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Would it be ethical to use Motivational Interviewing to increase family consent to deceased solid organ donation?

In this article, we explore whether it would be ethically permissible to use Motivational Interviewing (MI) in conversations with families about deceased solid organ donation. After briefly outlining what MI is (§1) and providing some context around organ transplantation and family consent (§2), we describe how MI might be implemented in this setting, with the hypothesis that it has the potential to bring about a modest yet significant increase in family consent rates (§3). We subsequently consider the objection that using MI in this context would be manipulative (§4). Although we cannot guarantee that MI would never be used in a problematically manipulative fashion, we conclude that its use would nevertheless be permissible as a potential means to increase family consent to deceased solid organ donation. We propose that MI be trialled in consent situations with next-of-kin in nations where there is widespread public support for organ donation.

1. What is Motivational Interviewing?

Motivational Interviewing (MI) is 'a collaborative conversation style for strengthening a person's own motivation and commitment to change'.[1] Initially developed for use with unmotivated problem drinkers,[2] MI has a robust evidence base over a wide range of applications,[3, 4] and is 'effective both in reducing maladaptive behaviors [...] and in promoting adaptive health behavior change [...] for use when client ambivalence and motivation appear to be obstacles to change'.[5]

MI has been shown to be efficacious as a short, single-session intervention. In most of the 200 plus randomised controlled trials where the efficacy of MI has been tested, the MI intervention has consisted of one or two sessions. In summing up the MI research, Miller and Rollnick conclude that 'MI has been tested most often as an intervention of 1 to 4 sessions, and even with relatively brief consultation of 15 minutes or less'.[1] Other reviews have found short interventions to be as effective as long interventions.[6]

Two complementary components of MI, client-centredness and directionality, are thought to be active in successfully influencing behaviour, although a complete theory explaining how MI

brings about behaviour change has yet to be developed.[5] The *client-centred* component emphasises empathy and 'MI spirit'. Empathy involves 'an active interest in and effort to understand the other's internal perspective, to see the world through her or his eyes'.[1] MI spirit '(a) is collaborative [...], (b) evokes the client's own motivation rather than trying to install [*sic*] it, and (c) honors the client's autonomy'.[5] MI requires practitioners to evoke the client's own reasons for and against change, and to understand and accept them. MI emphasises collaboration and power sharing in interactions between client and practitioner, requiring the latter to refrain from assuming an expert role, and accepting that the final decision in favour or against change rests with the former. Finally, MI requires the practitioner to reinforce the client's perception of control and ability to choose.

The *directional* component of MI consists in the practitioner '*selectively* eliciting and reinforcing the client's own arguments and motivations for change [emphasis added]' ('change talk'),[7] while taking care not to evoke 'sustain talk', which favours the behavioural status quo.[5] Thus, 'MI departs from traditional conceptions of client-centred counselling [...] in being consciously goal-oriented, in having intentional direction toward change'.[7]

2. Organ transplantation and family consent

Organ transplantation is an effective means of managing end stage solid organ failure. Transplant recipients have a reduced risk of mortality and improved quality of life compared to patients receiving alternative treatment.[8] Transplantation may also offer significant benefits in terms of cost effectiveness for healthcare providers.[9] However, '[i]n virtually all [the countries where transplantation is practised] the questions constantly being posed are where and how enough organs for transplantation are going to be obtained'.[10]

In respect of deceased donation, debate over how to meet the shortfall of solid organs has centred on the legal framework for transplantation, in particular, the effect of a switch from an explicit consent, 'opt-in', regime (e.g. United Kingdom, United States), to an 'opt-out' regime under which individuals are required to register an objection in order to prevent donation upon death (e.g. Belgium, Singapore, Spain).[11] While there is evidence of an association between opt-out systems and increased organ donation, it has been advanced that 'factors other than [opt-out contribute] to the variation in organ donation rates'.[12] Adoption of opt-out

legislation may therefore only be one element in a framework approach that addresses organ need.[11, 13]

