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The Untapped Power of "We Don't Know": Epistemological Humility in the Era of COVID-19

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Abstract

The SARS-CoV-2 (COVID-19) pandemic introduced many challenges and nuances that have transformed medical practice and research. The uncertainty caused by COVID-19 led to inevitable challenges to patient–provider relationships. The ever-changing landscape of COVID-19 research and policy proved to be challenging for the medical community and patients. These challenges also exacerbated long-standing issues regarding patient–provider communication and trust. On the other hand, these challenges gave voice to a burgeoning patient advocacy community. Through social media, advocacy and patient organizing, patients harnessed their power and organized over challenges relating to COVID-19 fears and concerns, ramifications of "Long COVID," and much more. During this unprecedented pandemic, there was a realization that the science and research surrounding COVID-19 is evolving and that there may be a benefit to embracing the dynamic nature of research and the scientific process. We propose that providers and the medical community should consider epistemological humility, which acknowledges insufficiencies related to the state of medical knowledge with a sense of understanding and respect for not having all of the answers. We argue that there is untapped potential in saying, "We don't know" and explaining why. There is an implicit culture that providers should be responsible for knowing everything and solving every problem. Epistemological humility challenges this culture, and inherently gives credence and voice to patient perspectives. We assert that epistemological humility is necessity when addressing contemporary health challenges such as COVID-19.

Keywords

clinician–patient relationship, COVID-19, patient expectations, physician engagement

The SARS-CoV-2 (COVID-19) pandemic transformed medicine and patient–provider communication. The rapid implementation of telehealth approaches and increased sophistication of patient–provider communication portals,[1] for example, have been recognized as beneficial innovations during a time of unprecedented challenge for patients and providers.[2] A potentially deadly illness spread via person-to-person contact, the availability of a COVID-19 vaccine reignited conversations regarding vaccine hesitancy[3] and health disparities.[4,5] Relatedly, the term "Long COVID," was spurred by the disenfranchisement of patients suffering lingering effects after contracting COVID-19.[4] In many ways, the acknowledgement and adoption of the term Long COVID is one of the most profound patient advocacy campaigns to date. Beginning on X (the platform formerly known as Twitter) before being adopted by the media and the World Health Organization, patients with Long COVID have initiated and led conversations about "epistemic authority,"[4] and in doing so, have upended our understanding of COVID-19 and its long-term effects. These examples illustrate more broadly how the limitations of medical knowledge about COVID-19 spur the need for greater humility regarding what we (as health researchers and clinicians) know, and how we know.

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However, the challenges that Long COVID brings are not unique. Throughout history, grand challenges have forced the medical community to reckon with the limitations of the scientific process and medical knowledge. Our knowledge of COVID-19, and its associated risks with stroke,[6] depression,[7] anxiety,[8] and other conditions, has developed in real time, despite the fact that, on average, it may take up to 17 years for research and innovation to be implemented in clinical practice.[9] The challenges of COVID-19 research happening in real time has brought about many consequences including medical misinformation and poor patient–provider communication. These consequences have in turn fostered medical mistrust and compromised shared decision making—further undermining the patient–provider relationship and fueling a turn toward misinformed health behaviors (e.g., vaccine hesitancy). These circumstances require a shift in how providers speak with patients about such uncertainty. We argue that acknowledging the uncertainties related to the state of knowledge in general[10] and recognizing the limitations of the scientific process and timeline of translational research requires leaning into epistemological humility.

Building on prior research,[11–13] we define *epistemological humility* as the acknowledgement of insufficiencies related to the state of medical knowledge in general. Put simply, we assert that there is untapped potential in saying, "*We* don't know" and explaining why. This is distinct from admitting "*I* don't know," which refers to the lack of knowledge of an individual. As health researchers and practitioners, we have expertise in patient–provider communication, and have examined the content and consequences of interactions in which epistemological humility is lacking. Like the shift from cultural competence to cultural humility (which reflects a process of continuous learning),[14,15] epistemological humility and cultural humility are necessary to avoid perpetuating stereotypes (e.g., "It's all in your head")[16] and to facilitate serving the needs of diverse patients.[17]

There is a need for epistemological humility,[17,18] especially given the contemporary emphasis on evidence-based medicine. The era of evidence-based medicine presents both opportunity and challenge. On one hand, there is an appreciation for making informed decisions based on established evidence and scientific rigor. On the other hand, it is the nature of scientific inquiry that our evidence is inherently tentative, and this approach necessitates that we remain open to new findings which may call into question such evidence. Nurturing the patient–provider relationship can be accomplished when providers feel more at ease about acknowledging the limitations of what is known about a particular health issue. Several studies have examined predictors and outcomes of these successful patient–provider interactions and the implications for health outcomes and population health. However, the translation of these findings into clinical research has been slow and challenging. Yet, adopting epistemological humility in the era of Long COVID has the potential to transform the patient–provider relationship, medical practice, and ultimately health outcomes.

We recognize that this paradigm shift challenges previously established norms in medicine and research and poses inherent challenges. There is the ongoing threat of malpractice which can lead to hypervigilance, thereby enabling mistrust.[19] There are also individual-level factors that can impede efforts toward epistemological humility. For example, a review revealed that imposter syndrome and self-doubt affects physicians and providers throughout their medical careers and there is a need for a culture and safe space for providers to feel comfortable asking questions and sharing their challenges.[20] Admitting insufficiencies regarding the state of knowledge generally may threaten one's ego, self-efficacy, or self-worth as a provider. There is an implicit culture that providers are supposed to be responsible for knowing everything and solving every problem. Epistemological humility challenges this implicit culture and is a necessity when addressing the contemporary threats of health issues such as Long COVID.

Health disparities are pervasive and largely attributable to institutional racism, classism, and other forms of discrimination and prejudice. There are several arguments for how saying "We don't know" might benefit patients. The absence of epistemological humility leaves an unacknowledged gap between patients' lived experiences and the (lack of) medical knowledge about their illnesses. This gap leaves the provider vulnerable to bias. Racialized, gendered, classed notions about whose bodies are "really" sick may begin to prevail.[7]

It is also important to humbly recognize how a long history of imbalanced power dynamics between patients and physicians and a lack of humility have perpetuated and exacerbated these disparities. Epistemological humility offers providers the freedom from feeling obliged to act without acknowledging or considering the lack of knowledge and/or risks or benefits to a situation.[8] Epistemological humility emphasizes that patients are the experts of their experience. Though we may not have the answers, we are merely admitting the limitations of the current state of knowledge in the field—not necessarily their own lack of knowledge. True epistemological humility reflects the distinction between the collective state of knowledge and an individual provider's level of knowledge.

To conclude, we argue that providers and the medical community should tap into epistemological humility, as doing so can have a myriad of benefits for both patients and providers. There is considerable research regarding COVID-19 and Long COVID that is ongoing. Providing "We don't know" as an answer is not just epistemological humility, it may very well be the truth. By affirming patients' truths about their own bodies and acknowledging the fluid and ongoing nature of COVID-19 and related research, we are positioning ourselves to foster fruitful patient–provider relationships and to serve our patients to the best of our ability.

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