

The Ethical Limits of Waiting for Certainty: A Proportionality Framework for Clinical Decisions Under Prognostic Uncertainty, Irreversible Harm, and Conflicting Patient Priorities

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Abstract

Clinical decisions under prognostic uncertainty are often framed as a conflict between acting on incomplete information and waiting until confidence improves. That framing is ethically incomplete because postponement is not a neutral interval. Additional time may improve prognostic reliability, reveal treatment response, permit communication, and reduce the risk of an irreversible decision based on premature judgment. Yet the same delay may expose patients to avoidable suffering, progressive deterioration, loss of treatment opportunities, prolonged burdensome intervention, or erosion of meaningful choice. This normative analysis examines when uncertainty justifies waiting and when waiting itself becomes disproportionate. Using proportionality and threshold reasoning, it distinguishes the epistemic value of additional time from the moral costs generated by delay, then examines how irreversibility and conflicting patient priorities modify that balance. The central argument is that uncertainty alone cannot determine the permissibility of postponement. Waiting remains justified while the expected decision-relevant value of additional information is sufficient to warrant the burdens and option losses created by delay, taking account of whether action or inaction is more reversible and whether the temporal strategy remains aligned with the patient's priorities. The analysis therefore rejects both automatic action under uncertainty and indefinite deferral in pursuit of unattainable certainty. Clinically defensible decisions require explicit purposes for waiting, time-bounded reassessment, attention to losses that cannot later be repaired, and recognition that reasonable patients may rank survival, function, comfort, hope, preparation, and decisional control differently.

Keywords: Prognostic uncertainty, Proportionality, Clinical decision-making, Irreversible harm, Treatment delay, Shared decision-making

Introduction

Prognostic uncertainty is unavoidable in many areas of clinical medicine, but its ethical significance is often described too narrowly. It is commonly treated as an informational deficit: clinicians lack confidence about

diagnosis, trajectory, treatment response, or likely outcome and therefore seek additional evidence before committing to a consequential decision. Yet uncertainty is also communicative and relational. Patients may want clinicians to acknowledge it explicitly, even when disclosure increases anxiety or worry [1]. In serious illness, prognosis cannot be separated cleanly from conversations about goals, acceptable burdens, and preparation for possible deterioration [2]. The ethical problem therefore concerns more than how much certainty clinicians possess. It concerns what they should do while certainty remains incomplete.

Research on prognostic communication reinforces that this problem has no uniform technical solution. A realist

Access this article online

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Received: 15 April 2026; Accepted: 17 July 2026

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How to cite this article: Mitchell S, Thompson D, Carter E, Lee M. The Ethical Limits of Waiting for Certainty: A Proportionality Framework for Clinical Decisions Under Prognostic Uncertainty, Irreversible Harm, and Conflicting Patient Priorities. *Asian J Ethics Health Med.* 2026;6(2):13-22. <https://doi.org/10.51847/oBy76p2BrC>

review of prognostic-uncertainty communication in advanced illness found substantial contextual variation in the mechanisms through which communication affects understanding, coping, trust, and decision-making [3]. Even communication that is more consistent with shared decision-making does not necessarily eliminate prognostic misunderstanding. In intensive care, greater alignment with shared decision-making practices was not uniformly associated with improved prognostic understanding across all surrogates, although particular subgroups appeared to benefit [4]. These findings matter normatively because they undermine the assumption that a decision can always be made safer simply by communicating uncertainty more extensively before acting. Some uncertainty persists after communication because the underlying clinical future has not yet unfolded.

The intuitive response is to wait. Additional observation may reveal whether organ failure reverses, whether treatment produces a meaningful response, whether neurologic signs become interpretable, or whether a patient and family acquire enough information to clarify priorities. Waiting can therefore have genuine epistemic value. At the same time, it can alter the very decision it is intended to improve. A patient may deteriorate while clinicians observe. A potentially beneficial intervention may become unavailable. Burdensome life-sustaining treatment may continue despite diminishing prospect of achieving the patient's goals. Symptoms may persist. Families may remain in prolonged uncertainty. The option set at the end of a delay may differ from the option set at its beginning.

