

HOPE AND DECEPTION

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ABSTRACT

Convinced of hope's therapeutic benefits, physicians routinely support patients' false hopes, often with family collusion and vague, euphemistic diagnoses and prognoses, if not overt lies. Bioethicists charge them with paternalistic violations of Patient Autonomy.

There are, I think, too many morally significant exceptions to accept the physician's rationales or the bioethicist's criticisms, stated sweepingly. Physicians need to take account of the harms caused by loss of hopes, especially false hopes due to deception, as well, as of the harms of successfully maintained deceptive hopes. As for autonomy, hopes — even if based on deception — can protect and enhance autonomy, understood broadly as the capacity to lead a chosen or embraced life.

Deception aside, patients' hopes often rest on beliefs about possible rather than probable outcomes — beliefs themselves supported by optimism, 'denial', or self-deception. Such 'possibility-hopes' may conflict with physicians' often more fact-sensitive 'probability-hopes.' To resolve such conflicts physicians may try to 'down-shift' patients' or parents' hopes to lesser, more realistic hopes. Alternatively, physicians may alter or enlarge their own professional hopes to include the 'vital hopes' that define the lives of patients or parents, as well as 'survival hopes' needed to face and bear the loss of loved ones, especially children.

A principle of Hope-giving might help guide such sympathetic hope-accommodations. More generally, it would give Hope a distinct place among Beneficence, Autonomy, and the other moral factors already highlighted by canonical principles of Medical Ethics. To formulate such a principle, however, we will need a collective Project Hope to pursue deeper philosophical and psychological studies.

Physicians worldwide follow Ambroise Paré's maxim, 'Always give the patient hope, even when death seems at hand.'¹ To give or

¹ *Life and Times of Ambroise Paré [1510?–1590]*. New York: P.B. Hoeber, 1921.

sustain a patient's hope, they are often willing to deceive a patient with the help of the family. Given the supposed benefits of hope, they feel fully justified in doing so.² Bioethicists, however, tend to take issue: Deceptive prognoses violate patient autonomy, and since Autonomy trumps Beneficence in all but extreme cases of harm, physician deception is not justified. Consequently, to add Paré's maxim to the standard canon of principles for medical practice would only strengthen the lesser Principle of Beneficence and serve to weaken the superior Principle of Autonomy.

As with many debates, I have trouble joining either side. *Contra* the doctors, deceptive hope-giving is often *not* an act of beneficence, if we take into account often neglected risks and harms. *Contra* the bioethicists, deceptive hope-giving is often *not* a violation of patient autonomy, properly understood. In explaining these points, I will review physicians' methods of clinical hope-giving, deceptive and otherwise; suggest useful distinctions between kinds of hope and hopelessness; and consider how an especially acute conflict of parents' and pediatricians' differing hopes might be resolved. In concluding, I'll briefly take up the question of adding a Paré-like maxim to the canon of medical ethics principles.

These remarks are often tentative, speculative, or commonplace. My hope (and excuse) is to reopen a topic that contemporary medical ethics largely ignores, except in a few semi-religious studies.³

HOPE'S BENEFITS

Hopeful patients may be thought to fare better in treatment, for several reasons. First, hope is often supposed to have direct therapeutic benefits closely akin to placebo effects. Secondly, hopeful patients are thought more likely to comply with taxing, protracted therapeutic regimens, thereby deriving whatever benefits they provide. Thirdly, compliant, persistent patients may well get more attentive care from the medical staff. By contrast, patients without hope not only forego these various benefits, but allegedly risk despair and suicidal desires.

² Here, as elsewhere, the East/West contrast is overdrawn and the 'twain are meeting' after all. Reportedly, Japanese physicians are increasingly pressed for truthful diagnoses and prognoses, at least by younger patients (Blackhall *et al.*, *JAMA* 1995; 24:820–25), while North American physicians are increasingly pressed by immigrants to conceal dire facts, at least from older family members.

³ For example, Edmund Pellegrino and David Thomasma, *The Virtues in Medical Practice*. New York: Oxford UP 1998.

Although plausible, this account exaggerates or simplifies hope's therapeutic benefits in several regards. First, if hope has placebo-like effects, they are likely to be rather slight. Secondly, the benefits of many protracted treatments are questionable, especially if continued to maintain a patient's hopes. Thirdly, patients whose compliance is due in part to false hopes sustained by deception may well get less, not more attention from the staff. Lastly, even when patients lose hope, they may continue treatment without despair or suicidal impulses for the sake of still hopeful family and physicians.

