A Process-Based Approach to Responding to Parents or Guardians Who Hope for a Miracle

Trevor M. Bibler, MTS, PhD; Devan Stahl, MDiv, PhD; Sophia Fantus, MSW, PhD; Alex Lion, DO, MPH; Kyle B. Brothers, MD, PhD

When parents or guardians hope for a miracle for their child who is critically ill, ethical and professional challenges can arise. Often, although not always, the parent or guardian’s hope for a miracle entails a request for continued life-sustaining interventions. Striking a balance between the pediatrician’s conception of good medicine and the parent or guardian’s authority requires a response that is sensitive, practical, and ethically sound. In this article, we recommend 3 cumulative steps that promote such a response. First, we recommend ways of exploring essential issues through open inquiry, interdisciplinary dialogue, and self-reflection. As part of this exploration, pediatricians will discover that parents or guardians often have unique ideas about what a miracle might be for their child. The second step includes analyzing this diversity and seeking understanding. We classify the hope for a miracle into 3 distinct categories: integrated, seeking, and adaptive. After the pediatrician has categorized the parent or guardian’s hope, they can consider specific recommendations. We detail context-specific responses for each kind of hope. By attending to these nuances, not only will the parent or guardian’s perspective be heard but also the pediatrician’s recommendation can strike a balance between advocating for their conception of good medicine and respecting the parent or guardian’s beliefs.

Ethical and professional challenges arise when patients, surrogates, or parents or guardians request aggressive medical care while waiting for a miracle. Despite the persistent challenge the hope for a miracle can present, research on this topic is limited, with only a few publications addressing this kind of hope in pediatric medicine. Although similarities arise between adult and pediatric medicine regarding the hope for a miracle, the challenges found in pediatric medicine are notable for 2 reasons. First, adult medicine assumes patients have the capacity to make informed medical treatment decisions. In pediatric medicine, however, the patient’s expressed medical preferences play an evolving role over the course of childhood: from no role during infancy to a substantial role in late adolescence. Therefore, incorporating a patient’s expressed preferences into shared decision-making becomes increasingly complex. Rather than beginning with an obligation to respect autonomy, pediatricians begin, but do not end, with promoting the child’s interests by recommending interventions that maximize good consequences and minimize harmful ones. In adult medicine, health care professionals give great weight to an incapacitated patient’s previously expressed values, beliefs, and preferences. When these medical preferences are known, non-consensual interventions are more difficult.

abstract

Dr Bibler conceptualized, outlined, and drafted the initial manuscript and was responsible for editing and revising the manuscript throughout its creation; Dr Stahl outlined the initial draft, contributed to the conceptualization of this article, critically reviewed the manuscript for important intellectual and clinical content, and reviewed, revised, and edited the manuscript during its development and finalization; Dr Brothers contributed to the conceptualization of this article, critically reviewed the manuscript for important intellectual and clinical content, and reviewed, revised, and edited the manuscript during its development and finalization; Drs Fantus and Lion critically reviewed the manuscript for important intellectual and clinical content and reviewed, revised, and edited the manuscript during its development and finalization; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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a surrogate decision-maker is tasked with making a decision that promotes the patient’s individual interests. If unknown, then adult medicine relies on surrogates to act in the patient’s best interests. Young children rarely have established beliefs to rely on, leaving pediatricians and family to rely on more impersonal standards such as best interests or minimizing harm.

A second reason the hope for a miracle can pose a persistent challenge is that pediatric medicine, consistent with the laws of the United States, allows parents or guardians broad discretion when determining what medical interventions are in their child’s interests. Religious or spiritual beliefs of parents or guardians can orient pediatric care in many scenarios, with exceptions often limited to instances in which there is a high risk of serious, preventable harm to the child. In these circumstances, pediatricians often seek legal solutions to override parental authority. However, parents or guardians who hope for a miracle typically request that interventions begin or continue, not be withheld. Although it is a professional consensus that pediatricians must respect parental rights, the scope of this right, and what “respect” entails, is uncertain in this context. Responding well to parental requests requires finding a balance between the obligation to provide interventions that promote the well-being of the patient while also allowing parents or guardians appropriate authority over the care of their child.

