# Priorities, Professional Humility, and Communication in the Setting of Medical Uncertainty

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In this issue of *Pediatrics,* Prins et al[1] present a study of discussions with parents of patients in intensive care units, in the setting of uncertainty. Their findings and subsequent suggestions should be helpful to young physicians developing their approach to such situations, as well as to those more experienced yet still looking to learn.

By recording and then analyzing serial conversations between physicians and parents, Prins et al provide information about what physicians say in the setting of uncertainty, rather than reporting what we believe we say. They note that physician communication strategies seemed to follow the phases of the child's illness: (1) an unstable condition, where communication centered around short-term uncertainties, and a presentation of a range of possible explanations for the cause of the current situation, (2) a deteriorating condition, where physicians emphasized uncertainties by making parents aware of possible negative outcomes and sought to reduce the burden of uncertainty with reassurance about care being provided. Uncertainties about the disease trajectory were sometimes illustrated by presenting parents with various possible scenarios. (3) During the imminent death phase, physicians' strategies often aimed to eliminate any remaining uncertainty, prepare parents for the dying process, and manage parental expectations.

Of course, not all settings of medical uncertainty will follow this unfortunate clinical trajectory, but the observations of how it was done by several physicians in the Netherlands are nevertheless helpful. What may be even more helpful are observations of what was not done. For example, physicians did not ask parents about their informational and emotional needs. The authors rightly point out that in discussions of uncertainty, as with all communication, the same approach might not best serve all parents. Effective communication includes speaking clearly, honestly, and with compassion, but also includes (and commonly first) listening to parents, about what they need, how they want information presented, and how they are experiencing events as they unfold. One might hope that the physicians observed during this study did indeed elicit that information in a nuanced way that was not picked up by the methods of analysis, but that cannot be assumed.

Communication with parents in conditions of uncertainly should incorporate 2 fundamental concepts: priorities and medical humility. These discussions are important, yet often extremely uncomfortable, for all involved. The physician's obligation to be honest must be tempered with an understanding of the parents' anxiety, their need to hold onto some hope, and a need to have confidence in the physician. Physicians might be concerned that revealing their uncertainty, for example about etiology, diagnosis, or

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prognosis, could add to parental stress, or could be seen as an admission of ignorance or weakness, and thus undermine parental confidence in them. Here is where an understanding of priorities is essential.

There are (at least) 3 parties whose interests should be considered in these discussions: the patient, the parents, and the physician. The priority of interests should be in that order. The needs of the child should supersede all others, and what the child needs most, relevant to these difficult discussions, is a capable and informed surrogate decision-maker, most often the parent(s). The parents cannot perform that role, and fulfill their obligation to the child, without a clear understanding of the situation. Hence, they need to know the truth, however difficult it is for them to hear or for the physician to say. One of the hardest things for some physicians to say is, "I do not know." If the truth is that we are uncertain about the cause, or prognosis, or best course of treatment, then they need to be told.

The second priority is the parents. In many critical settings of uncertainty, they will be suffering, and the physician owes attention to that suffering. Information, including the degree of uncertainly, should be presented in a manner that best enables them to fulfill their obligation as surrogate decision-maker, but also considers their particular needs at that point in time. Emotional support is essential to helping them cope, and to helping them fulfill their obligations to the child.

The third priority is the clinician. Most find it easier to share information in a setting of surety and confidence, and discussions are made more difficult for physicians by our uncertainty, especially when parents probe for more concrete answers. Even in the most critical situations, it is commonly easier for physicians to communicate when confident in their knowledge about what is occurring and what will occur. Uncertainty is harder. Support from colleagues can be helpful here, as can self- awareness of how difficult for us these conversations might be. Ultimately, though, avoidance of difficult subjects to reduce our own discomfort is not acceptable, based on our obligations to the patient and the parents. Prins et al, for the purpose of their study and analysis, take the definition of uncertainty from Han,[2] as "the subjective consciousness of ignorance … self-awareness of incomplete knowledge about some aspect of the world." Our uncertainty, and hence our ignorance, is sometimes not easy to admit. This gets to the importance of professional humility in the setting of medical uncertainty.

Professional humility will be defined here as having 3 essential components: (1) admit what you do not know, (2) admit what you cannot do, and (3) admit, especially to yourself, what your motives are; components (1) and (3) are directly relevant here. It might be difficult to admit our ignorance in a critical medical setting, to the parents and to ourselves, but professional humility requires exactly that. How we present that uncertainty, and how we help parents deal with it, are essential components of the art of medicine, and the observations and suggestions outlined by Prins et al[1] will be helpful in that regard. We can and should tailor these discussions to the parents' needs, abilities, and wishes, but we must be honest with ourselves about our motives as we choose our words, and we must remember priorities. The discussion should not be tailored, or information about uncertainty limited, to reduce our own discomfort.

## REFERENCES


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