First, hope and placebos. In giving a placebo, the physician typically says, 'This treatment has been shown to work and should help you', and the trusting patient fully expects it to do so. By contrast, hopeful patients may have no such trusting expectations that a treatment will work. They may hope for benefit from a treatment that they know rarely works, or indeed has never yet worked. It is often enough that the patient believes that the treatment *could* help. Such hope may rest on nothing more than their physician's unenthusiastic 'We don't have any reason to think that it can't help'. In short, their hopes rest not on probability, but possibility. (More on this below.)

In such cases, hopefulness is clearly a different mental state from placebo-expectations. If distinct mental states are, or are correlated with, distinct neural states, then hopes and placebo-expectations should have different physiological pathways and therapeutic benefits. Of course, if mental and neural states are *not* so related, then these pathways and effects *could* be similar. But this vexed philosophical issue aside, there may be one point of comparison. Reportedly, there are placebo-effects even when a physician says, 'I am not sure this treatment will work but let's just try it'.⁴ In such cases the placebo patient's mental state may be very like that of a patient with hopes resting solely on a physician saying, as above, that benefit was not impossible.

This point of comparison, however, gives little support to Hope's advocates. With such an unenthusiastic introduction, a placebo has only relatively weak effects. Presumably, the effects of possibility-based hopes would be no greater, unless these hopes were supplemented by a patient's robust optimism. I'll return to possibility and optimism below. Let us first turn to the often unnoted risks that hope runs, especially when based on deception.

⁴ Sandra Blakeslee, 'Enthusiasm of Doctor Can Give Pill Extra Kick', *Science Times*, *New York Times*, October 13, 1998, p. 4.

HOPE'S DANGERS

As just mentioned, patients' hopes may rest on very little evidence, or none at all. Moreover, there may be little correlation between the strength of those hopes and the strength of the evidence, if any, on which they do rest. Accordingly, unless placebo-like effects of hope are greater and wider than we now know, many hopes are likely to fail. Failed hopes not only disappoint; they often cause prolonged suffering. Accordingly, any accounting of hope's net benefits must include the harm of failed hopes. We cannot assume that 'it is better to have hoped and lost than never to have hoped at all.'

On the other hand, we should not assume that the loss of hope is always harmful. Not all hopelessness is despair, with resulting refusals of treatment and suicidal desires. Patients may lose hope of recovery or remission but continue treatment in order to satisfy their still hopeful physicians or family, or because they are carried along by the momentum of a routine course of treatment they do not have the will or desire to disrupt.

We need a distinction between *being without hope* and the emotionally fraught condition of *being bereft of hope*. Which of these two states of hopelessness patients incur may turn on the content and strength of their prior hopes and the manner in which they lost those hopes. Patients whose high hopes (of quick, easy, or total recovery) are abruptly and irrecoverably dashed by events may be especially vulnerable to despair. Hope-destroying events may be medical, for example, the sudden recurrence of dire symptoms or failure of a previously effective drug. Or, the events may be social, for example, the death of someone who was the patient's *raison d'être* — or discovery that one's hopes have been based on the lies of family or physicians in collusion. In the latter case, patients may lose trust as well as hope, or react with outrage or other alienating feelings. Ironically, the result may be the very despairing refusal or desire to die that deceptive hope-giving was meant to prevent.

Again, we must avoid simplistic generalization. Discovering deception may be liberating. Even if immediately alarming and depressing, the truth may enable patients to give up a fight that family and physicians were imposing, perhaps in large part to maintain or conceal their own fading hopes. And, if family or physicians' visits had been curtailed to reduce the risk of inadvertent disclosure or probing inquiry, the truth may renew intimacy. Freed of their respective burdens of treatment and collusion, patients and their physicians and families may well

draw closer. If so, discovery may on balance prove beneficial, and false hope on balance not harmful.

In short, Hope's risk/benefit ratio has higher risks, lower benefits, and more complex calculations than Hope's champions often allow. These complications do not disprove the claim that hope is generally beneficial, even deceptive hope. But they do show that a putative principle of hope-giving would not simply follow from a more general principle of Beneficence in medical practice.

DECEPTIVE HOPES AND AUTONOMY

Any principle of Hope-giving that allowed deception would, of course, be accused of violating the Principle of Autonomy that many bioethicists rank first among principles of medical ethics: False or misleading prognoses prevent patients from making informed choices about therapy, and lies to dying patients prevent them from 'putting their affairs in order'.

These criticisms presume, of course, that there are therapeutic decisions to be made, and that dying patients can, if informed, order their affairs. Often neither is the case. Continued hospital chemotherapy may, for example, be the only way of keeping a dying cancer patient relatively comfortable, conscious, and clean. And, deception may be the only way of keeping a patient from *disordering* their affairs. Even if the prospect of death does 'focus the mind', it may focus it on the wrong things. Suddenly facing death, patients may become preoccupied by regrets about what they have or have not done in the past, or on what they will not live to see in the future. Thereby, they may cease attending to the people and projects that define the lives they have long been leading.