In this article, we promote a process-based approach that includes 3 cumulative steps: (1) exploring essential issues related to the parent or guardian’s hope, (2) seeking understanding of the parent or guardian’s perspective, and (3) making recommendations for care. This approach enables responses that account for the pediatrician’s professional identity, independent of the pediatrician’s personal spiritual commitments or faith tradition. Additionally, the pediatrician needs not attempt to distinguish between authentic and inauthentic appeals to religious tenets to implement our suggestions. Of note, although we focus on conflict, the hope for a miracle does not necessarily entail conflict between pediatricians and families.

We confine our discussion to situations in which (1) parents or guardians identify with 1 of the 3 largest religious traditions in the United States (Judaism, Christianity, or Islam), (2) the child is receiving at least 1 life-sustaining intervention (LSI), (3) the child has not developed their own spiritual beliefs, (4) the pediatrician directly responsible for the child’s care has concluded that continuing or initiating LSI is inappropriate, and (5) the family disagrees, saying that LSI must continue as they wait for a miracle. These parameters constrict our discussion but are necessary given the complexity of the topic.

**STEP 1: EXPLORING ESSENTIAL ISSUES**

**The Invocator’s Perspective and Relationships**

When a pediatrician hears miracle language, they should seek out the invocator’s perspective on a number of essential issues: the first being what they mean by “miracle.” The pediatrician could ask, “You say you are hoping for a miracle for your child. I have found that ‘miracle’ can mean different things to different parents. What would a miracle look like for you and your family?” Asking open-ended questions shows investment in the invocator’s perspective and serves to normalize the hope for a miracle; additionally, honest inquiry into what the family values may help build rapport.

The pediatrician should inquire into possible relationships between the invocator and a religious community. A question such as “It sounds like the support of your community is important. Could you tell me about them?” can create the conditions for conversation about the authorities the invocator trusts. If they have not mentioned community, consider asking if they have ever been part of a religious community. Uncovering and appreciating religious support systems becomes essential when building trust and making recommendations, as we detail below.

Asking the invocator for their current understanding of the child’s condition serves to continue conversation, build rapport, and, when necessary, educate. Hoping for a miracle does not necessarily entail a misunderstanding of the child’s diagnosis, treatment options, or prognosis. Indeed, invocators may have an above-average understanding of the clinical picture. The pediatrician might ask, “I know there have been lots of different teams coming by and talking with you about your child. What have they been saying to you over the last 2 days?” With such a question, the pediatrician recognizes that the family may feel overwhelmed by many factors, including the number of professionals caring for their child, the turnover between services, or the amount of information the teams convey. The question also creates a time frame to ensure that the family begins their account with recent events. Emphasizing the care team’s responsibility for providing accurate information can minimize the perception that the pediatrician is interrogating the invocator rather than genuinely inquiring.

Negative emotions, distress, and suffering often accompany pediatric illness, especially at the end of life. The invocator may be struggling with feelings of despair, anger, or helplessness; they may be questioning whether they are good parents or faithful members of their
religious community. Not all invocators experience and display such emotions (and neither are these emotions confined to miracle invocations). For those who do, responding with empathy\textsuperscript{29} provides a foundational response that acknowledges the invocator’s emotions and establishes the pediatrician as an invested presence who cares about their feelings and perspective. Empathy requires inquiry into the life of the invocator; it also requires imagining the invocator’s world and their unique experiences.\textsuperscript{7} Empathy is not a quick remedy to the affective turmoil a parent or guardian may be living through, nor is it intended to be. An empathic disposition serves as a starting point to address the invocator’s emotions and interests. By asking, for example, “What can I do to help you be good parents?” the pediatrician invites the invocator to openly reflect on their conception of parenthood. A prompt for reflection such as “I know having a child in the ICU can be very difficult emotionally. What has been the most difficult part of [the child’s] sickness?” similarly asks for open reflection without judgment. By asking these questions, the pediatrician can begin connecting with the invocator without rushing to resolve the concurrent emotional and intellectual unrest some invocators experience.