This temporal transformation creates the central normative problem addressed here. The ethically relevant comparison is not simply between an uncertain decision now and a more certain decision later. It is between alternative temporal strategies whose informational quality, reversibility, burdens, and consequences change over time. Waiting can improve the evidence base for a decision, but waiting can also consume opportunities, generate harm, and alter what future choices remain possible. Conversely, early action may prevent loss while simultaneously foreclosing options that further information would have preserved.

A proportionality analysis is useful because neither uncertainty nor urgency has lexical priority. The question is whether the reason for delaying a decision remains proportionate to what the delay costs, and whether the reason for acting despite uncertainty remains

proportionate to the risk of acting wrongly. This article develops that analysis without assigning numerical thresholds to ethical values or pretending that uncertainty can be reduced to a single probability. Its narrower purpose is to identify the point at which “waiting for more certainty” ceases to function as epistemic prudence and begins to require an independent justification because delay itself has become morally consequential. The argument proceeds in three stages before turning to clinical implementation and critical appraisal. First, prognostic uncertainty is separated from the moral costs produced by postponement. Second, the analysis examines irreversible harms and the problem of conflicting patient priorities, including cases in which survival, function, comfort, hope, preparation, and control over decisions point in different temporal directions. Third, these distinctions are integrated into a non-quantitative proportionality account of acting under uncertainty. The resulting approach does not presume that acting earlier is generally preferable. It asks instead what additional waiting is expected to accomplish, what may be lost while waiting, whether those losses can later be repaired, and whether the temporal strategy remains faithful to the patient's priorities.

Prognostic uncertainty and the moral cost of delay

The first analytical distinction is between the epistemic value of waiting and the moral cost of waiting. They are related but not interchangeable. An empirically grounded ethical analysis of intensive care admission decisions found that clinicians may face a direct tension between taking additional time to improve decision accuracy and exposing patients to harms associated with delayed admission or delayed treatment [5]. This tension illustrates a broader principle: the passage of time is not external to the decision. It is one of the ethically relevant conditions under which the decision is made.

Waiting is most defensible when it is expected to produce information capable of changing what ought to be done. Time-limited trials in critical care provide an especially useful example because they convert otherwise open-ended continuation of treatment into a temporally bounded period with a specified purpose. Recent normative analysis has emphasized that such trials have multiple ethical dimensions and require explicit justification; merely designating treatment as “time limited” does not resolve disputes about benefit, burden, autonomy, or fairness [6]. Their significance for the present argument lies elsewhere. They demonstrate that

continued treatment under uncertainty can be understood as an information-generating intervention whose permissibility depends partly on what will be reassessed and what consequences accrue during the trial.

The empirical and ethical literature on time-limited trials also cautions against idealization. A review of this literature found limited empirical evidence, considerable heterogeneity, and inconsistent implementation [7]. Time-bounding a decision therefore does not by itself make waiting proportionate. A poorly specified interval can reproduce the same problem as indefinite delay if clinicians have not established what information they seek, how improvement or deterioration will be interpreted, or what decision will follow reassessment.

More structured accounts make those requirements explicit. An American Thoracic Society workshop characterized time-limited trials through phases of considering, planning, supporting, and reassessing treatment [8]. The important normative feature is the planned return to the decision. Waiting becomes epistemically purposeful because the clinical team and patient or surrogate know what changes are being observed and understand that treatment will not simply continue by inertia. This differs from postponement whose only rationale is that clinicians remain uncomfortable acting under uncertainty.

Some clinical contexts make the epistemic case for waiting particularly strong. Neuroprognostication is vulnerable to premature conclusions because sedating drugs, acute physiologic disturbances, evolving injury, and incomplete neurologic recovery can make early findings misleading. Reviews of neurocritical practice therefore emphasize the risks of prognostic judgments made before relevant confounders have resolved or adequate observation has occurred [9]. In these circumstances, delay may protect the patient against an irreversible decision made from a transient or uninterpretable state.

Yet the existence of such cases does not establish a general presumption in favor of waiting. Traumatic brain injury illustrates why. Clinicians may experience substantial uncertainty about neurologic trajectory and long-term outcome [10]. Shared decision-making in neurocritical care therefore requires communication that acknowledges the limits of prognostication rather than translating uncertain estimates into unwarranted confidence [11]. For surrogates, however, additional time is not merely an opportunity to receive better information. Qualitative evidence from severe acute

brain injury shows that surrogates can experience profoundly different senses of choice and responsibility while making decisions under uncertain conditions [12]. Prolonging uncertainty may consequently preserve options while also extending psychological, relational, and decisional burdens.

