Caring prevails if evidence cannot

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As 21st-century surgeons, our role is to provide patients with care supported by the highest-quality evidence. During our clinical training, we learn from landmark studies that shape our decisions — extending survival in prostate cancer,[1] counseling patients on stricture recurrence,[2] and justifying treatment intensification for kidney stones,[3] among many others. But what can we do when the evidence does not exist? What can we do when there is no randomized controlled trial to advise our decision or when there is no major observational study to quote? What should we do when our patient's mother expectantly looks at us and asks, "Doc, should my child get this surgery?" We rely on our clinical experiences, the advice of our mentors, and attempt to provide excellent care, nonetheless.

As surgeons, we offer the most invasive form of medicine, and in pediatrics, we ask parents to allow us to provide this intervention for their most important person. As a junior resident, I cared for a six-month-old boy in clinic — completely healthy on the outside but diagnosed with prenatal hydronephrosis. An overall silent condition, there were no outward signs of the ongoing significant renal insult. On serial visits, his kidney continued to swell, and surgery was "indicated;" however, the "indication" for pyeloplasty in pediatrics can be highly variable because of the paucity of high-quality evidence. Sure, I explained the evidence behind hydronephrosis grading, the risk reduction in infections with adjuvant treatments, and thoroughly went over each investigation, but these were just numbers to the patient's parents, and their son was the only number they were concerned about. From the parents' perspective, I was suggesting that their child should be anesthetized, cut open, and fixed. Then the parents asked, "Does he really need surgery urgently?"

There is limited evidence in this condition to precisely decide each child's risk of kidney damage, infection, or other adverse events from non-treatment. This is when we go back to our first class in medical school and return to the humanism that grounds us as doctors. We listened to the parents' concerns, walked them through the benefits and risks of surgery based on both evidence and experience, and introduced them to the full pediatric care team. We openly acknowledged the uncertainty in the data but explained how specific features of their son's case signaled a need for timely intervention. In other words, we showed them that their child's well-being was our priority — even if we couldn't quantify the risks and benefits down to the decimal.

The patient underwent surgery and continues to do well.

This experience taught me two key lessons. First, it's not just how much you know, it's how much you care that helps patients place their trust in you. Second, we must recognize the gaps in evidence and pursue these research questions with the same drive that pushes us to become better surgeons. My discomfort with the uncertainty that sometimes accompanies medical decision-making fuels both my clinical work and research. Together, these efforts will help us provide the best possible care — even when evidence-based medicine reaches its limits.

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