**Interdisciplinary Actions**

The pediatrician should continue exploring these issues by seeking the assistance of other health care professionals. Gathering a second opinion from another pediatrician regarding the patient’s diagnosis and prognosis, as well as the appropriateness of continued LSI support,\textsuperscript{26} reduces the possibility that the pediatrician is employing a biased standard for inappropriate treatment. To reduce the possibility of confirmation bias, the pediatrician should ask a colleague to review the case impartially and use their own clinical judgment rather than rubber-stamping their conclusion. Pediatricians should also consider requesting consultations from chaplains and palliative care professionals\textsuperscript{14,30} to provide psychosocial and spiritual support. Ethicists\textsuperscript{22,31} may help the pediatrician analyze and address the values that underlie the conflict, especially regarding the pediatrician’s conceptions of benefit and harm. Finally, a conversation among members of the pediatric care team can establish a consistent message, which, in turn, minimizes the possibility of miscommunication or disagreement between pediatric professionals.\textsuperscript{32,33} These interdisciplinary conversations can serve to facilitate clear communication throughout this process.

**Self-Reflection**

After asking the invocator questions and speaking with other professionals, pediatricians should explore their own perspectives, biases, and assumptions about proper pediatric care and spiritual belief. Self-reflection and preparation for future conversations\textsuperscript{34} can help pediatricians better understand the reasons these requests may pose a challenge. Asking questions such as “What am I assuming about good medical care?” can serve as a foundation for active self-reflection (see Table 1). If the pediatrician believes continued LSI will harm the child or is not in the child’s best interests, they should interrogate what they mean by “harm” and “best interests.” Appealing to such concepts requires professional and personal exploration. Perhaps the pediatrician feels complicit in causing harm to the child’s body or the child’s dignity. Pediatricians must be honest and forthcoming about their reasons for viewing continued LSI as harmful, inappropriate,\textsuperscript{26} or nonbeneficial\textsuperscript{35} to

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### TABLE 1 Exploring Essential Issues

<table>
<thead>
<tr>
<th>Process</th>
<th>Question</th>
<th>Issue</th>
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<tbody>
<tr>
<td>The invocator's perspective and relationships</td>
<td>What might a miracle look like for you?</td>
<td>Conception of miracle</td>
</tr>
<tr>
<td>Interdisciplinary actions</td>
<td>Could you help me determine if continued LSIs are inappropriate?</td>
<td>Interdisciplinary support</td>
</tr>
<tr>
<td>Self-reflection</td>
<td>What am I assuming about good medical care?</td>
<td>Perceptions on medicine</td>
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<tr>
<td></td>
<td>What biases am I harboring about the child’s quality of life?</td>
<td>Benefit and harm</td>
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<tr>
<td></td>
<td>Do I believe in miracles?</td>
<td>Conception of miracle</td>
</tr>
<tr>
<td></td>
<td>What might a miracle look like here?</td>
<td>Invocator’s struggle</td>
</tr>
<tr>
<td></td>
<td>What is the invocator struggling with?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What kind of stress are they undergoing?</td>
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guard against the possibility that they are covertly using their personal values rather than their professional judgments as the basis of their arguments. Pediatricians should investigate their own conceptions of the miraculous by asking questions such as “Do I believe in miracles?” Independent of the pediatrician’s spiritual commitments, these questions promote an exploration of the pediatrician’s own perspective and how their perspective might influence their response.

