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The Art of Saying Nothing

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Doctors are generally good at talking. Across 3 decades, iterative studies have shown that physicians often interrupt or talk over patients.[1,2] In 2019, a seminal study of primary and specialty care clinicians demonstrated that physicians interrupted patients after a median of 11 seconds.[3] In some ways, listening has become a lost art in medicine.

As pediatric clinicians with clinical and research expertise in pediatrics and communication science, we teach students and health care professionals about the value of saying nothing. Offering quiet presence offers important benefits in medical conversations. Especially when news is difficult, emotions are high, or complex decisions are needed, silence allows patients and families the space to think, sit with information, share their feelings and perspectives, receive support, and grow trust and solidarity. Mindful silence is an accessible and cost-free communication tool, yet it often remains undervalued and underutilized in health care. When we ask trainees to practice silence during role play scenarios,[4] many struggle to sit quietly for longer than 5 to 10 seconds. Clinicians are trained to learn information and speak what we know; comparatively, we spend much less time practicing how to say nothing.

Keeping quiet, particularly when one has expert knowledge and recommendations to share, is not easy. As with development of any skill in medicine, building confidence and competency in silence requires conscious effort and repetition. In our experience, learning to sit in silence at times can feel awkward and frustrating. We start to fidget.

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We are not sure where to focus our eyes, and we wonder if our gaze seems intrusive. How much silence is enough? How much is too much? Is it ok to speak now? Adding further complexity, differences in culture, sex, age, language, sensory processing, and other personal characteristics may influence comfort and perception of silence.

A decade ago, Back et al[5] highlighted a key failure in communication skills training around use of silence: namely, we over-rely on the directive to "use silence" during difficult medical discussions, without sufficiently emphasizing the need to create meaningful experiences within the space of silence. We see this phenomenon unfold frequently during communication skills training for pediatric subspecialty trainees, in which didactic reminders to integrate silence into medical conversations can inadvertently increase trainees' focus on the quantity of silence (eg, How many seconds has it been? Should I wait longer?) instead of on the quality of silence.

Intuitively, we know that quality matters more than quantity for silence, just as it does for all facets of skillful communication. Yet what does quality mean in the context of silence? Historically, psychologists have studied and characterized silence by its potential for therapeutic value.[6] In the field of communication science, researchers have examined differences between silences that engender connection, distance, or neutrality within patient-clinician encounters.[7,8]

In general, "connectional" silences that grow therapeutic alliance occur less often during medical dialogue, whereas silences that represent distance and neutrality are found more commonly.[8,9]

Another typology of silence within medical dialogue focuses on the function or purpose of silence.[5] Silences that occur because of disorganization, not knowing what to say, or simply a misguided effort to "use more silence" can feel confusing or uncomfortable. Coined "awkward silences,"[5] these moments are unlikely to be helpful for a patient or family, regardless of length. In other words, silences that are defined by absence of speech alone are less likely to feel meaningful and may be interpreted negatively by patients, families, and clinicians.[5]

Alternatively, silences deliberately offered by the clinician to encourage a patient or family to process or share their emotions and thoughts have the potential to be practical and therapeutic. Such "invitational silences"[5] are often preceded by open-ended questions ("Tell me more") or empathic statements ("I can't imagine how you are feeling"), and they are consciously crafted to create space for coping, exploring, and trust-building. In our experience, these silences are not complicated to create: the trickier part is learning to remain still and actively engaged, without interrupting or attempting to control the trajectory of conversation.

Yet in our experience, these categories insufficiently capture those silences that feel profound—the wordless spaces within emotionally charged conversations that viscerally communicate support, affirmation, respect, deep caring, solidarity, and a commitment to bearing witness.[7] During difficult conversations with patients and families who are suffering, these types of silence facilitate a sense of shared understanding and communion. Palliative

care clinicians have called this compassionate silence, defined as a contemplative practice toward shared intentions for a good outcome (eg, attending to suffering).[5] Researchers in the social sciences further capture its sacred quality when they describe this sort of silence as "the stillness of listening to humanity."[10]

Few medical studies, however, have examined the use of silence as a means of connection during clinical encounters.[8,9] In pediatrics specifically, the role of sacred silence as a communication tool remains understudied. What makes silence feel profound during difficult conversations between clinicians, children with serious illness, and their families? Over 5 years, our research team audio-recorded serial conversations about disease progression between clinicians, children with advancing cancer, and families across their progressing illness for 24 months or until time of death. We performed inductive content analysis across recorded dialogue to examine different types of silence, with a specific interest in trying to identify and characterize moments of "sacred silence." We found that, within periods of intentional silence, nearly half were coded as meaningful, or sacred, in their ability to create a profound sense of support, connection, and intimacy. Sacred silences often followed times of visceral emotional expressions, were bookended by empathic and affirmational statements, and yielded a shared sense of understanding or enlightenment. We also found a frequent phenomenon in which a string of silences, each lasting 5 seconds or more, were juxtaposed closely within dialogue. We called this phenomenon "stacked silence," and we were interested to discover that the majority of sacred silences involved the "stacking" of multiple silences close to one another.

We believe that formal communication didactics for pediatric clinicians lack sufficient emphasis on the importance of learning, practicing, and teaching the "stillness of listening to humanity." We advocate for communication educators to deemphasize the concept of "plugging in" 5 to 10 seconds of silence for the sake of using silence. Instead, we champion the importance of 5 key tenets. First, listen actively for emotional cues, such as crying, statements of grief, shock, or vulnerability. Second, respond genuinely with an empathic statement (eg, "I can't imagine how difficult this is"), an affirmational statement (eg, "Every parent feels overwhelmed when they hear news like this"), or a supportive statement (eg, "You are not alone"). Third, deliberately create a wordless space that is saturated with active presence, bridged by connectional body language, and anchored in an intention to bear witness. Fourth, consciously allow the patient and family to lead us out of the silence. And fifth, be deliberate about introducing a series of quiet spaces across the conversation. Rooted in our clinical and research experiences, we advocate for the concept of "stacked silences" to be taught as an integral aspect of communication training for clinicians. Instead of inserting silence after the provision of bad news (eg, pausing for 5 to 10 seconds, and then plowing ahead with more information), we encourage learners to practice layering one moment of silence on another, with self-awareness and purpose.

Poet and scholar Rumi famously said, "Listen to the silence. It has much to say." Just as we prepare and exercise procedural skills in our clinical repertoire, we must rehearse and practice silence if we wish to truly hear—and heal.

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