, these stewardship ideologies, I argue, are not simply about the complete domination and
control over feline lives, but a balancing of feline interests within the human constructed societal structure; including the dual status of animals as legal objects and individual subjects.

As I point out in both chapters seven and eight, some practices within the veterinary hospital, such as declawing and euthanasia, are not unilaterally constructed as in both feline and human interest, but rather, there is a continuum of legitimacy. In this continuum, it appears that the more that the practice is defined to service the human quality of life the less acceptable it becomes to a greater number of human participants. Moreover, staff participants are not cohesively in agreement on where the moral line of legitimacy should be drawn.

In chapter seven, I draw out the continuum of acceptance involving onychectomy and show how human-feline encounters are influenced by this continuum of legitimacy. Unlike the practices of both neutering and preventative health, declawing is not defined as ideally in their best interest. This actually makes sense given the underlying assumptions about the dangers that felines face outside of human control and the larger public’s irresponsibility. If being “out there” outside of human control (vulnerable to the dangers of human irresponsibility and nature) is dangerous, it makes sense that declawing fails to enjoy the same ideological consensus that preventative health and neutering does. Declawing is understood by many participants to leave the feline “defenseless.” The number of claws removed signifies the greater danger that a feline is subject to.
Since felines are socially defined subjects, they can suffer from the removal of their claws. Greater suffering is involved in patients who are older because they are more “used to having them.” Older patients are also understood to feel more pain and take longer to heal because of the greater body mass that they have. Finally, one staff member made an interesting point during our conversation regarding the rear declaws of felines; “how are they supposed to scratch themselves?”

The continuum of acceptance within the local setting has an impact on the staff members’ feelings of tension and expressions of affection within social encounters with felines. Simply put, the more that the practice is defined as serving the client’s interest more than the patient’s interest, the more that staff members find their participation in this practice problematic. The more problematic the practice becomes, the harder it is for staff members to simply dismiss a patient’s pleas for attention or anger at being subjected to forceful control tactics.

In chapter eight, I outline the continuum of acceptance or “legitimacy” (Sanders 1999) that is constructed to guide the encounters involved with euthanasia. Similar to the results from Sanders’ (1999) study of euthanasia ideology in a veterinary hospital, patients who are defined as suffering from incurable or severe injury or illness are “the most legitimate candidates for euthanasia” (76). Sanders suggests that although staff members consider these situations as legitimate reasons to engage in the practice of euthanasia that the practice itself remains emotionally problematic for both staff and clients. In contrast, I suggest that while it remains emotionally problematic for many clients because they are presented with the dual loss of a significant other (Belk

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1996) and possibly part of their own selves (Hewitt 1997); it fails to present a great deal of tension for staff members. Indeed, sometimes for staff members, euthanasia relieves the tension that is involved in seeing a socially defined subject suffer from severe pain.

I think that the slightly differing results of staff members' tension within this circumstance presented by Sanders (1999) and myself is the difference involved in client present euthanasia. Clinton Sanders claims that most of the clients in his study chose to be present during the euthanasia. In contrast, the clients in my study often chose not to remain. The staff member tension then, from Sanders' study could be a result of the client’s presence rather than euthanasia itself. In fact, he himself points out that “from the veterinarian’s perspective, the presence of the client was potentially problematic” (81). This perspective, that client’s presence makes the euthanasia encounter more tense for staff members, is supported by other veterinarians accounts of “the problem with euthanasia.”

Given the contrasting evidence about staff member tension within some euthanasia encounters between my research and Sanders research, I would suggest that further research be conducted to explore the impact that client presence has on the experience of staff members’ tension. This can be accomplished through a comparative analysis of observations of both client-present and client-non-present euthanasia. In addition,

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271 I have to point out here that the differences between our studies in whether the clients chose to remain could involve the companion’s species. Sanders study involves canines while mine involves felines. Are clients more likely to remain present during canine euthanasia than feline euthanasia? If so, is this because canines are socially defined as more dependent on humans while felines are socially defined as more independent?

what impact does the choice of the client to remain present or not present during the
euthanasia of a companion have on their ability to cope with that death? Does
watching their companion die increase or decrease their tension involved in such a
decision? Finally, given that veterinary medicine is also about serving the best
interests of the patients (albeit within the larger social structure), how does the
presence of the client impact the experience of the patient? Does the patient appear to
be more or less comforted by the presence of the client during this practice? One
might think that the client’s presence will have a comforting effect on the patient. On
the other hand, if the client is tense and that tension increases a staff member’s
tension, and patients are influenced by this tension, then one might expect that the
client’s presence will actually make the process of euthanasia more scary for patients.
Comparative analyses of these encounters not only offers a broader understanding of
the impact that social context has on human-‘other’ animal encounters, but it also has
important practical and ethical implications for veterinary medicine.

When participants define a patient’s behavior as suffering, little human tension
and a great deal of affection is involved in the encounter while felines are
experiencing the complete opposite. While individual agents work together to define
the feline as suffering and they do so through observations and interpretations of
feline behavior, this lack of tension is also a result of the ideological framework
within which the encounter occurs. If, for example, the ideological framework
supported an interpretation that humans have no rights to control death, the
definitional negotiations including the interpretation of the patient’s actual behavior
might result in a completely different encounter (even if the humans in both cases
defined the ‘other’ animal as a subject using similar criteria for subjecthood).

The staff member’s experiences of tension between themselves and within the
social encounter increases with their inability to define or disagreement over the
definition of the euthanasia as in the patient’s best interest. Similar to the practice of
declawing, the greater difficulty staff members have in defining the practice in the
patient’s best interest, the more influence the feline’s behavior ultimately has on the
staff member’s experiences of tension and affection.

