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Uncertainty as a driving force

PERSPECTIVES

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This publication recently focused on the under-communication of uncertainty among doctors both at medical school and in clinical settings. This is likely to be a driver of over-diagnosis and over-treatment. But could it also be a useful asset?

Symptoms without any detectable pathology – subjective health complaints – are extremely common. In the primary health service, such complaints account for nearly 40 % of consultations. They are also the cause of a considerable number of referrals to the specialist health service (1). In the absence of objective findings, the conclusion is often a 'functional disorder'. A recently published article in the Journal of the Norwegian Medical Association suggested that this is a better term than 'medically unexplained physical symptoms' (MUPS) (2).

Most people consider functional disorders to be a result of biological, psychological and social factors. Subjective health complaints tend to arise when life is problematic. Yet it is possible to feel discomfort without experiencing other difficulties. Another perspective therefore, is that aches and pains are universal and should be considered a price we pay for living (3). For most people, these symptoms are short-term and transient. For others, however, things do not improve. The health complaints persist and may even increase in intensity and magnitude. The causes are probably multiple and complex. Our hypothesis is that some may be associated with tolerance of uncertainty.

Uncertainty is not always a negative factor

Uncertainty can be defined as a *metacognitive awareness of ignorance* (4). In other words: you know that you don't know. This awareness involves a subjective experience, which often is unpleasant. 'The natural man dislikes the dis-ease which accompanies the doubtful and is ready to take almost any means to end it', wrote John Dewey in *The Quest for Certainty* (5). Uncertainty, then, is something that all human beings will normally want to do away with.

Suffering patients can feel uncertain about a lot of things. What is wrong with me? What is causing this? What can my body take? How will this end? Doubts may arise, even in the most trivial of settings. Should I dare go to work, clean the house, empty the dishwasher, get out of bed? In the long run, this clearly becomes wearying, and killing the uncertainty with certainty is a natural response because certainty is less unpleasant. The patient's certainty may be expressed in this way: 'Something must be wrong'. 'If I do that, I will be bedridden the day after'. Or, 'this will not get any better'. In other words, the individual has no doubt that something is wrong, is certain of what they can and cannot do, and is entirely convinced that recovery depends on a specific medical intervention.

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Patients who feel this way are often referred to as being difficult or unmotivated. However, while this is unlikely to be correct, it is also an attitude which is unconstructive in our encounters with patients. These patients are locked in a situation and may, paradoxically, have insufficient uncertainty to escape it. Uncertainty prevents overconfidence and opens our mind to new knowledge (6). In other words, uncertainty is a driving force that may bring us closer to a solution, whether this is found in our surroundings or in our own minds. Patients who are certain will therefore benefit from being made uncertain. Moreover, their uncertainty must be met with a mindset that seeks other avenues of action than merely enduring or eradicating it. We suggest that it be met with tolerance.

Tolerance of uncertainty

Tolerance of uncertainty can be defined as an adaptive capacity to enact individual and contextual responses to uncertainty (7). This is all about being able to face what is unknown and unclear in different ways, depending on the context. This ability is closely linked to personal qualities or strengths, referred to as *virtues* in the literature (6).

There are four such qualities that we believe to be particularly important for patients with subjective health complaints. *Humility* steers us from being unaware of our own ignorance to becoming aware of what we do not and cannot know. In other words, a degree of humility is required to become uncertain. *Flexibility* is required for us to be adaptive in our responses to what is uncertain. For example, in some situations, uncertainty should be endured, while in other situations it should motivate us to find a specific solution. *Courage* leads us forward, from the known present towards the unknown. *Curiosity* enables us to do so with an open mind and an outward-looking approach. If we face uncertainty with these qualities, it becomes not solely constraining but also liberating (8).

Doctor and patient, together in uncertainty

Doctors can reduce some forms of uncertainty; 'what is wrong with me?' is one example. To do this effectively, the doctor will need to examine the patient carefully, disprove potential illnesses and then explain why the symptoms nevertheless persist. The outcome may be that patients not only trust their doctor but draw the conclusion that they can trust their own body as it encounters life's many challenges, whether minor or major (9).

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Uncertainty about the future, however, is by definition irreducible. This is probably the reason why reassuring statements such as 'you will be okay' have been found to be, at best, of short-term benefit (10). Confronted with the genuinely unknown (the future), it would be better for the doctor to acknowledge uncertainty and develop qualities within the patient that will help them address it.

This is likely to be best achieved by engaging in a Socratic dialogue, in which the doctor does not provide the answers but promotes reflection by asking questions. For the doctor, in this phase, to admit their own uncertainty, thereby demonstrating humility in their role as expert, is not a sign of incompetence, but rather of credibility. It can be challenging for the doctor not to have a definitive answer readily available, and a doctor who wonders may not be what the patient expects. But when the patient and doctor approach uncertainty together, a stronger alliance is formed, based on relational support. What outcome they may arrive at, is entirely open.

Curiosity-driven exploration

One might ask whether what we have described here brings anything new to the table. There are similarities with many of the cognitively focused treatments already being provided by the health service. However, it is not only at medical school and among colleagues that we find under-communication of uncertainty as a some-time benefit, and the idea that tolerance of uncertainty is about more than either enduring or eliminating it. This is also not being communicated to patients. We believe that tolerance of uncertainty influences the prognosis in functional disorders, and we suggest that in order to help patients more effectively, doctors need to change their mindset. For example, we could stop talking about motivated or unmotivated patients and rather form an impression of whether they feel certain or uncertain. We can also seek to reduce our attempts at reassuring our patients and instead appeal to personal qualities that will make them adaptive in the face of their own uncertainty. We believe that what we describe justifies curiosity-driven exploration, both in our encounters with individual patients and through further research.

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