Communication itself can add another layer of uncertainty. Families may interpret prognostic language differently from clinicians, and bias or discordance may influence how uncertain evidence is framed and understood [13]. A delay undertaken to “gain certainty” may therefore fail to achieve its intended epistemic purpose if the principal obstacle is not insufficient observation but disagreement about values, interpretation, or acceptable outcomes. More time does not necessarily resolve every kind of uncertainty.

The distinction can be made more precise by separating at least three questions. First, what uncertainty is expected to change with time? A physiologic trajectory or treatment response may become clearer; a fundamental disagreement about what counts as an acceptable outcome may not. Second, is the anticipated information decision-relevant? Additional detail that cannot alter any available course of action provides a weak justification for exposing the patient to continuing burdens. Third, what happens to the patient’s options while clinicians wait? The moral cost of delay rises when postponement causes deterioration, prolonged suffering, missed therapeutic opportunity, unwanted continuation of invasive treatment, or loss of the capacity to participate in later decisions.

Waiting therefore has an ethical purpose only when its informational value remains connected to a future decision. The clinically important threshold is not complete certainty, which is rarely attainable. It is the point at which additional time is still capable of improving a decision enough to justify what is being risked or endured during that interval. This threshold cannot be specified numerically across conditions. It depends on the nature of the uncertainty, the trajectory of the illness, the reversibility of available interventions, and the burdens accumulating while information is sought.

The temporal asymmetry is crucial. A decision postponed today may not be the same decision tomorrow. Some choices remain available; others disappear. Some harms can be reversed; others cannot. For that reason, clinicians should not describe waiting as the absence of a decision. Continuing treatment, withholding an intervention,

deferring transfer, maintaining mechanical support, delaying withdrawal, or postponing a goals-of-care decision are themselves temporally consequential choices. Their justification must therefore be evaluated with the same seriousness as more visible acts of intervention.

The relationship between epistemic uncertainty and delay-generated harm can be summarized without converting either into a numerical score. The relevant question is whether time remains epistemically productive while remaining morally tolerable. Once

further observation has little realistic prospect of changing the decision, or once the harms and lost options created by postponement become disproportionate to the informational benefit expected from additional time, uncertainty no longer functions as a sufficient reason to defer action.

The ethical distinction is operationalized in **Table 1** through the different reasons a clinician may be uncertain, what additional time could plausibly clarify, and what is simultaneously placed at risk by waiting.

Table 1. When waiting remains epistemically productive and when delay acquires an independent moral cost

Uncertainty situation	What additional time may clarify	Moral cost that can accumulate during delay	Sign that waiting remains epistemically productive	Sign that delay requires stronger justification
Evolving clinical trajectory	Direction and pace of deterioration, stabilization, or recovery	Disease progression, symptom burden, loss of treatment opportunity	New observations are likely to alter the choice among available interventions	Further observation is unlikely to change management while deterioration continues
Uncertain treatment responsiveness	Whether a reversible or trial intervention is achieving a patient-relevant effect	Continued treatment burden, complications, unwanted prolongation of invasive care	Response criteria are specified and reassessment is time bounded	Treatment continues without defined response criteria or a decision point
Confounded prognostic signal	Whether temporary factors resolve sufficiently for prognosis to become interpretable	Prolonged burdens of supportive treatment and delayed planning	Known confounders are expected to diminish within a clinically meaningful period	The anticipated gain in interpretability becomes small relative to ongoing burdens
Uncertain long-term functional outcome	Range of plausible recovery or disability trajectories	Loss of other options, prolonged intervention, psychological and relational burden	Additional evidence could materially change judgments about acceptable treatment	Greater precision would not alter any feasible option or patient-defined priority
Communication or interpretation uncertainty	Whether prognostic meaning, treatment alternatives, or patient priorities are understood	Persistent conflict, decisional distress, treatment by inertia	Clarification can resolve factual misunderstanding or elicit relevant preferences	The disagreement concerns values rather than missing information and is merely being postponed
Surrogate uncertainty about patient priorities	Previously expressed values, acceptable outcomes, or substituted judgment	Surrogate burden, continued unwanted treatment, diminished opportunity for patient participation	Further information about the patient's values is realistically obtainable	Repeated delay yields no new preference information while burdens continue
Genuine clinical gray zone	Whether evolving evidence moves the case toward a more defensible option	Risk attached to either premature action or prolonged inaction	Both principal options remain available and reassessment can meaningfully discriminate between them	One option is becoming irreversibly unavailable solely because the decision remains deferred