Interestingly, while both practices fail to enjoy a unilateral consensus among
human participants, the owner of the hospital under any circumstance unquestionably
provides declawing while euthanasia is more contextually negotiated. Dr. Curtis’
explanation for unquestionably providing declawing is that he does not know the
context of the situation. This is interesting, because he does not know the context of
the situation with euthanasia either – until he investigates it. From this, it is easy to
conclude that he finds the outcome of euthanasia to be more problematic for patients
than the outcome of declawing. Indeed in his own words, “if I had a choice between
death and declaw, I would pick declaw for sure.” However, in chapter eight I point
out that death is not inherently problematic. Sometimes staff members define death
as the preferred solution to a patient’s situation. Some might argue that declawing is
unquestionably offered because the practice is economically advantageous for the
Doctor and his reasoning is simply a rationalization for a behavior that does not serve
a patient’s interest – but rather serves the doctor’s and client’s interests. Indeed that
was my original assumption about why Dr. Curtis unquestionably provides declawing. While, this in part may explain why the disparity of negotiation between the practices, I no longer believe that his reasoning on the practice of declawing is a simple rationalization to bring more income to the hospital. Rather, as I point out in the discussion section in chapter seven, it is part of the balancing act that veterinarians are forced to engage in within the social structure. As Anthony Giddens (1984) suggests, participants are knowledgeable about the constraints placed upon them by the various interconnected social institutions that we call social structure – and their lines of actions reflect this knowledge.

The Pediatrician and the Mechanic

While practice ideology and ideological consensus and conflict has an impact on everyday human-feline encounters in the veterinary hospital, other social contexts appear to influence these encounters as well. The main social contexts that I explored in this study include the role that the doctor plays, the presence of the client, the patient’s age, and the patient’s social status between felines. Early in my research, I observed that Doctor Curtis encountered felines through a kinship metaphor and directly spoke to patients, while Dr. X encountered felines through a mechanical metaphor and never addressed a patient, nor touched them except out of medical necessity. This is an important finding in its own right because it indicates that veterinarians differ among themselves in their approaches to medical treatment.
toward ‘other’ animals and their roles will result in differing types of doctor-patient encounters.

This finding lends itself to further investigation. First, do these roles exhaust the possible approaches to medical treatment in veterinary medicine as Rollin (1999) implies? Second, what social or psychological factors promote these differing approaches to veterinary medical practice? One factor suggested by various veterinarians is veterinary medical socialization. Elizabeth Atwood-Lawrence (1994) suggests that veterinary educational institutions promote the adoption of the mechanical metaphor and devalue medical approaches that are compassionate and affective. Evidence of her claim can be seen in the admission qualifications in veterinary universities.

In a book published in 1978, designed to introduce veterinary medicine to prospective students, Leon and George Whitney point out that a dean of admissions is less likely to admit a student – let a student through the professional gate – based upon his/her love for animals. The more “promising” students recognize the economic importance of ‘other animals’ to human society and although they may define the ‘other’ animal as subject and care about their well being, they focus on the medical and human interest aspects of veterinary medicine. If that prospective student also has experience working on farms and inspecting the meat in slaughterhouses, their chances of professional entry are significantly improved.

Try writing the dean of admissions of any veterinary college. Say you are a city person who has always loved animals. You have kept rabbits and hamsters and your family has always had a dog. Even if your marks are excellent, you almost certainly will not be accepted.
But suppose you could say, 'I've grown up on a stock farm. We have 600 heads of White Face cattle. We market about two carloads of hogs annually. I hope you find my marks acceptable....' The dean can scarcely turn down such an applicant.

And then there's the in-between applicant. He may write: 'I hope the fact that I was reared in a suburb won't be held against me. All my life I've handled animals. As Dr. Smith's letter will tell you, I have worked in his hospital in my free time and have ridden with him on his outcalls to assist him in caring for farm animals. Every summer I've worked on a different kind of stock farm to learn all I could about animals.... Such a student is wanted by veterinary colleges.

The last two applicants talk the language of the stockman. They speak of '200 head of cattle' or '120 head of hogs.' They are unlikely to say '200 cows' or '120 pigs.' (7-8)

Bruce Fogle (1999), an author, and veterinarian suggests that the application requirements have not changed since the late 1970's.

I would venture to say that if a veterinary student candidate to almost any Western veterinary school says that his or her primary motivation to study veterinary medicine is a passionate love of animals, that student's chances of admission is not enhanced. Admissions committees look for dispassion not passion. (235)

Moreover, even those students who have gotten through the veterinary gates despite their inclination to employ roles outside of the mechanical metaphor indicate greater emotional difficulty during their training. For example, while describing his veterinary training at Cornell University College of Veterinary Medicine, Allen M. Schoen (2001) explains institutions push toward the mechanical approach.

Throughout my life I had been interested in nature - and therefore in natural healing. But there was no place for creative thinking or for expanding the boundaries of standard medical practice in veterinary school. Unlike human medical school, where students studied one species, at veterinary school we studied dogs, cats, cows, horses, sheep, goats, pigs, fish, lab animals, and wildlife. Everything was mechanical and all that mattered was memorizing the location and purpose of every muscle and bone, every nerve and neuron, every cell of every different species and the differences between them. And often we were learning techniques only to palliate and suppress disease, not to cure it or treat its underlying causes....the majority of the professors tended to be cool and aloof [toward animals under their care]. (30)
His training, from his perspective, left little room for empathy or compassion for the ‘other’ animals under veterinary care at the University. It did little to foster recognition that patients need comforting because they are emotional and social beings.