Reflecting on the experience of the parent or guardian can continue the process of building empathy and create the foundations for future conversation. As mentioned previously, the invocator may be struggling with what it means to properly care for their child; they may feel a tension between fulfilling their obligations to their child and the Divine. Asking oneself questions such as “What is the invocator struggling with?” can help avoid transferring the pediatrician’s emotions onto the family while also building an empathic bridge between the pediatrician and the invocator. Active and intentional self-reflection creates the conditions for continuing the conversation after the pediatrician has invested time in speaking with others.

**STEP 2: SEEKING UNDERSTANDING**

Invocators will offer diverse responses to the questions posed by pediatricians. We suggest that pediatricians continue this process by seeking to understand and categorize specific perspectives. Eventually, the pediatrician’s understanding will allow them to tailor their responses to the invocator. To that end, we describe 3 common ways parents or guardians invoke the possibility of a miracle: integrated, seeking, and adaptive. Within each category, we describe defining characteristics that serve as identifiable elements meant to assist pediatricians in understanding the invocator’s perspective. It is important to remember that invocators might not remain in a single category throughout the child’s illness. Our suggestions provide structure to the diversity of answers one hears when exploring issues; these suggestions do not promote simply labeling the invocator for the sake of a quick fix to fundamental issues.

**Integrated**

The parents or guardians who use the word “miracle” in an integrated sense put their trust in the guidance of their religious communities (ie, they are wholly integrated into the community). An integrated invocator views the world, medical care, and illness through their community’s lens and places trust in their spiritual authorities. These authorities, however the invocator defines them, often visit, lead the family in prayer, and attend family care conversations. For example, an integrated invocator may connect their conception of a miracle with their evangelical Protestant community’s conception of a miracle; a Sunni Muslim may rely on their imam’s word as final on what the Divine requires of humanity. From their respective conceptions of a miracle to their views on the illness, integrated invocators rely on their communities to form their worldviews and rarely disagree with their authorities.

The integrated invocator’s hope for a miracle often includes an instantaneous cure from illness or some kind of quick recovery. However, this conception might change with the assistance of trusted spiritual authorities. For example, an integrated invocator who at one point believed their community required continued LSI as a way of showing faith finally time rather than experience a complete recovery from a terminal cancer.

Seeking invocators incorporate the notion of a miracle into their medical decision-making, but the pediatrician should not be surprised if their idea of the miracle changes over time and they decide, for example, that it would be a miracle if they could see their child smile one final time rather than experience a complete recovery from a terminal cancer. Seeking invocators exhibit an openness to explore what the miracle they are seeking might be in both prayer and conversation. They often welcome chaplains, ethicists, social workers, and others to explore the meaning of a miracle with them. Seeking invocators incorporate
clinical information into their spiritual worldviews directly and are less likely to conclude that medicine has an antagonistic relationship with the Divine. Instead, medicine and the Divine work together to promote good medical care. Akin to integrated invocators, seeking invocators also read religious texts and often have sacred objects at hand.

Adaptive

Not every invocator relies on their communities in the same ways as integrated and seeking invocators. Adaptive invocators consciously adapt their conceptions of the Divine to make the case for their personal conception of good medicine. These invocators may state that they are part of a faith community that requires a specific kind hope for a miracle (similar to integrated invocators). However, an adaptive invocator may be unaware of their community’s commitments regarding LSI, lack a close connection to the community, or completely reject the community’s authority. A notable percentage of Americans seldom (or never) attend religious services, although they identify as Jewish (31%), mainline Protestant (24%), Muslim (22%), or Catholic (20%).25 Adaptive invocators often fall into this category by stating that they are part of a faith tradition while also lacking a close connection to that community. We are not assuming or asserting that a gap between service attendance and religious identity demonstrates an inauthentic faith. But adaptive invocators may tell the pediatrician that their faith requires the hope for a miracle when, in fact, it may not, or the adaptive invocator may be hoping that by employing miracle language, the pediatrician will simply accept their request for continued LSI. Rarely will the pediatrician find an adaptive invocator praying, worshiping, interacting with sacred objects, or weaving canonical stories of healing into their conversations.