Note: The categories are an original normative synthesis derived from the cited evidence. They are qualitative decision distinctions, not numerical thresholds or validated prediction rules.

Irreversible harm and conflicting patient priorities

The moral significance of delay becomes clearer once irreversibility is separated from severity. A severe outcome is not necessarily irreversible, and a

comparatively modest loss may nevertheless matter greatly if it cannot later be repaired. The relevant ethical question is therefore not only how bad an outcome might

be, but whether waiting changes the patient's future option set in ways that cannot be restored.

Patient priorities complicate this analysis because they are neither perfectly fixed nor independent of communication. In an experimental study involving advanced-cancer scenarios, different ways of presenting prognosis and prognostic uncertainty altered participants' perceptions, preparation, and treatment preferences [14]. The finding does not establish how an individual patient will decide in real clinical care, but it demonstrates why preference elicitation cannot be treated as the simple extraction of a stable choice that already exists in fully formed condition. How uncertainty is explained can influence how options are understood.

Qualitative synthesis in palliative cancer care similarly indicates that shared decision-making depends on timing, relationships, perceived choice, and the degree of involvement patients and relatives want [15]. A patient may simultaneously prioritize longevity, avoidance of burdensome treatment, cognitive or functional independence, time at home, hope, preparation for death, or relief of family burden. These priorities can become internally conflicting when a decision under uncertainty protects one value by placing another at risk.

Uncertainty itself can support more than one ethical trajectory. In serious-illness conversations in hematology, clinicians and patients sometimes used uncertainty in ways that permitted simultaneous preparation for adverse outcomes and maintenance of hope [16]. Pediatric oncology evidence likewise suggests that honest discussion of uncertain or poor prognosis need not extinguish hope and may be compatible with ongoing relational support [17]. These findings challenge the common assumption that uncertainty must be suppressed until a clearer answer is available before meaningful planning can begin.

The opposite pattern also occurs. Prognostic uncertainty and apparent clinical stability have been identified as barriers to serious-illness conversations in advanced cancer, contributing in some cases to the postponement of discussions that might otherwise clarify priorities before deterioration [18]. Uncertainty can therefore function either as a reason for dialogue or as a reason to defer it. The ethical difference depends on what postponement protects and what it risks losing.

This matters because participation in decision-making can remain incomplete even in settings formally committed to shared decision-making. Observational work examining interactions between oncology and

palliative-care professionals found that actual decision processes did not consistently realize the full participatory ideal [19]. A patient's priorities can consequently be underrepresented not because clinicians intentionally disregard them, but because institutional routines, professional interactions, timing, or assumptions about readiness shape when and how those priorities enter the decision.

Nor can structured support be assumed to remove decisional conflict. In a large intensive-care trial, an interprofessional family-support intervention improved some aspects of communication but did not significantly improve the principal psychological outcomes measured among surrogates [20]. The result is important for the present normative argument: improving process is valuable, yet a better process does not guarantee convergence on a single ethically correct choice. Prognostic uncertainty may remain, values may conflict, and reasonable participants may continue to rank outcomes differently.

Some of this residual difficulty reflects the nature of uncertainty itself. Serious illness contains not only epistemic uncertainty about probabilities but also forms of complex uncertainty concerning interpretation, values, relationships, and what future states will mean to the patient [21]. Additional testing or observation may reduce the first category while doing little to resolve the second. Waiting becomes ethically questionable when clinicians implicitly treat value disagreement as though it were an informational deficit that more time will eventually eliminate.