Once, during my senior year, I was on night duty in the animal intensive care unit. There a lonely yellow Labrador, recuperating from surgery for a fractured femur, lay whining and squirming around in his sterile stainless-steel cage, a pathetic ball of quivering fur and flesh, licking the crusted blood around his surgical site, whimpering as students and residents walked by, ignoring his calls for help.

I couldn’t stand it. The moment the others left I started monitoring his intravenous fluids and antibiotics. Then I opened the cage door and lay down next to him on the floor, petting him, stroking him, talking to him.

Boom! The door opened and the resident on duty stormed in to angrily ask me what I was doing on the floor with this dog. “Petting him,” I said. I asked if he had any painkillers.

The resident snorted. “How do you know the dog is in pain?” he asked. “You’re anthropomorphizing.”

“Isn’t whimpering a sign of pain?” I asked.

“Absolutely not,” the man retorted and strode away. (28-29)

While medical training might encourage the doctor to adopt a mechanical approach toward their encounters with patients, my findings indicate that it may not be the primary factor involved in the choice between roles because the doctors at the Loving Care Cat Hospital had similar medical socialization. As Dr. X informed me during an informal chat, he and Dr. Curtis, “went to the same school, same classes, and had the same friends.”

Another factor that may influence the doctor’s choice of medical roles is early childhood socialization. Dr. X indicated that he grew up on a hobby farm and Dr. Curtis in middle-upper class subdivision next to a wildlife preserve. Possibly, early childhood exposure to various human-animal encounters modeled by significant
others result not only in choices of careers working with animals, but also approaches to doctor-patient relationships. There is evidence that attitudes toward animals can be influenced by childhood socialization. For example, Raupp (1999) surveyed 160 university students to determine what their socializing experience regarding animals was like during their childhood and what the student’s present attitudes and behaviors were regarding animals. Comparing the two, she found that “parental modeling exacerbates the risk that pets will be given away. There is intergenerational transmission of the habit of discarding pets.” In other words, if a mother or father easily discarded pets during childhood, one is more likely to do the same as an adult. We might extend this to explore the effect that childhood socialization has on the likelihood of choosing one role over another in veterinary practice.

During my analysis, I found that across medical contexts, the doctor playing the role of the pediatrician is associated with the most affectionate encounters. This greater association is partly due to a limitation in my analysis. If encounters are defined differentially by the three most salient individual member’s displays of affection (client, patient, staff), I include encounters with the doctor as staff member, and the differing doctors’ roles hinge on differing levels of affectionate displays then I will obviously have this greater association. However, it is significant that the patients themselves reciprocate the affection or lack of affection by the doctor because it supports Alger & Alger’s (1999) empirical evidence that felines are attuned to the social expectations of those around them and often act accordingly to these expectations. However, we must remember that human social expectations are not
always met by felines or we would not have the practice of declawing or convenience euthanasia. In other words, there is a limit to this ability or desire to conform to human actions. When felines fail to conform to our socially constructed expectations, humans are forced to make a decision that may have profound effects on the feline-human relationship.

In chapter five, I pointed out that I expected the role that the doctors played would have a significant impact on the human-feline encounters in the veterinary hospital. I expected this because in Arluke & Sanders’ (1996) comparison of human treatment toward animals in two laboratories, they observed that laboratory technicians appeared to model their behavior toward the lab animals under their care—after the person in authority. I expected that clients might be influenced by these roles to act accordingly toward the patient. I also fully expected that staff members would conform their behavior to match the behavior of the doctor on staff. What I found was that sometimes humans conformed to the encounter model that the doctor presented and sometimes they did not.

Interestingly, the doctor’s role has more of an impact on other human participants’ experiences of tension and affection in the context of ideological ambiguity. This finding is not surprising in light of the weight of social psychological evidence that indicates that the actions and expectations of authority figures influence other human actions and expectations, and that this influence is increased in ambiguous situations. Extension of this finding might be usefully used in the examination of human-‘other’ animal encounters in various occupational settings. What are the boundaries of this
influence? Is the likelihood of abusive behaviors toward animals also influenced in ambiguous situations? In settings where animals are locally defined as objects similarly influenced by the authority figure? If Arluke & Sanders (1996) had compared the practice ideologies within the laboratory settings and the degrees of consensus and conflict within them, might he be more hesitant to suggest that the managers have such a uniform influence on human action toward the laboratory animals? Nevertheless, this influence only lends further support for my argument that human-feline encounters are not driven by individual or even group perception or definitions of the animal other but are contextually situated.

**In the Presence of the Client**

Across medical situations, I found that many felines are considerably more tense outside of the presence of the client. Not surprisingly the felines that are most influenced by client presence are the companions. What does this tell us? Simply stated, but overlooked in other research on human-animal encounters, is that felines can become attached to humans and that they experience and respond differently to differing relationships. Victoria Voith (1981) expands Bowlby’s (1969) definition of interhuman attachment as “an emotion or affective state that causes an individual to keep another in proximity or in frequent communication, and that results in physiological and behavioral responses by the former when the individuals are separated” (272) to include interspecies attachment. Her case study examinations
suggest that humans do become attached to their companion animals evidenced by the measures they take to keep animals close (or alive) and the grief or tension they experience when their companions die. Employing the same definition of attachment, my research expands Voith’s (1981) study to suggest that companion animals also become attached to human companions. This finding indicates that social bonds between humans and felines are reciprocal bonds and need to be studied as such. It also supports Raymond Murphy’s contention that human constructs can only go so far in describing human relationships with nature. The constructs that we build, while having a profound impact on human action toward ‘other’ animals, does not present the whole story.

