CLINICAL ETHICS

Framing, truth telling and the problem with non-directive counselling

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In this paper several reasons as to why framing issues should be of greater interest to both medical ethicists and healthcare professionals are suggested: firstly, framing can help in explaining health behaviours that can, from the medical perspective, appear perverse; secondly, framing provides a way of describing the internal structure of ethical arguments; and thirdly, an understanding of framing issues can help in identifying clinical practices, such as non-directive counselling, which may, inadvertently, be failing to meet their own stated ethical aims. The effect of framing on how individuals interpret information and how healthcare choices are influenced by framing are described. Next, the role of framing in ethical discourse is discussed with specific reference to Judith Jarvis Thomson's philosophical mind experiment about abortion and the violinist. Finally, the implications of this analysis are examined for the practice of non-directive counselling, which aims at communicating information in a neutral, value-free way and thereby protecting patient autonomy.

the individual parents and the risks and benefits for a specific child. The choice of frame is not of course one that the provider of information makes in isolation. Instead, it is a choice influenced by cultural factors, including those of the prevailing medical culture and of the healthcare system and institution within which the practitioner trained and now practises; the historical context within which the communication is taking place; the prevailing economic and political climate; and the personal values, beliefs and experiences of the provider of information.

The way in which the recipients of the information receive and respond to the information offered will depend on their particular social and cultural context as well as on their values and preferences, which is sometimes referred to as the patient narrative. As the priorities and preferences of the patient become clearer during the consultation, the provider may find better and more appropriate ways of framing the information. Although the patient's narrative is an interesting factor in the nature of the communication that takes place, it is not the focus of this paper.

WHY FRAMING MATTERS

Economists, psychologists and literature scholars attribute great importance to framing, challenging the idea that the decisions people make, about the equivalence or otherwise of alternate choices, are objective. Psychologists Daniel Kahneman and Amos Tversky^{3,4} have shown experimentally that the way in which factually identical information is presented to people can have surprising consequences for the choices they make. For example, in one study, research participants were asked to consider the merits of implementing a new immunisation programme and to decide whether they would wish it to be introduced as a public health measure. By reframing the same facts—in the first case by focusing on the lives that would be saved if the programme were implemented, and in the second by focussing on the lives that would not be saved even if the programme were implemented—the researchers were able to make two identical propositions seem unequal in their appeal. When the question was framed such that the lives lost were emphasised, respondents did not favour the new programme. When the question was framed such

Benjamin Freedman¹ has argued that patients should be offered the truth rather than having it imposed on them. This accords well with Dan Brock's² understanding of autonomy whereby patients are entitled to but should not be obliged to take an active role in medical decision making. While acknowledging that not all patients will want to have an active role in decision making, my focus will be on those instances when they do, and on the related need for access to appropriate information on which to base their choices. Information is usually communicated via an oral or written narrative. To communicate information to the patient, the provider of information must therefore decide what kind of story to use to do so or, in the terminology used in this paper, how to frame the information. My concern is the effect that the framing of the communicated information can have on the patient's ability to make informed decisions.

For example, in communicating the facts about the measles, mumps and rubella (MMR) vaccine a public health frame could be used whereby the emphasis is on the health, social and economic benefits, and risks to the entire community. Here the greater good of the entire population is emphasised rather than the effect on any particular person. Alternatively, a frame could be chosen that focuses on the choices and values of

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that the lives saved were emphasised, respondents did favour the proposed programme.

Economist David Kreps⁵ has suggested this occurs because people tend to think of decisions as deviations from the status quo, and that the way in which dilemmas or choices are framed establishes in the mind of the person what exactly that status quo is. In the first framing, it was established in the respondents' minds that without the programme 600 people would die, and the status quo was thereby established of 600 dead. Given this status quo, the saving of 200 lives by the implementation of the immunisation programme is seen as an improvement. In the second framing, the status quo is established as being before these predicted deaths, so that before the immunisation programme no one is dead. Even though the immunisation programme will save 200 lives, by the end of the programme 400 others will have died. This deviation from the status quo is not perceived as an improvement.