Unlike seeking invocators, adaptive invocators often reject attempts at exploring their conceptions of a miracle. Unlike integrated invocators, an adaptive invocator will not rely as heavily and explicitly on their stated religious identity. For example, an adaptive invocator might lean on a stated religious affiliation and insist that the team accept their request for continued LSI because rejecting this request would mean infringing on their rights and liberties as a person of faith. Other family members may show surprise at the invocator’s upswell of religious expression. Although many factors might spark an adaptive invocation, including a deep desire to acquaint oneself with a religious community, we have found 2 common motivations: a lack of trust in the care team’s ability to provide good care41 and a desire to establish oneself as the child’s sole medical decision-maker. Adaptive invocators may recognize that health care professionals could be reluctant to inquire further into their conception of the miraculous. An adaptive invocation might capitalize on this reluctance to establish sole decision-making authority over their child’s care.

Our description may appear harsh or judgmental. However, we intend to describe rather than make normative judgments. Adaptive invocators may be parents or guardians who find the idea of a miracle important and supportive in challenging times. We recognize this, but it will not serve the pediatrician to assume all invocators have a close, intimate connection to their communities (compared with integrated invocators); nor is it accurate to assume all invocators are open to conversation and looking for a better understanding of the Divine (compared with seeking invocators). Like integrated and seeking invocators, adaptive invocators deserve a tailored response that attends to their motivations, values, and priorities. In the next section, we proffer practical responses to the spiritual diversity pediatricians encounter.

STEP 3: MAKING RECOMMENDATIONS

Given the complex psychosocial and spiritual considerations the hope for a miracle displays,42 in this section, we attend to this complexity without curtailing the pediatrician’s authority to discuss their professional perspective on good medical care. As we will show, some responses (such as time-limited trials and making concrete recommendations) could be offered to all invocators; however, the timing, purpose, and content of these responses will vary on the basis of the unique invocations and clinical contexts.

Response: Integrated

When responding to integrated invocations, the pediatrician should identify religious authorities and incorporate them into the conversation, if the family so desires. The pediatrician might ask, “Given [the spiritual authority’s] importance in your lives, would you like to invite them to our next family care conversation?” This invitation respects the invocator’s worldview, takes seriously their commitment to their community, and invites a nonclinical party into the conversation who may assist in translating43 between the health care team and the invocator. The pediatrician should not insist on including these spiritual authorities because it is the invocator’s decision to include or exclude them in conversation. Although never guaranteed, including these authorities may lead to breaking the impasse between the pediatrician’s conception of good medicine and the invocator’s request for continued LSI.38 On the other hand, if the spiritual authority affirms the invocator’s perspective, the
pediatrician should consider speaking with the authority one-on-one to convey their concerns and inquire further into the community’s commitments. Chaplains or ethicists might assist in ensuring that the pediatrician’s view and the community’s perspectives are heard. The relationship between the invocator and the religious authority can result in spiritual guidance that no member of the care team could provide.

To continue this conversation in a productive manner, the pediatrician might acknowledge that they are not questioning the validity of the invocator’s belief, nor are they insisting that the invocator set aside their hope for a miracle. An integrated invocator is not coping, in denial, or reactionary. Rather, the pediatrician is witnessing the application of a religious worldview to the life of a child who is sick. Therefore, restating a prognosis or making the same case ad infinitum without incorporating the community is unlikely to result in an accepted recommendation (Table 2).