The Aging Patient

If we examine the impact that the patient’s age has on affectionate encounters in my study, apart from all other social contextual factors, it might be concluded that, on average, kittens are affectively encountered more so than adults. We might then come to Belk (1996) and Tuan’s (1984) conclusion that because humans are more likely to affectively interact with kittens they must progressively lose fascination with the animal as they age. However, this conclusion is inaccurate once other social factors are added into the analysis.

Kittens are fun to be around and their playful behavior as Tuan (1984) suggests can bring some nonsense into what he refers to as modern tedious and rational
existence. Many of my participants stated as such. For example, during an informal chat with one of the receptionists about why she likes to spend so much time with the rescue kittens (including bringing them home on occasion) she answered; “kittens are so cute and cuddly and they are so much fun. They just lighten my day and they make me laugh.”\(^{273}\) However, whether or not a kitten is more associated with an affectionate encounter also depends upon other contextual features of that encounter. For example, in the context of preventative health, I did not note a significant difference between the amount of affectionate interaction between humans (both staff members and clients) and kittens versus adults. However, I did note a qualitative difference in the affection given to kittens, in the sense that kittens were spoken to more often in higher pitched tones and through pursed lips. This qualitative difference indicates that while we might encounter kittens differently than adults, it does not imply that people get bored with adult companions. Indeed, if the reader recalls, clients often expressed more grief over the loss of an adult companion than a kitten companion.

If we combine the stewardship ideology that underlies the medical practices in differing ways, there is a practical reason that staff members and most likely clients might be more likely, on average, to affectionately interact with kittens than adults. Kittens need to learn to function in the human constructed family institution. The more they learn to behave according to human expectations – including being socially responsive to humans – the better they will function and be kept within the family

\(^{273}\) Statement from Anna during an informal chat about why she likes to bring rescue kittens home.
system. Indeed, studies often report "behavioral problems" such as aggression, non-responsive behavior, and peeing outside of the litter box as one of the major reasons cited by relinquishers for abandoning their companions to shelters.\textsuperscript{274} Staff members recognize this from experience with successful and unsuccessful client-patient relationships and are more affectionate to kittens. In addition, we have to remember, that relinquishment for most reasons, including transgressing the boundaries of human expectation, is enabled by the social status of felines as private property. While felines are most often locally constructed and acted toward as subjects, the larger social structure within the United States locates these "family members" as the property of the owner which enables people, when they want to, to treat them as such by trading them, selling them, and abandoning them without fear of human social sanctions.

This social status also enables other social institutions to make discriminatory rules about how many companion animals may be included in the family and what public and private places these companions may occupy. Combine this institutional discrimination with physical reactions by other individual family members (allergies), the frustration with 'other' animals failing to follow human constructed rules of social order, and the legal status of companion animals as property and we have a better understanding of why people relinquish companion animals. According to the staff participants and the studies mentioned above, when kittens first enter into the family structure (the metaphor most used by clients and staff), they are often accorded

\textsuperscript{274} Salman et al. 1998; Miller et al. 1996
temporary social allowances for “misbehavior.” However, if these kittens continue
temporary social allowances for “misbehavior.” However, if these kittens continue
behavior that people do not accept, it gets frustrating. Add any other situational,
cultural, or economic factor and the “owner” can easily get overwhelmed by various
social forces that facilitate a break in attachment toward the feline which may reduce
the affectionate displays between the two.

I have to admit that some people probably do get bored with animals as they age.
However, my suspicion is that these people are coming from a perspective that locally
constructs animals as objects – as toys. Simply look in any child’s closet and you
will see toys that were once cherished, now crushed and dusty beneath the weight of
other discarded toys. No doubt, while some clients may have come from such a
perspective in the veterinary hospital, it did not appear to me to be the vast majority.

This brings me to mention a limitation in choosing the ethnographic method
without explicitly interviewing the clients. I could not verify my observation and
interpretations of the client’s perspectives of felines as object or subject as I could
with staff members. Given that I could not ethically disrupt the flow of the work day,
I could not interview or even in many cases, informally chat with clients about their
attitudes toward the proper place or care of felines. These interviews would have
helped me to better understand whether their actions toward felines are influenced
more by the context of the situation or their individual perspectives on the proper
place of animals in society. As it is, I have to rely on my interpretation of their
perspectives based on their interactions with the patient and their discussions with the
staff members. In other words, with clients I could not engage in a “members check.”
I think that a more comprehensive analysis is needed to distinguish between these two perspectives (indeed between various human perceptions of 'other' animals) and the likely disparate influence that the social context has on them. If the reader will recall, I provided one example where the woman who expressed little bond with a feline, appeared to experience little tension in the context of requesting a euthanasia that was locally defined as questionable. Did she, I wonder, always have this lack of bond with the feline (as a result of her perception of felines as object), did it break as a result of the patient’s behavior (peeing outside of the litter pan), or more likely was it a combination of these various social influences? Moreover, did clients who exhibited observable tension during the process of death negotiations experience this tension from the combination of the expectation of a loss of another subject and the social context, or is the tension simply a result of conflict over the definition of the situation between human actors. Goffman (1970) suggests that humans are often engaged in presenting a positive image to others. If a client expected that the doctor would label them “a bad client” if they expressed a belief about felines as objects, they may have used familial labels and acted affectionately toward the patient even if “at home” they completely ignored or abused the cat.