In another study, Davey *et al*⁶ carried out telephone interviews with a convenience sample of 106 women aged 45–70 years. The aim of the study was to assess whether the way in which statistical information about the risks and benefits of taking part in a mammographic screening programme was presented had an effect on the women's willingness to participate. Interestingly, respondents indicated markedly greater willingness to have a test when the benefit of a new screening test for breast cancer was expressed as relative risk reduction (RRR) than when it was presented in terms of either absolute risk reduction (ARR) or all-cause mortality. Although a detailed description of the sorts of information that RRR and ARR are intended to convey is beyond the scope of this paper, a brief explanation may be helpful in explaining why people may respond to these equally valid statistical interpretations of a given dataset in such different ways. RRR expresses the difference in event rates between two groups (in this case, death from breast cancer in those undergoing screening and those not undergoing screening) as a proportion of the event rate in the untreated (or unscreened) group. RRR is usually constant across populations, whether the event rates are low or high. The ARR, on the other hand, is the arithmetic difference between two event rates and varies with the underlying risk of an event in each patient. Unlike the RRR, the ARR becomes smaller when event rates are low. In the case of screening of breast cancer, this translates to an RRR of death from breast cancer of 20% in women above 50 years of age in the screening programme compared with the saving of one life if 1000 women above 50 years of age are screened for 10 years.

Davey's results are therefore consistent with Kahneman and Tversky's claim that the way in which (the same) information is framed has a direct effect on the way in which people make decisions about healthcare. They also, however, raise questions about what exactly it means to be informed in this context. Breast surgeon Michael Baum⁷ has argued that the use of RRR constitutes an effective, although admittedly not deliberate, misrepresentation of the facts about screening, and that conveying information in terms of RRR leaves women with falsely optimistic expectations of what screening can and cannot achieve. As a direct result of the way in which this information is framed, Baum argues that women are left ill-informed to make choices about participation⁷ or, indeed, governments to make choices about resource allocation. Paradoxically, if this argument is accepted, then providing patients with meaningful information may require withholding of information that is framed (even inadvertently) in such a way that it effectively misinforms rather than informs. In choosing to do so the framers are, of course, making a judgement about what the correct interpretation of that information should be.

REFRAMING AND THE MMR VACCINE

A contemporary example of the way in which framing can influence the choices people make concerns the ongoing controversy surrounding the MMR vaccine for measles, mumps and rubella. Some parents believe that in rare but tragic cases a child will develop autism after receiving the MMR vaccine. Although the evidence that MMR is a causal agent in autism is unconvincing, what interests me here is the effect of framing on how the issue is perceived by some parents. Immunisation, in general, is after all not without acknowledged risk. All immunisation programmes carry some morbidity and mortality. That this is understood by at least some parents is evidenced by the many questions parents ask about side effects, and the implications of, for example, allergies to egg or swellings at previous vaccination sites. What seems to have occurred in the MMR debate is a reframing of the dilemma faced by any parents who are asked for consent for their child to be vaccinated. The current public health framing of immunisation is one where the high risk of something mild to very bad happening (the illness, disability and death associated with measles, mumps and rubella) is traded for the much lower risk of something mild to severe (the mild to severe side effects including death associated with all immunisation programmes). For communities with living memory or day-to-day experience of the ravages of diseases, such as polio, measles and tuberculosis, the risks that immunisation seeks to minimise are the status quo and, as evidenced by the World Health Organization immunisation programmes in developing countries, when vaccination programmes are available, the uptake is high. Nowadays, in developed countries, there is, at least among the current generation of young parents, little memory of these diseases but there is a raised awareness of autism. It is perhaps easier for some of these parents to imagine autism afflicting their child than it is to imagine measles once more becoming a killer disease.

FRAMING ETHICAL ARGUMENTS

An objective examination of the way in which arguments are framed can be revealing about the value systems and assumptions of those doing the framing. Consciously or subconsciously, people frame their arguments to achieve specific and desired effects. The choices people make about how to frame arguments are, I believe, a natural and logical consequence of the beliefs and values held by those people. Public health officials advocating the implementation of a new immunisation programme and concerned with the greater good are likely to emphasise the lives that will be saved, which would otherwise have been lost. General practitioners, concerned at the consequences of a potential outbreak of measles, and unimpressed by the research connecting MMR and autism, are likely to emphasise the protection immunisation offers against a potentially deadly disease. Breast surgeons who consider screening programmes a waste of limited resources are likely to consider frames that suggest otherwise to be misleading. Conveying information is therefore about far more than choosing which facts to share; it is about the way in which those facts will be presented or framed, with the choice of frame in turn shaping the nature of the truth that is conveyed.