Perivability provides a particularly clear boundary case. Decisions at the limits of viability involve uncertain outcomes, high stakes, and profound variation in how families may value survival, disability risk, suffering, and the burdens of intensive treatment. Contemporary ethical recommendations therefore resist reducing these decisions to rigid cutoffs and instead preserve a genuine gray zone for individualized deliberation [22]. The lesson is not that all high-uncertainty decisions should remain open indefinitely. It is that an ethically defensible threshold for action cannot be separated from the values that make one outcome preferable to another.

Irreversibility sharpens that conclusion. If acting now permanently forecloses a future the patient would regard as valuable, additional waiting may have strong moral justification. If waiting progressively destroys the possibility of achieving the patient's most important goal, postponement becomes increasingly difficult to defend.

Where both action and delay carry irreversible risks, the task is not to identify a risk-free option but to determine which losses are being accepted, for whose sake, and with what justification.

The patient's priorities therefore influence proportionality in two ways. They affect the weight of the consequences and the meaning of reversibility. A reversible intervention in physiological terms may be experienced as unacceptable if it entails burdens the patient has consistently rejected. Conversely, a period of intensive treatment may be proportionate for a patient who places exceptional value on even a small possibility of meaningful recovery, provided the burdens and conditions of reassessment are understood. The same medical uncertainty can therefore justify different temporal strategies for different patients without making the decision arbitrary.

The next stage of the analysis must consequently integrate four elements that cannot be collapsed into a single score: the decision-relevant information expected from additional time, the harms and burdens generated during that time, the reversibility of acting or waiting, and the patient's own ordering of the outcomes at stake. Proportionality becomes ethically useful only if it preserves these distinctions rather than disguising them behind the language of balance.

A proportionality framework for acting under uncertainty

Proportionality is useful here only if it does more than redescribe difficult choices as a balance of competing considerations. Formal proportionality tests can themselves generate counterintuitive conclusions when the interests being compared, the relevant alternatives, or the consequences of restriction are poorly specified [23]. Clinical proportionality therefore requires an explicit account of what additional waiting is expected to achieve and what becomes harder or impossible because of that waiting.

High-stakes pediatric treatment disputes illustrate the problem. The Charlie Gard case exposed disagreement about uncertain benefit, treatment burden, parental authority, and the significance of pursuing an intervention whose prospects were contested [24]. Analysis of the same dispute also shows that procedural safeguards can remain ethically important even when delay and litigation impose costs of their own [25]. Neither rapid action nor extended process is intrinsically proportionate. Their justification depends on what each preserves and forecloses.

The proposed threshold is consequently qualitative rather than numerical. Waiting remains proportionate while the expected decision-relevant epistemic gain from additional time is sufficient to justify the burdens, risks, and option losses produced during that interval. Its justification weakens as three conditions emerge: additional information is increasingly unlikely to change the decision; delay is creating losses that cannot later be repaired; or continued postponement conflicts with priorities the patient has already made sufficiently clear. Reversibility modifies the threshold. Where a temporary intervention can preserve meaningful future choice without imposing disproportionate burden, it may be preferable to either irreversible action or passive delay. Prospective emergency-care planning similarly demonstrates that structured prior deliberation can inform later best-interests reasoning without mechanically determining it [26]. The normative aim is therefore not maximum delay or maximum decisiveness, but preservation of the most ethically important options while uncertainty is being reduced.

These relations can be expressed as a temporal proportionality field in which the moral status of waiting changes as information gain, delay-generated burden, reversibility, and patient-priority fit change over time.

Figure 1 illustrates the relationships discussed above.