**Patient Status Between Felines**

Not only does the legal social status of private property influence the everyday encounters between humans and felines; felines are further ranked hierarchically...
among themselves, which has an effect on human-feline encounters in the veterinary hospital. This ranking system appears to be interwoven within the underlying assumptions that support the ideological constructions about specific medical practices. In this study, I found that encounters with strays are, by far, the most distant encounters. As I pointed out in the discussion section in chapter five, this finding lends credibility to Arluke & Sanders (1996) theoretical position that humans rank and accordingly act toward ‘other’ animals based on their perceived social distance. Insects, for example, are perceived by a large segment of the U.S. population to be most unlike humans and are thereby subject to eradication. Mammals, on the other hand, specifically those we bring into our homes (such as cats and dogs) are perceived as having more similarities with humans and are treated with greater respect for their quality of life. Extension of this theory suggests that felines might be treated with more affection and comforted more often based upon their perceived inclusion into the domestic realm. Companions share our homes, rescues stand on the human/nature cusp and strays, stray from the human constructed domestic realm. Thereby, following from Arluke & Sanders’ (1996) sociozoologic scale, we might expect that encounters with companions will be most affectionate, rescues the second most, and strays the least.

Indeed, I found that staff members treated strays with the greatest amount of physical and social distance. Staff members informed me that this distance was intended to protect themselves and other patients from possible contagion. However, when I observed Marcie and other staff members carry and snuggle a rescue kitten
who had one of the most contagious diseases around, I began to doubt that this was all it was. Moreover, even after these strays had been checked for possible disease, they remained in isolation cages and were not interacted with — even when they called for attention. This does not mean that all people, all of the time, ignored strays or failed to interact with them. Some clients brought in strays for vaccinations and checkups — intending to release them afterward — and I found some of these encounters to be surprisingly affectionate. However, for the most part, strays are the felines that are dropped off at the hospital doorstep. In most cases, the stray is held there until he or she is “rescued” (brought under foster care), and then CAT assumes cost of their care. Vaccinations, neutering, and declawing are not automatically practiced on them; because they are outside of human control, their interest (defined as proper care) is not serviced until they become property.

What might be inferred by the evidence that encounters with strays are more distant than encounters with companions and rescues? We might adequately apply, as Arluke & Sanders (1996) theorize and Rajecki, Rasmusen & Craft (1993) suggest, the “social psychologists’ theory of ‘groupness’ (ingroup/outgroup).275 From this, we can argue that, as individuals, animals may be accorded a moral status “as a consequence of their admission to human networks and value systems” (Midgley 1984:10). This status then influences human treatment toward them. Strays are less like us, because they stray from the domestic realm. Maybe, given some of the underlying practice assumptions about nature, they signify a lack of control over

275 See also Midgley 1984.
nature. Strays disturb human spatial ordering – they transgress human defined boundaries of where felines are expected to be (Philo & Wilbert 2000) and this unconsciously threatens some people.

Further support for Arluke & Sander’s (1996) theory is that during surgical pick-ups and drop-offs companion patients and regular clients were associated more often with reciprocally affectionate encounters than rescue patients and CAT clients. However, rather than simply the label (based upon perceived similarity/difference) being the prominent social factor, I suspect that the social relationship or bond has a greater influence on this association. Regular clients have invested a great deal more emotional and economic investment into their relationship with the companion than CAT clients. Likewise, companion patients have spent a greater degree of time and emotional investment (trust) developing an attachment for a single family or individual than rescue patients who often spend their nights in cages (separated from the human) or dividing their time with a number of other humans and cats. Moreover, strays might be affectionately interacted with simply because of the emotional hesitation to become attached to them or encouraging an attachment to humans, given that they are likely to be sent to a barn where they will more likely than not socialize with members of their own species more so than with human species. Finally, I found that staff members, for the same purpose that they interact with kittens more frequently, are more likely to be affectionate toward rescues.

Arluke & Sanders (1996) sociozoologic scale really appears to be an extension of the social distance scale that was developed by Bogardus (1926) and extended by
others in the area of race and ethnic relations to measure the degree of social distance that various racial and ethnic groups create between them. This scale is based upon the similarity attraction principle described above. Although I am now more leery of the cross-species application of theoretical models, the researchers that discuss social distance between ethnic groups point out that this distance is mediated by various other social and social-psychological factors. In other words, while my findings offer some indication that Arluke & Sanders’ (1996) scale may be relevant to the study of human-‘other’ animal encounters, this scale needs to be balanced against the ideological frameworks, situational, relational, and cultural contexts that the encounters occur within.

I question whether this scale can even be extended between species for two reasons. First, I have found that humans have a qualitatively different way of relating to ‘other’ animals; they are recognized as both subjects and objects simultaneously and the subject is not the same subject as we generally apply to human species. Second, I think that while humans and ‘other’ animals are similar and can engage in social interaction, we are also different and encounters should be recognized as such. While I now question the applicability of this model for human-‘other’ animal encounters, I am still inclined to suggest further investigative analysis of it to rule out or in interspecies generalizability. A comparative analysis between more than one veterinary hospital (i.e. urban versus rural), a study of types of encounters between the species in a mixed animal veterinary clinic, cross-cultural interspecies encounters where various labels are applied to differing species, or a cross situational (i.e. war

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versus peace or economic stability versus instability) analysis of encounters between the species might help us carve out whether this model can be usefully applied and which factors might mediate this scale.

**Other Social Factors Mediating Human-Feline Encounters**

I quickly wish to refer back to some of the other social factors that I noted during my findings influence social encounters with felines. First, I wish to point out that while there is, no doubt, personality differences between individuals humans and individual animals on how we encounter each other, I found that occupational roles had some degree of association with specific social encounters. I noted earlier that the role chosen by the veterinarians were highly influential to dyadic encounters. Likewise, the roles played by various staff members were also associated with differing encounters. The caretaker was most associated with reciprocally affectionate encounters. It seems that the patients are not threatened by her as her occupational tasks are to comfort and care for them. On the other hand, the receptionists are expected to attend to client needs more so than the patients. Not surprisingly, I found that encounters with them were significantly more likely to be distant. Finally, the veterinary technicians and veterinary technical assistants were, from my perspective, defined by the patients as most threatening (shots, bloodwork) and were most often associated with patient-tense encounters. As Pam, the caretaker, once remarked when a patient chose to hiss only at the veterinary technician, “she probably knows who is the one that is going to give her the poke.” While, as Buber
(1970) suggests, I do not have experience with the minds of ‘other’ animals and therefore can not assertively suggest that this statement is “valid,” I do have observational evidence that indicates that patients do respond to these various roles.

