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The Power of Cognitive Reframing in Surgical Communication: An Ethical Framework for Patient Counselling Before and After Surgery

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Abstract

Background: Surgical encounters are emotionally charged, especially around major decisions, consent, and the communication of good and bad news. Surgeons and patients alike are prone to automatic, emotion-driven interpretations that amplify fear or false reassurance. Cognitive reframing, a core strategy from cognitive behavioural therapy, helps individuals identify distorted thoughts and replace them with more accurate, regulated interpretations.

Objective: To extrapolate principles of cognitive reframing into a practical, ethical framework for surgical patient counselling before and after operations, including the communication of both favourable and unfavourable outcomes.

Methods: Conceptual analysis of cognitive reframing (prediction loops, bias correction, neuroplasticity) is integrated with typical stages of surgical communication: preoperative counselling and consent, immediate postoperative updates, and the breaking of good and bad news along with illustrative clinical dialogues to demonstrate the application.

Results: Applying reframing principles guides surgeons to (1) recognize their own automatic catastrophic or minimizing narratives, (2) re-anchor conversations in evidence rather than worstcase predictions, (3) avoid toxic positivity while maintaining realistic hope, and (4) communicate bad news in a way that validates emotions without reinforcing distorted beliefs. This supports autonomy, beneficence and non-maleficence while reducing distress for both patients and surgeons.

Conclusion: Cognitive reframing offers a teachable, ethically grounded approach to surgical counselling that may improve patient understanding, trust, and shared decision-making while supporting surgeons' emotional regulation and professionalism.

Keywords: : Cognitive behavioural therapy; Surgical communication; Cognitive reframing; Physiological stress

Introduction

Surgical communication is not merely the communication of clinical facts. It shapes how illness, risk and outcomes are understood. Preoperative counselling, consent, and postoperative updates often occur under high stress, where the brain tends to rely on prediction loops that fill in gaps with worst-case scenarios rather than balanced evidence [1-3].

Cognitive reframing involves identifying distorted thoughts and replacing them with other possible interpretations, thereby improving decision-making [4]. This article proposes a structured application of cognitive reframing to surgical counselling, outlining how reframing principles can guide conversations before and after surgery, especially when breaking good and bad news.

Conceptual Foundations: Cognitive Reframing and the Stressed Brain

Cognitive reframing is a core tool from cognitive behavioural therapy, designed to help individuals notice biased interpretations and replace them with more balanced ones. When reframing occurs, the prefrontal cortex takes a more active role, amygdala-driven alarm signals decrease, physiological stress responses are reduced, and emotional regulation improves [5-7].

Under stress, the brain may rely on emotionally driven interpretations and catastrophic assumptions rather than balanced evidence. In daily life, this may manifest as all-or-nothing thinking ("I failed at this so I am not good enough"),

catastrophizing ("Everyone hates me"), or global negative labels [8,9]. Similar patterns appear in surgical communication, where complications may be perceived as total failure and high-risk procedures as near-certain disasters.

From inner reframing to interpersonal communication

While cognitive reframing is usually discussed as an internal, individual process, the principles can be extended to interpersonal communication. A surgeon's internal interpretation of events strongly shapes choice of words, tone, and non-verbal behaviour.

If a surgeon unconsciously adopts catastrophic narratives ("If this goes badly, I will have harmed this patient irreparably"), communication may become overly pessimistic. Conversely, if the surgeon relies on minimising narratives ("This rarely goes wrong; it is not worth worrying them"), the conversation may gloss over the risks. Reframing encourages a return to evidence-based, balanced explanations.

Ethical grounding: why reframing matters in counselling

Ethically, surgeons must respect autonomy by supporting informed decision-making, while also practising beneficence and non-maleficence. Cognitive distortions can undermine these duties by skewing how information and options are presented.

By re-anchoring communication in accurate, balanced interpretations, reframing supports truthful disclosure, patient-centred communication, realistic expectations and shared decision-making [10]. Reframing is explicitly not false reassurance; rather, it corrects bias and emotionally driven distortions. This balance is crucial when patients must weigh high-risk or high-benefit surgical options [9,11].