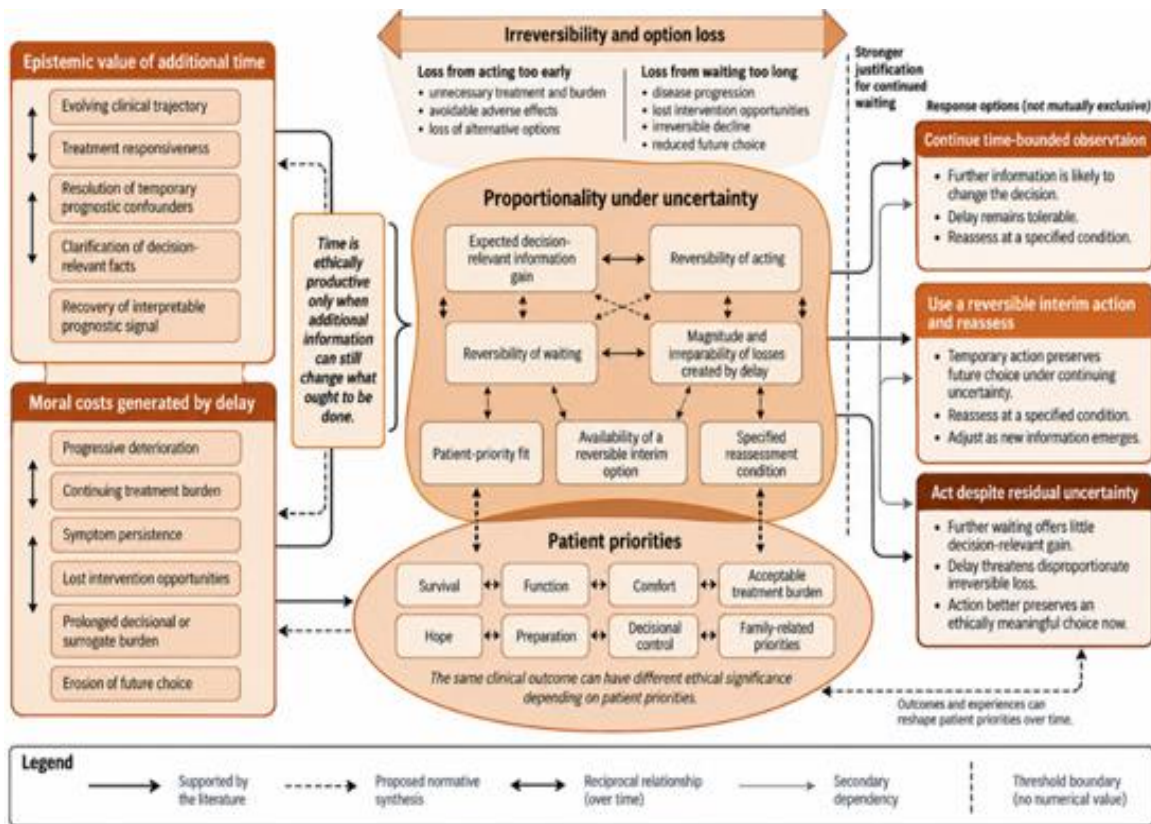


Figure 1. The point at which waiting for certainty ceases to preserve ethically meaningful choice

Implications for clinical decision-making

The proportionality account changes clinical practice primarily by making the purpose and cost of waiting explicit. Decision support cannot be reduced to reminders to communicate. In intensive care, clinician nudges designed to promote serious-illness communication did not reduce hospital length of stay, although some end-of-life care processes may have changed [27]. Communication interventions should therefore be judged according to the outcomes they can reasonably influence. Where possible, clinicians should clarify priorities before a crisis narrows the available choices. Structured serious-illness communication programs can improve aspects of clinician–patient communication [28], and some studies have reported selective psychological benefits rather than uniform effects across outcomes [29]. Their normative value lies in reducing avoidable uncertainty about what matters to the patient before clinical uncertainty becomes urgent.

When waiting is chosen, its purpose should be documented in ordinary clinical terms: what remains

unknown, what information is expected to emerge, what burdens are being accepted meanwhile, and what event or interval will trigger reassessment. Continued treatment without such a decision point risks becoming inertia rather than proportionate observation.

Persistent disagreement should also trigger recognition that more clinical information may not resolve a normative conflict. Routine ethics involvement in ECMO care has exposed recurring disputes concerning prognosis, treatment burden, goals, and institutional responsibility [30]. Clinicians may also approach end-of-life decisions through different autonomy- or best-interests-oriented ethical frameworks [31]. Ethics consultation is therefore most useful when disagreement concerns how values should govern action, not merely when prognostic data are incomplete.

These implications are summarized in **Table 2** as changes in the justification required for waiting or acting under different combinations of irreversibility and patient priorities.