Whether legislation takes the form of opt-in or opt-out, one factor that exerts significant influence on donation rates is family objection.[14-16] This is notwithstanding survey evidence that demonstrates, in nations such as the United States and United Kingdom, high levels of public support for organ transplantation.[17, 18] Rosenblum et al analysed the legal regimes of 54 nations, of which 25 had enacted opt-out legislation and 29 had enacted opt-in legislation.[11] The authors found that 21 of 25 nations with opt-out legislation 'allow the next-of-kin to object and prevent a potential donation'.[11] In the four remaining opt-out nations 'health professionals do not override the deceased's registered wish to be a donor in the case of an objection from next-of-kin but will respect an objection if there is no such record'.[11] All 29 nations with opt-in legislation require family consent where the deceased's wishes are unknown.[11] In 25 of 29 opt-in nations, family consent is required even where the deceased has a validly registered wish to donate, and in the remaining 4 opt-in nations, family objection may prevent donation notwithstanding a legal right to retrieve.[11]

In practice, family objection may account for a large percentage of potential donors not becoming deceased organ donors.[19, 20] In many countries, rates of family refusal greatly exceed the proportion of people who are opposed to organ donation. Commenting on their findings from a qualitative study of relatives who refused to donate a deceased relative's organs, Sque et al write:

> ... many participants who had positive views of donation, and who knew of the similar views held in life by their deceased relatives, declined donation. Understanding what influenced participants to decline donation despite having positive views may help us to understand why populations that generally support organ donation and transplantation have high refusal rates.

Of course, respect for strongly held beliefs and values that militate against donation renders unfeasible a consent rate of 100 per cent among families approached to donate. Nevertheless, there may be room to increase family consent rates,[11, 12] and a number of modifiable factors have been associated with improved rates, in particular, the provision to and understanding of

information by families, who makes the request, and the timing and setting of the conversation between requestor and next-of-kin.[16, 21]

Indeed, it may well be that the procedure for requesting family consent has a crucial influence on rates of donation. As Vincent and Logan write:

> It is a consistent finding among other work that a sensitive and empathetic manner (or lack of) during family discussions is a discriminator between donor and non-donor families, and that those families who feel pressurized or feel that staff are uncaring are less likely to donate.[16]

With this in mind, an MI-based procedure for consent to organ donation may be an excellent candidate for increasing family consent rates. In the next section, we outline why and how MI might be successful in this setting.

3. MI and family consent to organ donation

MI is used to help individuals resolve ambivalence in the direction of change.[3] Before discussing why and how MI could work in the context of family consent to organ donation, it is helpful to outline how MI might (hypothetically) work in a setting where its efficacy has been demonstrated: alcohol use.[i][22] A problem drinker might be ambivalent about cutting down. He may take pleasure in drinking, yet is aware that his (excessive) alcohol consumption is taking its toll on his work and family life. If he does not reduce his alcohol intake, his professional and social situation is likely to worsen considerably over time. MI might be used to elicit and strengthen his motivation in favour of change, possibly leading him to reduce alcohol use.

Similarly, next-of-kin may be ambivalent about whether to donate the organs of a loved one. This ambivalence is often conceptualised as a kind of 'dissonance' or psychological inconsistency in the decision-maker.[23, 24] Thus on the one hand, the potential donor's

[i] For example, as a brief intervention for heavy- or low-dependent drinking, MI has been found to produce low to moderate effects in reducing alcohol consumption when compared to no treatment or other interventions respectively.

family may believe that organ donation is good (this would seem likely in nations where public support for organ donation is high). On the other hand, support for donation may be displaced in concrete situations by a number of reasons, such as dissatisfaction with the person and/or process by which consent to donation is sought.[21] Even where organ procurement practice is optimal, next-of-kin may have reasons associated with the loss of a loved-one that count against donation. Such reasons may emanate from a desire to protect the integrity of the body,[23, 25] and individual responses to grief. Where the reasons that count in favour of donation are outweighed by reasons that count against it, family refusal to donate is likely.

MI may help next-of-kin resolve this ambivalence about donating a loved one's organs in favour of donation, by evoking and reinforcing statements that point toward consent, while avoiding dwelling on utterances leaning toward refusal. At least in terms of what the practitioner does, the family consent to donation context is arguably analogous to the alcohol use context. Would the consequences be similar for the problem drinker and the next-of-kin decision-maker? Most of us would accept that it would be better if the drinker reduces his alcohol consumption. He might enjoy a better family and work life, which would benefit those around him too. Conversely, not cutting down would have opposite negative consequences. In the family consent context, it is relatively uncontroversial to claim that donation is better for recipients and their families. We might also claim that it would be better for the decision-maker. In two separate studies, Sque et al found that, on the one hand, relatives who consented to donation 'remained supportive of their donation decision' over time,[24] and, on the other hand, some experienced 'feelings of guilt and selfishness' following a refusal to donate the organs of a loved one.[23]

It is submitted that the structure of the ambivalence and its consequences in the organ donation setting is sufficiently similar to other contexts in which MI has been successfully employed. Moreover, since the evidence base suggests that MI is efficacious in 'small doses', we advance that it might feasibly be applied to organ donation situations – circumstances in which the requestor has a limited window of opportunity to gain family consent.