During my analysis, I also noted that sometimes the human constructed physical ecology, (cat carriers, and cages) had an impact on human-feline encounters. Philo & Wilbert (2000) and Michael (1996) take a Marxian analysis and argue that the material world, although often mediated or created by human constructions, can impact human social encounters with nature. The physical construction of the cat carrier and the location of the cages limit the feline and human’s ability to reciprocate affection. Likewise, the physical distance of differing cages also enables and constrains various interactions. Staff members are better able to distance themselves from the suffering of patients when the cages are further removed. They are also less likely to ignore patients who are physically closer to the waiting room. Finally, I need to add that it is possible that physical distance is a social factor in social distance – strays are placed in a closet and the door, while allowing patients to be physically visible, enable them to be audibly silent. In any regard, this material reality must be accounted for when exploring encounters between the species. However, this can not be the only factor if one wants to understand human action or attitudes toward ‘other’ animals. Taking that factor alone, how do we account for the variability between human action toward spiders who are seasonally in daily sight and dolphins who are oceans away?
In chapter seven, I brought up another important social context that ought to be considered when trying to understand the nature of human-feline encounters or even human action toward ‘other’ animals; the expressed economic ability to pay for services within a capitalist economic structure. I found that the expressed economic ability to care for an animal has a significant impact on everyday social encounters in situations where a feline needs expensive medical services. I suspect that the economic social position of any person will have an impact on their encounters with ‘other’ animals. To care for someone, it takes money in a capitalist economic structure. When I was speaking with another sociologist, she stated that ethnic minorities are less likely to care for pets (including providing veterinary care) in the same way that Caucasians are. She pointed to the evidence indicating that many animal welfare and right advocates happen to be Caucasian. While there may be racial attitudinal and practice variations mediating social encounters between humans and ‘other’ animals (Elder, Wolch & Emel 1998), I suspect that there is also an economic and political factor that needs to be accounted for. Indeed, those animal welfare and rights advocates also had the economic position that enabled them to think about the welfare and rights of other species.

Dealing with Uncomfortable Feelings

My observations and analysis of tension management strategies employed within the veterinary hospital helps us to understand the various ways that people can
participate in what they define as problematic animal practices; practices which they define through their experiences with the animals themselves as not in the animals' ultimate best interest. Human-animal Interactionists pointed to the technique of objectification to maintain "practices of domination and control" (Adams 1995). I found that staff participants did not generally employ this tension management strategy. Rather, individual agents explicitly rejected the objectification of another even as they colluded in the objectification enabled by the structural frameworks within which their encounters were contextually situated. This lends itself to further investigation of not how or why objectification might occur, but under what social context this technique is more or less likely to be used. A comparative analysis of various social situations where 'other' animals play a central role might be a good place to start answering this question.

Concluding Remarks

In this research, I argue that human-feline encounters within the hospital are a product of multiple interacting social and social psychological factors. The major social factors explored in this study include ideological consensus/conflict, role of the veterinarian, client presence, feline age, and cat status. The social psychological factors most significant in this study and important elements of human-feline encounters in a veterinary hospital include the social construction of feline identity and the tension management strategies employed by staff members. The picture that
should emerge is that by combining certain factors one is more likely to find different types of human-feline encounters.

Focusing my analysis specifically on staff-patient encounters I show that mutually affectionate encounters are most often associated with the social factors of ideological consensus, the medical doctor that plays the role of the pediatrician, the presence of the client, and a companion kitten. The feline identity in this context, as controlled, does not become salient and staff does not need to rely on tension management strategies. In this context, the illusion of the kinship metaphor is unchallenged. It is unchallenged because the doctor’s role and the relationship between client and patient make this metaphor central. I call it an illusion because felines do not stand only as members of the family. As I clearly present in chapter eight, felines’ legal property status enables some people to dispose of them.

When animals become our kin, the metaphor implies that they will continue to nourish their human relatives eternally. Prey and predator are bound, like family, into a never-ending dialogue...But the use of the category ‘kin’ to describe our reciprocal relationships with animals...implies the category ‘not kin.’ And ‘not kin’ can devolve into the category ‘vermin’ and remorseless destruction can follow. (Katcher & Wilkins 1993:189)

As I point out in chapter four, this combination is most prevalent when the purpose of visit is preventative health. However, I suggest that while the ideological framework and its underlying assumptions do help to structure the staff-patient encounters, the ideological consensus has more impact than the practice itself. Ideological consensus, functions in two ways in human-feline encounters in the veterinary hospital. First, it enables cooperation among humans to care for the needs
of felines. As the humans define felines as worthy of care - as subjects - the
encounters can be mutually affectionate. Second, this cooperation can have the effect
of enabling not only connection toward felines, but also disconnection - when felines
challenge the definition of the situation. Had I failed to include felines as
participants, and defined encounters with tension and affectionate displays towards
felines I might have missed the impact of ideological consensus; during neutering and
preventative health very little tension was observed in humans but neutering did
present tension for felines. Likewise, I might have missed the significant finding that
felines do challenge human definitions of the situation. When they do, ideological
consensus works against them and ideological conflict makes it more difficult for
human participants to ignore this challenge.