If after a great deal of personal and professional reflection, interdisciplinary dialogue, and open conversation, the pediatrician continues to conclude that continued or additional LSI will harm the child, then it may be appropriate to state that LSI should be withheld or withdrawn by using concrete language (see Table 3). A straightforward recommendation is important for the parents or guardians to hear because they may not yet fully appreciate the pediatrician’s conviction that continuing or initiating LSI is harmful and inappropriate. The pediatrician might feel as though they are prioritizing their professional and psychological interests or even a physicalist-scientific worldview above the authority of the parent or guardian when making a recommendation to withhold or withdraw an LSI. We are not arguing that a pediatrician must make such a recommendation; instead, we are arguing that a pediatrician who has concluded that further LSI is inappropriate, while attempting to understand their own perspective, converse with colleagues about their conclusion, and build consensus with the invocator, would be ethically and professionally justified in making such a recommendation.

The timing of such a recommendation is essential. With integrated invocators, the pediatrician should consider making their recommendation after integrating the invocator’s spiritual authorities into the conversation. Below, we discuss appropriate time frames for recommendations for other invocators.

Response: Seeking

As we have shown, not everyone hoping for a miracle depends on their community in the same manner as an integrated invocator. The pediatrician may consider asking a seeking invocator to include their religious authorities in future conversations. Unlike integrated invocators, however, a seeking invocator may be especially hesitant to involve these authorities in their decision-making. Seeking invocators often consider institutional spiritual care resources, such as chaplaincy services, valuable and wish for them to be part of family care conversations. The chaplain’s ability to explore what a miracle might be is indispensable when responding to seeking invocators. Recall, seeking invocators often begin with a conception of the miraculous that includes complete recovery, but
their idea of a miracle may change over time. They may decide that the miracle they were seeking has already occurred, perhaps, when the child was conceived or born, or perhaps, the miracle was the child’s brief life. We recommend that pediatricians consider exploring these alternatives, with a chaplain taking the lead in the conversation.

Recommending time-limited trials of LSIs may be especially helpful for seeking invocators. With such trials, it is imperative that all parties agree on a time frame and concrete parameters for progress, stasis, and regress. The care team should note that these trials are not intended to place a stopwatch on divine action. The trial instead provides the pediatrician with the clearest picture of the patient’s possibility of recovering a specific organ system. We have found that seeking invocators show a keen openness to scenario-based projections. Specifically, when discussing paths moving forward, we suggest discussing best-case and most likely scenarios. As we suggest with integrated invocators, the pediatrician may clearly and directly recommend withholding future LSIs after an agreed-on time-limited trial. A time-limited trial may be applicable to other invocators as well, including those who identify as spiritual but not religious; however, notice that the time line for recommending a time-limited trial will be different depending on the mode of invocation (see below).

**Response: Adaptive**

Although many motivations can accompany an adaptive invocation, if the invocator does not trust the care team, establishing a therapeutic alliance that results in an accepted recommendation is unlikely. Independent of where the responsibility lies for the lack of trust, it is paramount that the pediatrician attempt to establish trust. By simply asking if the invocator has lost trust in the team, the pediatrician recognizes the situation and invites the invocator to share their perspective. After hearing the invocator’s account, asking, “What can I do to begin reestablishing trust?” shows a commitment to establishing trust, and focuses on what the individual pediatrician can do at that moment. Undoubtedly, the pediatrician can state their account as well, but relitigating past events is unlikely to serve the purpose of establishing trust. If the pediatrician concludes that the invocator is employing the hope for a miracle to establish himself or herself as the sole decision-making authority, the pediatrician might tell the invocator...
that decisions for the patient should be shared by the family and the care team.

Providing a recommendation to an adaptive invocator at this point may be counterproductive. Establishing trust takes time. Recommendations are more likely to be heard, understood, and accepted when spoken by a trusted source.41 When the invocator appears ready to hear recommendations, recommending a time-limited trial may serve to begin establishing time frames for withholding or withdrawing LSI. Depending on the development of the relationship, the pediatrician might also recommend that LSI be withdrawn if continuing to wait for a miracle harms the child’s well-being. When applicable, informing the invocator that the pediatrician will be handing over the child’s care to a trusted colleague, naming that colleague as an ally in building trust, and then informing the colleague of their recommendation will further promote trust. An adaptive invocator’s emphasis on their decision-making authority will likely decrease as trust increases.