It is, of course, possible for an argument to be framed in a way that seeks to mislead others about the value systems and assumptions of the person proposing the argument, again with specific and desired effects in mind. Here, the term spin is often used instead of frame, with spin implying a degree of duplicity and manipulation. For the sake of this paper, I am instead interested in the role framing has in the honest and sincere attempts of ethicists to make soundly reasoned and persuasive arguments. In the next section, I will detail the role of framing

in Judith Jarvis Thomson's widely discussed mind experiment about abortion and the violinist.

ABORTION AND THE VIOLINIST

Thomson⁸ asks us to consider the following scenario.

You wake up in the morning and find yourself back to back in bed with an unconscious violinist. A famous violinist. He has been found to have a fatal kidney ailment, and the Society of Music Lovers has canvassed all the available medical records and found that you alone have the right blood type to help. They have therefore kidnapped you, and last night the violinist's circulatory system was plugged into yours, so that your kidneys can be used to extract poisons from his blood as well as your own.

As Thomson uses the first person pronoun to identify the person who has been attached, while sleeping, to the violinist, I will also do so. Whether or not you find it easy to empathise with women and girls who find themselves unwillingly pregnant, the use of the first person pronoun makes this scenario personal for you. You are not asked to consider how another person may feel but instead how you would feel. By using the first person pronoun Thomson attempts to draw in and include the reader in the scenario.

Thomson tells you that so long as the violinist remains plugged into your circulatory system for 9 months then it will be possible to unplug him and he will be well. If, however, the violinist is unplugged any earlier he will die. Thomson then asks you to consider what, if any, your moral obligations are to the unconscious famous violinist. Thomson argues that if you are willing to remain attached to the violinist until he is able to live an independent life, then this may well be morally praiseworthy, but, argues Thomson, you will be doing nothing wrong if you decide to unplug the violinist who has no right to use your kidneys. He cannot, she argues, claim any right to the use of your kidneys.

Thomson makes it clear at the outset of this essay that she considers the personhood debate, so central to many of the arguments about abortion, to be flawed. Her case is a carefully constructed one that allows her to move the abortion debate beyond personhood, and the materials used in that construction merit examination. The dependent character in this scenario is a person by both conservative and liberal definitions, and moreover a famous, successful and talented person. This person will clearly lose something he values if unhooked and left to die. By framing her argument in this way, Thomson does not allow herself an alternative path through the moral maze based on arguments about personhood, but instead invites you to consider whether anything other than the definition of what it means to be a person is morally relevant to the abortion debate. Nor does she overplay the predatory nature of those who hook you up while you sleep. In the end, Thomson's argument is that you cannot be expected to stay hooked up to a stranger, no matter how successful, talented and desirous of a longer life.

No one would deny that this case is highly constructed. The fictional and fantastical nature of the case is, clearly, an intentional feature. Nevertheless, the way in which ethicists choose to construct these fictional cases is revealing of the issues they consider pertinent to and distracting from the main thrust of their argument. Thomson actively removed lack of personhood as a possible argument for unhooking the violinist or for abortion; she made sure that the person being asked to support a stranger was not anonymous and disempowered, as women with unwanted pregnancies often are, but was you, the reader. Finally, she ensured that you could not be held

responsible for the violinist's dependency. Indeed, those within his immediate circle were active in hooking up the violinist.