Arluke & Sanders (1996) refer to their canine participants as “mute.” My feline
participants certainly were not “mute.” They made it clear what they needed and what
they wanted. Most often staff members and clients were socially responsive to these
needs. However, sometimes they were rendered mute by the human social
constructions. For example, the ideological consensus of “for their own good,” and I
am not saying it was or was not, functioned to render subjects mute - enabled their
silencing - even with people who listened.

Sanders (1999) points out that defining ‘other’ animals as emotional and cognitive
beings -- as subjects -- is an important element to the structuring of social encounters
with ‘other’ animals. My research supports this argument that the perception of
others as minded social beings -- as subjects -- impacts the everyday encounters.
However, this human perception is not the only nor, I would argue, the primary "element" to the structure of human-feline encounters. Animals exist for many individuals as both subjects and objects simultaneously. Moreover, human perception of animal agency is not the determining factor in the resulting social encounters. Humans and animals live within intricately complex and interweaving social contexts that at various times impinge on the encounters themselves. Any sociological analysis of human-animal encounters that fails to examine the surrounding social context is extremely limited as both humans and other animals are intricately connected with each other, nature and culture.

"If not by outright encounter, exchange, observation, and perception, then by inference, intuition, and subjective immersion in more than one hundred billion different settings, contexts, circumstances, and moments...our species has made contact with other species. We are not alone on this earth, abundantly not. The more we deny this unambiguous truth, the more we clinically define the true terms of multiple-personality disorder with its tragic consequences for Mother earth. (Tobais 1998:155)"
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APPENDIX A

PARTICIPANT CONSENT FORM
Western Michigan University
Department of Sociology
Principle Investigator: Dr. Gregory J. Howard
Student Investigator: Ms. Dana Atwood

I have been invited to participate in a research project entitled “Breaking out of the Anthropocentric Cage.” This research is intended to study how veterinary clinics operate. In particular the research is an attempt to communicate despite language barriers, and what these interactions mean to human participants. This research is Dana Atwood’s dissertation project.

Should I choose to participate in this project, I will be observed while I conduct the practice of veterinary medicine. I may also be asked informal open-ended questions to clarify my actions as well as to help the researcher understand the meaning that I attribute to my interaction with others in the setting. Dana Atwood is both volunteering and observing at this clinic for a total of eight weeks for this research project.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to me except as otherwise specified in this consent form. The researcher will make every attempt to adopt a stance of noninterference in veterinary practice.

The immediate benefits from this research will be volunteer services (defined by my need) that Dana Atwood will provide during the observations. Dana Atwood agrees to help when needed in any way that will benefit the participants involved. Long-term benefits to the participants include greater understanding of interspecies interaction, which may lead to improvements in institutional policy and will most definitely aid in broader understanding of the connections that we make with each other and other species.

All of the information collected from me is confidential. That means that my name will not appear on any papers on which this information is recorded. The forms will be coded, and Gregory J. Howard will keep a separate master list with the names of participants and the corresponding code numbers. Once the data are collected and analyzed, the master list will be destroyed. All other forms will be retained for at least three years in a locked file cabinet in Gregory J. Howard’s office.

I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have any questions or concerns about this study, I may contact either Gregory J. Howard at 387-3595 or Dana Atwood at 372-8919. I may also contact the chair of the Human Subjects Institutional Review Board at 387-8293 or the Vice President for Research at 387-8298 with any concerns that I have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature.

My signature below indicates that I have read and/or had explained to me the purpose and requirements of the study and that I agree to participate.

Signature: _________________________________ Date: ________________________
APPENDIX B

VETERINARIAN INTERVIEW SCRIPT
VETERINARIAN INTERVIEW SCRIPT

Profiling Questions for Doctors Only

NAME: ______________________________

I have a strict ethic of respect for the participants of research. I want to assure your confidentiality, but I also want you to have the option of using your name in the research if that is what you would prefer. So the question is -- What name do you want me to use when I refer to you? Do you want me to use your real name, would you like to choose a name, or would you like me to choose one for you?

NAME:

I am finally in my writing stage of the research process and need to profile all of the participants. Some of the questions you may already have answered in one way or another, but I wanted to be certain that I am not misrepresenting you in any way. It is up to you whether or not to answer a question. If you choose not to answer, just say "pass" and we will move on to the next question. These questions mostly involve background and personal information to get a better idea of what your perspective is – where you come from and how this may have influenced your current choices.

■ How old are you?

■ What is the highest year of education that you completed?
- Who lives with you at home?
- How big is your present family? Who does this include?
- (if did not include pets) Do you have any pets? If yes, How many and what species and sex.
- Did you remember always having pets? As a child did you have any pets?
- What kind of place do you live in now? City, Suburb, Country/Small house, large house, apartment....
- Do you own a car?
- What type of car do you drive?
- Why did you choose to drive this particular type of car?
- What is your favorite thing to do?
- How would you describe your childhood?
(happy, troubled, chaotic, peaceful... only mention these words if asked)
- What sort of place did you grow up in?
- How big was your family?
- How close was your family – emotionally – did you get along well?
- What was high-school like for you? Did you have a click that you belonged to?
- Do you believe that, as a child, you were especially close to/or had an empathy or understanding of animals that other children may not have had.
(if yes, then what do you believe contributed to this extra understanding – special bond)
- What do you believe contributed to your decision to become a veterinarian?
In earlier discussions we discussed ethical decisions regarding issues such as Declawing, Euthanasia, and Overpopulation solutions. I feel that I have a good grasp on where you stand on these issues. But can you tell me, do you believe that you have always felt this way about these issues – or did they change for some reason? -- For instance, before I began working here, I was personally against euthanasia for almost any reason. Moreover, I would get physically ill and emotionally troubled any time that I witnessed a death of an animal. However, I recognized that my feelings about euthanasia and death have been substantially revised once I helped my mother-in-law make the decision and follow through with the euthanasia of her 38-year-old horse. She too was surprised at my reaction to it as well. I am much more calm and accepting of the practice and of death in general now that I have researched and helped out in the clinic.