Preoperative Counselling and Consent: Applying Reframing Principles

Recognizing patient and surgeon distortions

In preoperative conversations, both patients and surgeons bring their own prediction loops and distortions. Patients may think, "If I agree to surgery, I will definitely die on the table," while surgeons might assume, "If I emphasise risks, the patient will refuse a procedure that could help them."

Reframing begins with identifying these distortions. The notion that one adverse outcome or risk statistic dictates a certain personal fate is an example of all-or-nothing thinking or catastrophising [9].

Structuring information with reframed language

Reframed language focuses on accuracy rather than amplification or minimisation. Instead of "There is nothing to worry about" (minimising) or "This could be very dangerous" (catastrophizing without context), a reframed statement might be: "This operation carries both potential benefits and real risks; here is what we know about the likelihood of each, and how we will work to reduce those risks."

This mirrors the shift from "I failed, so I am not good enough" to "I failed because I am learning something new and my effort still counts". It moves from global, identity-laden statements to specific, contextualized interpretations. In counselling, this helps patients maintain hope while understanding genuine uncertainties.

Managing expectations while avoiding false reassurance

Reframing explicity, distinguishes between realistic optimism and false reassurance**.** It acknowledges distress while correcting emotionally driven distortions through balanced, evidence-based appraisal [5,9].

For example, when a patient says, "I cannot handle this surgery," a purely positive response might be, "You will be fine; do not worry." Whereas, a reframed, ethically stronger response could be: "It is completely understandable to feel overwhelmed. You have handled serious challenges before, and we will support you through each step of this process."

Immediate postoperative updates: reframing in early outcome communication

The immediate postoperative period is particularly vulnerable to misunderstanding, because patients and families often have limited information and high anxiety. Surgeons may also be tired, emotionally activated, or disappointed by intraoperative events.

Reframing can guide how early information is conveyed. Instead of delivering fragmented, highly technical updates that invite catastrophic assumptions, the surgeon can offer structured, balanced narratives anchored in what is known, what is uncertain, and what the next steps will be. Providing timely, balanced information may reduce catastrophic interpretation and support clearer understanding during periods of uncertainty.

Breaking good news: sustaining realistic hope

Even when outcomes are favourable, reframing principles are useful. Good news can sometimes lead to unrealistic expectations ("Now everything is cured forever"), which may later make recurrence or complications feel like betrayal.

A reframed approach to good news maintains realistic hope while acknowledging ongoing uncertainty. For instance: "The scans show that the tumour has been completely removed, which is excellent news. We will still need regular followup because this condition can sometimes return, but today's outcome is very encouraging" [2,11].

Breaking bad news: validation without catastrophic endorsement

Breaking bad news is where reframing becomes most ethically and emotionally challenging. Patients and families may leap to global conclusions such as "This means there is no hope" or "Life is over." The surgeon may internally echo similar catastrophic

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thoughts or, alternatively, feel an urge to minimise to avoid distress.

Cognitive reframing offers a middle path of validating emotional distress without reinforcing overgeneralisation. For example:

a) Patient: "So this means I am going to die soon, for sure."

b) Surgeon: "This diagnosis is serious, and it is understandable to feel that way. What we can say is that some people live months and some live years with this condition; our goal is to focus on the treatments and support that can give you the best possible time."

Supporting families: reframing shared narratives

Families often reinforce each other's catastrophic or minimising interpretations. A family member might say, "The doctors have given up on him," based on a single phrase or change in treatment goals.

Through reframing, surgeons can help realign these shared narratives with clinical reality. A possible response is: "We are not giving up; we are changing our focus. At this stage, treatments that aim to cure are unlikely to help and may cause more harm. We are now focusing on comfort and quality of life, which is a different but equally active kind of care." Here, the meaning of "doing everything" is reframed to include comfort-focused interventions, correcting the bias that only aggressive treatment counts as real care.