Judith Jarvis Thomson's scenario leads us carefully through the maze. One possible challenge to her conclusion—that those who choose abortion are not morally blameworthy—is that most pregnant women, with the possible exception of intellectually impaired or immature individuals, are aware that even when generally effective contraceptive methods are used pregnancy is always a possible outcome of sexual intercourse. This is a potential weakness in the scenario, because its inclusion implies that Thomson's case is dependent on a denial of any responsibility for the consequences of our actions. The use of this challenge, which Thomson anticipates in her essay, however, implies that even for those arguing against abortion exceptions exist, such as rape victims who cannot be said to bear any responsibility for any ensuing pregnancy and those who are intellectually immature or impaired. Thomson's framing, by removing personhood temporarily from the abortion debate, invites readers to consider whether there are any other factors of moral relevance in abortion, and may even lead those who are against abortion to inadvertently argue for exceptions to their own rules.

FRAMING AND THE PROBLEM OF NON-DIRECTIVE COUNSELLING

The tradition of non-directive counselling was pioneered by John Fraser Roberts,⁹ when he established the first clinic to offer genetic advice in terms of risk. This approach, whereby patients are provided with information but not given any indication about whether the person communicating the information considers one choice preferable to another, is advocated as a way of protecting patient autonomy by ensuring they are not only informed but also free to make decisions on their own, and not the doctor's or nurse's or counsellor's, interpretation of what that information could, should or may mean for them.¹⁰

Whether the counsellors prefer one choice to another will of course depend on the interpretation they place on the information available to them. This in turn will depend on their understanding of the factual information available and their values, beliefs and previous experiences, both professional and personal. Non-directive counselling requires the counsellors to convey the factual information while at the same time ensuring that this information is not coloured or biased by their values and beliefs. There is, however, anecdotal evidence that not all patients find this approach helpful, with some reporting that even when they ask for advice it can be difficult to get doctors to state clearly what they recommend or to answer the familiar question "What would you do doctor?" This experience accords with Carl Scheider's suggestion that "many autonomists are so devoted to a strong version of autonomy and its entourage of ideals and are so sensitive to the ways people yield to pressures to surrender their autonomy that they cannot easily credit that many patients truly want to waive their authority."¹¹ Nevertheless, if we accept that in some situations and under some circumstances, there are patients who will want to make their own decisions about healthcare then, as I will argue below, it will not always be possible for a totally neutral or objective sharing of information to take place. As a consequence, the model of non-directive counselling, however appealing it may or may not be, is philosophically flawed.

CAN INFORMATION BE RE-PRESENTED IN A WAY THAT IS BOTH TRUTHFUL AND VALUE FREE

Let us begin by assuming that it may be possible, in at least some circumstances, for people to re-present information in their possession in such a way as to render it free from personal

bias. Let us then consider a fairly straightforward case, unencumbered by any obvious normative concerns. In this hypothetical case, to enable a patient to make an autonomous decision about whether to accept drug treatment A, drug treatment B or no treatment, the doctor needs to explain the risks and benefits of either declining treatment or choosing drug A as opposed to drug B. The doctor knows that without treatment the patient will die and that drug A has an 80% chance of curing the patient and drug B has a 30% chance of doing so. Let us assume that all other things are equal in terms of risk to the patient from taking drugs A and B and that neither treatment is unpleasant to undergo. Given what the doctor knows, he or she is likely to have a marked preference for drug A even though drug B is better than nothing.

I would argue that if the patient, on hearing the doctor's representation of these facts, interprets these facts as evidence that treatment A is preferable to either treatment B or no treatment, then the communication has been successful and the patient has indeed received all the information required to make a decision. If the patient, on hearing the doctor's representation of these facts, interprets them as evidence that treatments A and B are equal in what they have to offer, then the communication will not have been successful, suggesting that the patient cannot, despite evidence to the contrary, have received all the information required to make a decision. If, as I have argued, the re-presentation of facts is not simply a neutral transfer of information from one person to another but is highly dependent on the frame chosen, then doctors who want to ensure that the patient's interpretation of the data reflects their own, well-informed interpretation will need to take care in their choice of frame. Indeed, if the doctors have a duty to provide the patients with all the relevant information they are in possession of, then it could be argued that in doing so, they are required to ensure that the patients, lacking the knowledge, skills and experience that have led them to seek the doctor's counsel in the first place, do not misinterpret that information.