- Declawing
- Euthanasia
- Overpopulation
- Animal research

Is there anything that you believe that I missed asking, that you feel would be an important thing to know about you to better understand your perspective?

- Is there anything about veterinary institutions that you want others to know or to learn about?
STAFF INTERVIEW SCRIPT

Staff Profiling Questions

NAME: __________________________

I have a strict ethic of respect for the participants of research. I want to assure your confidentiality, but I also want you to have the option of using your name in the research if that is what you would prefer. So the question is -- What name do you want me to use when I refer to you? Do you want me to use your real name, would you like to choose a name, or would you like me to choose one for you?

NAME:

I am finally in my writing stage of the research process and need to profile all of the participants. Some of the questions you may already have answered in one way or another, but I wanted to be certain that I am not misrepresenting you in any way. It is up to you whether to answer a question. If you choose not to answer, just say “pass” and we will move on to the next question.

Ok, first question:

- I realize that the atmosphere in this clinic is very cooperative and that everyone helps out where needed, however what is your official title at work? In other words what is your position?
- What type of training did this position entail?
What made you decide to work as a _______________________?

Why did you choose to work at this particular clinic/hospital?

Do you like working here and why or why not?

Where do you see yourself, career wise, in 10 years?

Why this goal? What do you believe contributed to this career choice?

The next section of questions involves background and personal information to get a better idea of what your perspective is – where you come from and how maybe this may or may not have led to your choice to work at a veterinary clinic.

How old are you?

What is the highest year of education that you completed?

Who lives with you at home?

How big is your present family? Who does this include?

(if did not include pets) Do you have any pets? If yes, How many and what species and sex.

Did you remember always having pets? As a child did you have any pets?

What kind of place do you live in now? City, Suburb, Country/Small house, large house, apartment....

Do you own a car?

What type of car do you drive?

Why did you choose to drive this particular type of car?
What is your favorite thing to do?

How would you describe your childhood?

(happy, troubled, chaotic, peaceful… only mention these words if asked)

What sort of place did you grow up in?

How big was your family?

How close was your family – emotionally – did you get along well?

What was high-school like for you? Did you have a click that you belonged to?

Do you believe that, as a child, you were especially close to/or had an empathy or understanding of animals that other children may not have had.

(if yes, then what do you believe contributed to this extra understanding – special bond)

A part of my research deals specifically with ethical issues in veterinary organizations. I want to make certain that I have an accurate understanding of just where you stand on these issues and possibly the reasons that you think help you to take this particular stance.

I want to make certain that I do not guide your answer too much, so I am just going to give you a topic and you tell me – unless you to choose to pass – what you think of the particular practice. If you have questions about anything, feel free to ask.

Declawing:

(make certain to check if there are levels of acceptance in this answer – hypothesis is that it gets less accepted as we move down the list)
■ front foot declaw of kitten
■ four foot declaw of kitten
■ front foot declaw of adult
■ four foot declaw of adult
■ Do you believe that you have always felt this way about declawing? Or has your feelings on this issue changed over the years, and if so what made you change your position?

■ Euthanasia
■ Euthanasia of terminally ill patients:
■ Euthanasia of sick patients that need extensive/costly medical cures:
■ Euthanasia of aggressive patients:
■ Euthanasia of patients for other behavioral problems such as not using the litter pan:
■ Euthanasia of Healthy/friendly patients (client convenience euthanasia):
■ Do you believe that you have always felt this way about euthanasia? Or have your feelings on this issue changed over the years, and if so what do you think made you change your position?

■ Early age spay/neuter
■ From your perspective, do you believe that there is a cat overpopulation problem?
■ What do you believe causes this problem?
What do you believe would be the most effective strategy in fighting this problem?

Do you believe that you have always felt this way about overpopulation? Or have your feelings on this issue changed over the years, and if so what made you change your position?

Is there anything that you believe that I missed asking, that you feel would be an important thing to know about you to better understand your perspective?

Is there anything about veterinary institutions that you want others to know or to learn about?
APPENDIX D

OUTSIDE CLINICAL INTERVIEW SCRIPT
OUTSIDE CLINICAL INTERVIEW SCRIPT

Declaw Local Clinic Questions

Hi, I have a cat and a kitten that I am thinking about having declawed.

1. Do you do declaws at your clinic?

2. What exactly do you do when you declaw a cat? I mean, what is the procedure?

3. Does it hurt them?

4. I heard from a friend that declawing causes cats to have behavioral problems like peeing around the house or biting. Do you believe that it increases the likelihood of these problems?

5. How much does it cost?

6. Does it cost more for a four foot declaw then a front foot declaw?

7. What do you think about four foot declaws?

8. My friend told me that I should definitely not declaw my cat – she is five years old – that it would be worse for her than for the kitten. What do you think?

9. Do a lot of people call and ask all these questions regarding declawing?
APPENDIX E

APPROVAL LETTER FROM THE HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD
Date: June 14, 2001

To: Gregory J. Howard, Principal Investigator
    Dana Atwood, Student Investigator for dissertation

From: Michael S. Pritchard, Interim Chair

Re: HSIRB Project Number: 01-05-17

This letter will serve as confirmation that your research project entitled “Breaking Out of the Anthropocentric Cage” has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: June 14, 2002