However, we concede MI might not work in all situations in which family consent to organ donation is sought. For example, two people of equal qualifying relationship under the relevant legislation may both wish to respect the deceased's wishes, but interpret facts about his or her

wishes differently. This factual uncertainty may lead to different conclusions (consent, refusal), though neither necessarily oppose donation in principle. Since such situations do not really involve the kind of ambivalence that MI is designed to resolve, using MI is unlikely to be any more successful that other strategies for requesting organ donation from next-of-kin.

Notwithstanding the preceding limitation (and perhaps others), MI might yield modest yet significant effects in gaining family consent when favourable attitudes to donation conflict with other factors pointing against it. This possibility provides a strong reason in favour of trialling MI in this setting, since more frequent family consent would increase the number of transplantable organs.

However, independent of the possible benefits, it might be argued that it would unethical to use MI to guide next-of-kin toward consent to organ donation, since this would be manipulative in a way that is problematic.

4. Manipulation

Understanding and applying a concept of manipulation is by no means straightforward.[ii] An objection to some practice on the grounds that it is manipulative involves a descriptive claim that i) A induces B to φ, and an evaluative claim that ii) A does this in a way that is unethical.[26] When considering procedures for gaining family consent in the context of organ donation, this indeed appears to be the structure of the objection.

For example, the 'presumptive approach' is a technique that has been developed in order to increase consent rates.[27] This approach relies on the assumption that most individuals, given the opportunity, will save lives, and that organ donation is a morally unproblematic way of saving lives.[27] Requestors use 'value positive' language, such as stating that a majority of individuals in a similar position would consent to donation, as well as presumptive statements, such as '[w]hen you decide to donate',[27] and '[i]f you do not have any more questions, I will now guide you through this process'.[28] Truog criticises the presumptive approach on the grounds that language typically employed by requestors is often 'clearly misleading or even

[ii] Thanks to T Martin Wilkinson and the handling editor at JME for pointing this out.

manipulative', which in turn 'undermines many of the core elements of informed consent'.[28, 29] As a matter of law and ethics, we typically take valid consent (sufficiently well informed, competent, and voluntary) to be a manifestation of autonomy. Truog argues that when consent is undermined by the (manipulative) presumptive approach, the individual's autonomy is violated. Therefore, the presumptive approach is unethical, as well as its progeny, the 'dual advocacy' approach.[29, 30]

Would MI use in organ donation conversations induce next-of-kin to consent – is it descriptively manipulative? Would gaining consent in this way be unethical – would MI use here be manipulative in an evaluative sense?

In respect of the first question, MI interventions are designed bring about behaviour change. Miller writes that 'we *hope* that our treatments are manipulative; that is, that they effectively alter behaviour [original emphasis]'.[26] The explicit focus on selectively 'eliciting the client's own change talk and *taking care not to reinforce counter-change talk* [emphasis added]',[7] demonstrates that we think what the practitioner does will influence the client's subsequent behaviour.[5] For example, Miller found that 'the very *style* with which one delivers a treatment or even speaks to a problem drinker during a single counselling session can predict a substantial share of the variance in his or her drinking behaviour a year later'.[26, 31, 32] Indeed, we would not be proposing MI as a strategy to increase family consent to organ donation if we did not think it might be effective in achieving this. Any measure that sought to increase consent to organ donation that was not manipulative in the descriptive sense would be a grave waste of resources.

In respect of the second question, the influence MI has on behaviour might be ethically problematic if it could be used to overbear individual autonomy. Miller and Rollnick have argued that MI is not manipulative in an evaluative sense, since its causal role in behaviour change consists in highlighting the contrast between status quo behaviour(s) and deeply held values and beliefs; individual autonomy is not undermined as an incident of change. They write: 'unless a current "problem" behaviour is in conflict with something that the person values more highly, there is no basis for [MI] to work'.[33] Similarly, in earlier work, Miller advanced that:

> The core processes of [MI] ... are designed to help the person experience the ambivalence, consciously see and feel the conflict between the problem behavior and that which is truly more important. The process is an inherently internal one, invoking intrinsic motivation ... enduring change of this kind [cannot] be engendered by trickery or by imposing someone else's values.[26]