The surgeon's internal dialogue: self-reframing during difficult conversations

Much of the power of cognitive reframing lies in changing the surgeon's internal dialogue, which then shapes outward communication. Before entering a room to give bad news, a surgeon may think, "I am about to destroy this family's life," a thought that may lead to avoidance or rushed explanations.

A reframed internal statement might be: "This family is already facing a lifechanging situation. My role is to be as clear, honest and compassionate as possible, which may help them cope and plan." This internal shift activates the prefrontal cortex, reduces emotional flooding and allows regulated as well as, patient-centred communication [6-7,11].

Practical framework: a reframing-based communication checklist

Drawing from cognitive reframing principles, surgeons can adopt a simple checklist when counselling patients before and after surgery.

i. **Notice:** Briefly identify automatic thoughts and emotions before entering a counselling conversation.

ii. **Name the distortion:** Is this catastrophizing, all-or-nothing thinking, or minimising?

iii. **Re-anchor in evidence:** Ask, "What do I actually know?" and "What is uncertain?" Use this to structure the explanation.

iv. **Validate emotion:** Acknowledge fear, sadness, or anger explicitly, without arguing against the feeling.

v. **Offer an accurate, balanced frame:** Phrase information in a way that is truthful, specific, and contextual, avoiding global statements.

vi. **Invite questions and corrections:** Encourage the patient and family to re-state their understanding so that distortions can be identified and gently reframed.

Repeated use of this process helps build new neural pathways (neuroplasticity), making balanced communication more automatic over time [4].

Conclusion

Cognitive reframing, identifying distorted thoughts and replacing them with more accurate and regulated interpretations, offers a powerful conceptual and practical tool for surgical patient counselling before and after operations. When applied to the communication of both good and bad news, reframing supports honest disclosure, realistic hope, and shared decision-making while helping surgeons and families avoid catastrophic or minimising narratives.

Embedding reframing principles in surgical training and everyday practice can align communication more closely with ethical duties, improve patient and family understanding, while protecting surgeons' emotional resilience across the arc of their careers.

References

1. Kruser JM, Taylor LJ, Campbell TC, et al. (2015) Best case/worst case: qualitative evaluation of a novel communication tool for difficult surgical decisions. J Surg Res 194(1): 292-298.
2. Politi MC, Han PKJ, Col NF (2007) Communicating the uncertainty of harms and benefits of medical interventions. Med Decis Making 27(5): 681-695.
3. Jeba J, Singh A, Munday D (2020) Indian Council of Medical Research consensus guidelines on 'Do Not Attempt Resuscitation': Communication is key. Indian J Med Res 152(4): 427-428.
4. Luciani M, Convertini J (2023) Patients and psychotherapists using concessive counter-argumentation: Co-constructing new framings. Couns Psychother Res 24(1): 169-179.
5. Gross JJ (2015) Emotion regulation: current status and future prospects. Psychol Inq 26(1): 1-26.
6. Buhle JT, Silvers JA, Wager TD, Lopez R, Onyemekwu C, Kober H, et al. (2014) Cognitive reappraisal of emotion: a meta-analysis of human neuroimaging studies. Cereb Cortex 24(11): 2981-2990.
7. Urry HL, van Reekum CM, Johnstone T, Kalin NH, Thurow ME, et al. (2006) Amygdala and ventromedial prefrontal cortex are inversely coupled during regulation of negative affect and predict the diurnal pattern of cortisol secretion. J Neurosci 26(16): 4415-4425.
8. Pike AC, Serfaty JR, Robinson OJ (2021) The development and psychometric properties of a self-report catastrophizing questionnaire. R Soc Open Sci 8(1): 201362.

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9. Beck AT (2008) The evolution of the cognitive model of depression. Am J Psychiatry 165(8): 969-977.

10. Ram TS, Thomas V, Sathyamurthy A, Ramireddy JK, John NO, et al. (2022) Training for next-generation gynaecologic surgical & radiation oncologists – opportunities & challenges. Indian J Med Res 154(2): 338-346.

11. Epstein RM, Street RL Jr (2011) The values and value of patient-centered care. Ann Fam Med 9(2): 100-103.

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