**CONTINUING THE CONVERSATION**

This approach can, we hope, assist pediatricians in responding to a parent or guardian’s hope for a miracle in a structured, sensitive, and effective manner. However, no matter how skilled the care team is, there are instances in which conversation cannot bridge the chasm between the pediatrician’s professional integrity and the invocator’s request that LSI continue. We are not advocating for a unilateral decision even in these circumstances. Instead, pediatric hospitals in the United States, especially those with NICUs and PICUs, should have policies that promote fair-as-feasible solutions (see Table 4).14,48 If an institution lacks a formalized committee-based policy, we suggest creating policies with the institution’s ethics committee, ICU service directors, and invested bedside staff. In most jurisdictions in the United States, these policies may not confer protection from legal liability if the pediatrician makes a unilateral decision, but they can ensure that the responsibility for navigating the ethical and professional challenges that arise is not the individual pediatrician’s alone.

**CONCLUSIONS**

We recognize a number of limitations that accompany our suggested practices. We have confined our suggestions to invocators of Abrahamic faiths. Future researchers would do well to concentrate on spiritualities expressed outside of these traditions, especially attending to those who identify as spiritual but not religious or affiliated given their growing numbers.25 Indeed, our analysis does not capture the complete spectrum of miracle invocation within these major traditions, and our approach cannot provide empirically validated recommendations. We recognize that incorporating additional qualitative and quantitative methods into this arena will be essential as the field moves forward. That said, we hope that our suggested process of inquiring, seeking understanding, and making tailored recommendations increases the possibility that pediatricians can develop a justified plan of care that attends to both the invocator’s and the pediatrician’s accounts of good medicine while also promoting care that serves the child’s well-being.

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**ABBREVIATION**

LSI: life-sustaining intervention

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**TABLE 4 Continuing the Process**

<table>
<thead>
<tr>
<th>Action</th>
<th>Purposes</th>
<th>Participants</th>
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<tbody>
<tr>
<td>Care team meeting</td>
<td>Update consultants</td>
<td>Pediatrician</td>
</tr>
<tr>
<td></td>
<td>Check own understanding</td>
<td>Consultants</td>
</tr>
<tr>
<td></td>
<td>Gather perspectives</td>
<td>Legal (if desired)</td>
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<tr>
<td></td>
<td>Create a plan of care</td>
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<tr>
<td>Family meeting</td>
<td>Listen to the family</td>
<td>Pediatrician</td>
</tr>
<tr>
<td></td>
<td>Ensure that the pediatrician is still caring</td>
<td>Family and those they trust</td>
</tr>
<tr>
<td></td>
<td>for the child</td>
<td>Appropriate consultants</td>
</tr>
<tr>
<td>Committee meeting</td>
<td>Hear and appreciate the pediatrician’s and</td>
<td>Pediatrician</td>
</tr>
<tr>
<td></td>
<td>family’s perspectives</td>
<td>Family</td>
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<td></td>
<td>Reason about the appropriateness of LSI (may</td>
<td>Appropriate consultants</td>
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<tr>
<td></td>
<td>be done with committee members only)</td>
<td>Committee members (including community member</td>
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<tr>
<td></td>
<td>Provide fair-as-feasible recommendations</td>
<td>ideally)</td>
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<tr>
<td>Implementation of recommendation</td>
<td>Implement the recommendation of the committee</td>
<td>Pediatrician</td>
</tr>
<tr>
<td></td>
<td>Continue to emphasis nonabandonment</td>
<td>Family</td>
</tr>
<tr>
<td></td>
<td>Continue listening to concerns</td>
<td>Appropriate consultants (especially ethicist)</td>
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