However, it is somewhat implausible to suggest that people only respond to core values when they change their mind or behaviour. While this may be true in the contexts for which MI was originally developed, it may not be true generally. It seems reasonable to think that the selective reinforcement of many utterances in a client-centred manner, not just those which relate to supposedly core values and beliefs, might influence behaviour. [iii] If it were only true that MI worked when an individual held a relevant core value in favour of change, there would be no concern when MI were employed in contentious settings such as sales. However, Miller and Rollnick, citing the work of Cialdini, recognise that 'psychological knowledge and techniques, including [MI], *can* be used to exploit, to pursue one's advantage and gain underserved trust and compliance'.[1] It appears therefore, that MI might be used to influence individuals in instances when their core values are not in play. This, however, would not necessarily overbear or even undermine autonomy, if the individual held a relevant preference that was reinforced.

The claim that MI works on intrinsic motivation (in some broader sense than core values or beliefs) is perhaps supported by evidence that MI is not 100 per cent effective in producing the desired behavioural outcome. In clinical trials where practitioners have been proficient in MI, change has not been observed in every client.[34] Thus, it is hypothesised that if an individual's preferences and behaviour are consistent, MI will not work. For example, next-of-kin religious objections to organ transplantation may align with a refusal to donate. Even if the practitioner is successful in evoking change talk, it may not be sufficient in quantity or strength to produce behaviour change. This evidence suggests that some preferences cannot be overcome, and thus MI does not overbear autonomy.

[iii] eg We are not necessarily acting on a core value when, following your successfully use of MI, we choose to buy a convertible, rather than an estate, which would have made transporting Nigel the Labrador practical,

However, it cannot be guaranteed that it is impossible to initiate change through the introduction of preferences that are not the individual's own. It might be true that MI is not manipulative in the evaluative sense in that it cannot be used to induce behaviour change that is inconsistent with an individual's core values and beliefs. However, without sufficient prior knowledge of the individual, it may be difficult to establish that the motivation for change was not internalised during the intervention. Therefore, proof that MI has not overborne an individual's autonomy, and is thus not problematically manipulative might be epistemically inaccessible, or at least difficult to gather.

Blatant attempts to instil motivation, such as advice giving, warning, confronting, leading questions, conditional threats, however, will be MI inconsistent and can be detected. The extent to which a practitioner adheres to the MI method can be measured using a variety of validated treatment fidelity instruments.[35-37] The use of instruments to ensure treatment integrity can safeguard against attempts to undermine individual autonomy, such as using more manipulative (and possibly less successful) strategies, perhaps such as the presumptive approach. However, we are unsure whether more subtle forms of manipulation that might overbear autonomy necessarily will be detected.

Since we cannot be completely confident that MI use would never undermine individual autonomy in a problematically manipulative way, it might be argued that what the requestor should do is counsel next-of-kin in a neutral way, that is, that the counsellor should not attempt 'to influence the client to take a particular path'.[1] Instead, the requestor should 'help the person make a difficult decision without influencing the direction of choice'.[1]

However, counselling with neutrality is a flawed strategy. It is unlikely that MI practitioners would be able to maintain neutrality throughout the interaction. Miller and Rollnick concede that neutrality may require 'a still higher level of clinical skillfulness than the directive variety of counseling, because one must avoid inadvertently tipping the scales in one direction or the other'.[33] MI is not easy to learn, and it may take a substantial period of time to acquire the skills necessary to influence client behaviour using directional MI.[38-40] It appears unrealistic, therefore, to think that requestors would be able to use neutral MI in conversations with next-of-kin over organ donation. Truax found that even Carl Rogers, the father of client-centred psychotherapy, was unable to avoid reinforcing certain client utterances, and was unaware that

he was doing so.[41] Requestors' views would more likely colour the direction of the conversation, probably in favour of consent to donation. Moreover, requestors would be unlikely to know if they were being neutral, given the very limited accuracy of self-assessments of practice.[38, 42]

It is less ethically problematic for requestors to inform next-of-kin that an approach aimed at securing consent to donation will be employed than to claim that requestors will not steer next-of-kin in the direction of consent, or that they will use a completely client-centred technique, when in all likelihood they will be directing unawares. The latter approach risks violating autonomy, insofar as the intervention to which next-of-kin consent would not be that which they receive. For any conversation around family consent to organ donation, including those which used MI, it would be important for requestors to be upfront about the goals and the methods used, and to gain valid consent. First, consent to discuss organ donation should be given, and it should be made clear that having a conversation about donation in no way commits next-of-kin to consent to donation; both consent and refusal are fine. Second, the requestor should disclose that their position is that organ donation is a good thing, and that their role is to explore how next-of-kin feel about donation in order to see whether their view aligns with that of the requestor.[iv] It should be stressed that consent to the conversation can be withdrawn at any time, and if it is, donation will not occur. Having these requirements would ensure that individuals were properly informed of the nature of the intervention, and also, through gaining valid consent, avoid adding an autonomy violation on top of a potentially problematically manipulative procedure.