Table 2. How irreversibility and patient priorities alter the proportionality of waiting and acting

Clinical configuration	Principal ethical concern	What favors continued waiting	What favors earlier action	Appropriate decision discipline
Action is highly irreversible; delay is comparatively reversible	Premature foreclosure of recovery or future choice	Further information is realistically likely to alter the decision	Delay begins to create substantial new burden or lost opportunity	Use time-bounded reassessment with explicit conditions for ending the waiting period
Delay is becoming irreversible; action retains some reversibility	Loss of an option through postponement	Additional information remains highly decision-relevant	Treatment window, function, comfort, or patient participation is being lost	Favor a reversible interim action where available and reassess
Both action and delay carry irreversible risks	No risk-free option exists	Waiting protects a patient-defined priority that would otherwise be permanently lost	Delay threatens another higher-ranked patient priority	Make the value conflict explicit and document why one irreversible risk is accepted over the other
Patient priorities are sufficiently clear	Respect for informed values under incomplete prognosis	The patient accepts delay-related risk to preserve a valued possibility	Continued waiting conflicts with a priority the patient has clearly rejected sacrificing	Anchor proportionality in the patient's ordering of outcomes, not clinician discomfort with uncertainty
Patient priorities remain unclear but are realistically clarifiable	Risk of acting on an assumed preference	Additional dialogue or prior-value evidence is obtainable within a tolerable interval	Clinical deterioration is rapidly removing meaningful alternatives	Set a short reassessment interval and prioritize preference clarification
Conflict persists despite adequate factual clarification	Normative disagreement is being mistaken for informational uncertainty	Further deliberation may genuinely clarify values or legitimate authority	Additional testing will not resolve the disagreement	Escalate to structured ethics support rather than extending diagnostic or prognostic delay

Note: The table presents the article's normative synthesis. It is not a validated scoring instrument, triage rule, or numerical decision algorithm.

Results and Discussion

The strongest challenge to this account is that caution under uncertainty may itself be morally required. That challenge is correct in an important class of cases. Neuroprognostication and time-limited treatment demonstrate that premature irreversible decisions can be ethically worse than temporary continuation of burdensome care when additional observation is likely to produce decision-relevant information [8]. The proposed account therefore reverses toward waiting when delay remains comparatively low burden, uncertainty is genuinely reducible, and action would irreversibly destroy a possibility the patient values.

The opposite error is to treat uncertainty as an indefinitely renewable reason for postponement. The distinction developed here identifies a limit: once waiting is no longer producing information likely to alter the decision, its justification must come from something other than uncertainty itself. Continued delay may still be defensible—for example, because the patient values additional time or because procedural safeguards require it—but those reasons should be stated directly.

This also explains why proportionality cannot replace autonomy, best interests, or shared decision-making.

These principles identify ethically relevant reasons; proportionality asks how those reasons bear on the timing and reversibility of action under incomplete knowledge. Patient priorities remain constitutive rather than supplementary. Evidence that uncertainty may either support reflective dialogue [16] or delay necessary conversations [18] further shows that its ethical significance depends on context rather than direction alone.

Institutional constraints create an additional boundary. Limited staffing, unavailable treatment, delayed transfer, fragmented communication, or slow decision processes can all extend uncertainty. Such constraints may be unavoidable, but they should not be redescribed as patient-centred reasons for waiting. Ethical transparency requires distinguishing delay justified by the patient's interests from delay produced by organizational incapacity.

The proposed threshold is deliberately non-quantitative. It cannot determine automatically when information gain has become too small or delay burden too great. Its contribution is instead diagnostic: it identifies the questions that must be answered before uncertainty can legitimately justify continued postponement. Empirical work could test how these questions are operationalized

in particular specialties, but their normative ordering cannot be validated by outcome prediction alone.

Conclusion

Prognostic uncertainty can justify waiting, but it does not justify waiting without limit. The morally relevant question is what additional time is expected to contribute to the decision and what is being lost while that information is sought. Waiting remains proportionate when it is plausibly decision-relevant, comparatively tolerable, and consistent with the patient's priorities. Its justification weakens when information gain diminishes while irreversible burden or option loss accumulates. The ethical limit of waiting for certainty is therefore reached not when uncertainty disappears, but when further postponement no longer protects a sufficiently important possibility to justify what delay is taking away. In those circumstances, responsible clinical action may require proceeding despite residual uncertainty.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

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