This analysis, in which the doctors are required to ensure that they frame the information in such a way that it enables the patients to have access to the doctors' informed interpretation of the data, while in keeping with Baum's argument, seems to be in sharp contrast to the demands of non-directive counselling. In non-directive counselling, people informing the patients about the pros and cons of the various alternatives open to them are meant to keep to themselves their own preference and instead to act merely as the channel for objective information. By allowing or indeed actively using specific frames, the doctors are of course acknowledging their subjective interpretation as an integral part of the information being shared, and thereby acknowledging that there is no such thing as objective information.

Let us, however, for the sake of argument, assume once more that a neutral way of conveying information does exist, and that the doctors have merely to choose to convey the information in this way. Next, let us consider exactly how the doctors may try to do so in the case outlined earlier. To quote the claim I made earlier in this paper, to be non-directive the doctors will need to convey the factual information while ensuring that this information is not coloured or biased by her values and beliefs. In this case this requirement is, however, highly problematic, because the original decision to frame the facts about treatments A and B in terms of survival is itself predicated on the assumption that life is a good that is inherently valuable. Trying to conceal this value is, I will assume we agree, a nonsensical objective for the doctor to adopt and certainly not a strategy that I can imagine a non-directive counsellor recommending. Why, you may well ask, would anyone want to conceal or deny that the doctor or counsellor,

along with most of us, values life. Indeed, given that this value is implicit in any framing of the discussion in terms of survival rates, the only way to do so, other than concealing from the patient the relative merits of drugs A and B, would be to reframe the discussion in a way that does not focus on survival rates. This could be done, for example, by focusing on the relative cost of the different drugs and the effect of opting for drug A rather than for drug B on the overall public resources available for healthcare spending. Indeed, this is an argument that has been used in discussions between several primary care trusts and women with breast cancer seeking funding for treatment with the drug herceptin. Although conveying true information, this public health framing would provide little in the way of helpful information to any other than the most altruistic of patients. Most patients would, I suspect, still want to know which treatment is more likely to work and will then want to be free to choose drug A, no matter how this decision affects overall public resources.

On reading this you may well believe that this is a flawed example, that this is simply not a case where non-directive counselling is required, that these facts are amenable to value-free objective communication and that it is obvious that no one, including even the strongest advocates of non-directive counselling, could possibly prefer the patients to be left in ignorance about what the doctors with their experience, clinical expertise, scientific training and knowledge of the patients' wishes and circumstances understands about the pros and cons of these particular alternatives. I agree that the patients should not be left in ignorance of the pros and cons of the particular alternatives, but respectfully point out that this is obvious only because we have assumed that the patient, like the doctor, values life. If instead, in another situation, the statistical data are difficult to explain and to understand, if the consequences of the choices available are beyond the patient's range of experience, and if it is not possible to assume a shared system of beliefs and values between counsellor and patient, then the best way to proceed is less obvious. We then need to ask whether it is reasonable, or indeed fair, to expect the patient to interpret the information conveyed without at least some rudimentary means of understanding the nature of the values that have informed the information provider's choice of frames.

CONCLUSION

I do not wish to underestimate the extent to which non-directive counsellors are aware of the difficulties inherent in their roles. As they work hard to help people who are faced with difficult healthcare choices, I suspect they are all too aware that "they cannot renounce their individual conscience or their obligation merely by invoking patient autonomy".¹² I would, however, argue that non-directive counsellors need to reconcile their desire to offer patients the truth in a non-directive manner with an understanding of the powerful effect framing can have on the healthcare decisions that people make. They will also need to be aware of the influence that their own beliefs, values and experiences can have on the frame they choose, or choose not, to use.

This leaves those who are committed to non-directive counselling with an uncomfortable choice: either they must communicate honestly while accepting that they will, in the process, disclose their own values and preferences to the patient, or they must present the information in a way which is, paradoxically, no longer as close to the truth as they see it, but which the patient will at least interpret as neutral and free of direction from the counsellor. If my analysis is sound, then the first choice is one which enhances patient autonomy, whereas the second choice, albeit unintentionally, undermines it. There is, however, fortunately, one other choice available to those

who favour non-directive counselling: to accept that there are circumstances when the patient will need to know what the counsellor values to properly interpret the information being conveyed. In these circumstances, sharing this additional information enhances, rather than diminishes, patient autonomy.

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