We have conceded that MI is descriptively manipulative, and we cannot guarantee that MI would never be problematically manipulative, insofar as it might be possible to use MI to instil preferences in favour of a particular decision, which would overbear individual autonomy. Is this risk of unethical manipulation unacceptable in the context of next-ok-kin consent to organ donation? We submit that in countries where support for organ donation is widespread, and most people hold the relevant preference in favour of donation, the risk of unethical manipulation would be relatively insignificant. Indeed, MI might help next-of-kin take decisions that are in accordance with more longstanding preferences. Are we going to allow a few

[iv] Thanks to Bob Truog for this point.

potential autonomy violations to stand in the way of saving of many lives?[v] This appears very unreasonable. Assuming high levels of support for organ donation, the situation in which MI might be used unethically to manipulate a few next-of-kin would be quite different to that of organ conscription, which many people find objectionable, and which would therefore involve frequent autonomy violations.

Moreover, in cases in which the potential donor has an established wish to donate, any wrongful manipulation of next-of-kin should be weighed against the violation of the deceased's interests.[vi] In such circumstances, manipulation of next-of-kin is not a freestanding wrong; there are various competing interests in the organ donation context, and some must necessarily yield to others. We submit that the balance should come down in favour of the potential donor. Furthermore, in cases where the potential donor's wishes are unknown or ambiguous, Wilkinson has argued next-of-kin 'do not have the status of consenters, but only the lesser status of people who ought not to be distressed'.[43] As such, violations of their autonomy might be less ethically problematic.

That is not to say, however, that the preceding claim undermines the case for using MI rather than other highly manipulative procurement practices. All others things being equal, it is better to employ the means of achieving one's ends that involve the least interference with the autonomy of others. MI could potentially be unethically manipulative in a few cases, whereas the presumptive/dual advocacy approaches, for example, involve something close to misrepresentation or falsehood as a matter of routine, and would thus involve interference with autonomy in almost all cases. The success or failure of organ procurement regimes in large part depends on public trust, and health professionals stand in a position of power vis-à-vis next-of-kin. Little is known about current strategies employed in conversations with next-of-kin about organ donation. This lack of accessibility could undermine confidence in the transplantation system. Moreover, if it became widely known that requestors employed unethical approaches in order to gain family consent, such as the presumptive/dual advocacy approaches, this would be quite likely to result in a net reduction of organs available for transplantation.[28, 43] MI is

[v] Of course, we are not claiming that a few autonomy violations would be justified in pursuit of some greater good if those violations were accompanied by serious additional harm.

[vi] Thanks to T Martin Wilkinson for raising the need to discuss the potential donor's interests.

attractive because its methodology is explicit, it contains a client-centred component, and fidelity can be monitored even in a clinical setting.[39, 40]

5. Conclusion

In this paper we argued that Motivational Interviewing, an evidence-based, client-centred and directional counselling style, might successfully be employed as a strategy to increase rates of family consent to organ donation. We considered an objection to the use of MI in this setting based on manipulation. Although MI is client-centred, we cannot guarantee that it would never be used to overbear individual autonomy, through the introduction of preferences that were not the individual's own, and thus be unethically manipulative. However, we advance that the risk of problematic manipulation would be relatively low in countries in which organ donation enjoys widespread public support, since most individuals would hold the preference for donation. Moreover, when we consider the interests of potential donors with an established wish to donate, the relative weakness of family interests in situations where the potential donor's wishes are not explicit, and the potential good brought about by donation, some problematic manipulation may be acceptable, provided that interference with autonomy is kept is to a minimum overall. Although we know relatively little about existing organ procurement strategies, MI may be an ethical candidate for use in conversations with next-of-kin about donation. No doubt implementing MI in this setting would be challenging. However, given the potential for a modest yet significant increase in rates of family consent, it might be worth giving MI a try.

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