That may not trouble philosophers who regard Autonomy as largely a matter of rational, informed choice. There may be nothing obviously irrational about those reactions to news of impending death. Yet, on a view of Autonomy that stresses 'leading embraced lives' more than making choices, those sudden preoccupations may count as a loss, not a gain for autonomy. On this latter view, Autonomy requires the capacity (or capacities) for leading a life informed by reflective values. What matters is not the usual rational, informed choices among options: there may be few of those, especially when ill. Rather, what Autonomy requires is the ability to continue, so far as circumstances allow, the life one embraces (or if that is

impossible, the capacity to make another life or, failing that, to end one's life.)⁵

Obviously, hope is crucial for autonomous living, so understood, in that uncertainty abounds and the outcomes of action are unpredictable, whatever one's choices. It is often, especially during illness, that our hopes depend on physicians and other caretakers. Physicians foster not only the hope needed to undertake and continue treatment, but also the hope needed to continue life-defining activities while ill and under treatment. To that degree, physicians support patients' capacity for and exercise of autonomy, so understood.

In some cases, physicians can do this only by deceptive hope-giving, for example, by withholding what would be in the circumstances life-shattering news. To withhold the truth and foster false hopes in such cases is not paternalistic, as critics charge. In doing so, physicians are not protecting patients from harms they would discount or not acknowledge. Rather, they are acting as unappointed surrogates for patients who are still competent, despite illness, to continue leading their lives just so long as they do not learn of their dire prospects.⁶ Thus they allow patients to continue to focus their minds on the 'right things', that is, the things that define and give meaning to their lives.⁷

SELF-DECEPTION AND DENIAL

Perhaps a greater threat to autonomy is self-deception, with which hope is often associated. Whether construed as a capacity for rational choice or continuing one's life, autonomy requires knowledge of one's capacities, values, and motives. Self-deception serves to make such knowledge highly selective and favorable to one's self-esteem. It does so by avoiding so far as possible situations and people who will challenge that favorable view of one's character and actions. In this regard, self-deceivers

⁵ That is the point of the title and plot of the Brian Shaw play, 'Whose Life Is It, Anyway?'

⁶ This is not an implicit advance directive: 'Don't disclose my impending death if I cease to be myself'; but rather, 'Don't disclose my impending death, lest I cease to be myself'. It is as if Ulysses had silenced the Sirens rather than stuffed his ears.

⁷ Reportedly, Paul McCartney did not tell his wife, Linda, that she had a fatal cancer so that she might continue composing and recording the music that 'was her life'. Presumably he thought that she would stop working if she learned that she would not live to finish the project, or perhaps become too distraught to work, even though there was still time to finish it.

are more given to evading counter-evidence than to denying its existence or import when it is encountered.

To succeed, self-deceivers need allies who keep challenges to a minimum. In this respect, self-deception like deception is social, involving at least two persons. But it is unlike deception in that the other party to self-deception need not know the truth and attempt to convince the self-deceiver of the opposite. S/he may only half-suspect the truth and take steps to avoid finding out more, wanting in fact to hold the very view that the self-deceiver holds. Given this difference, self-deception is only quasi-deception in misleading reflexive grammatical dress.⁸

What self-deceiving patients protect is their treasured belief that they are less ill, injured, disabled, or disfigured than they are. Likewise, they may protect their belief that they have the good fortune or judgment to be under the care of superior physicians in superior hospitals.⁹ Accordingly, they can easily be led to hope for a quicker, easier, or more complete cure than their case warrants. It may be enough for physicians merely to use their usual vague, euphemistic, and sanguine ways of presenting diagnoses and prognoses. When told she has 'an operable tumor' or 'treatable lesion', a self-deceptive patient will see no need to ask about tumor size, cell type, possible metastases, or 5-year remission rates (known euphemistically as 'cure rates'). She can easily hope that recovery will be rapid and complete. So long as her physicians, nurses, and relatives do not try to persuade her otherwise, her hopes may persist even if contrary evidence begins to appear.

It may be useful to distinguish here between self-deception and related habits of denial and optimism. Self-deceivers may be able to evade challenging evidence but not to deny its existence or import when confronted with it. Deniers, however, seem not to hear or remember dire diagnoses or test findings even when presented candidly and directly to them. Optimists tend not to evade or deny negative evidence, but to discount it in favor of the positive evidence they take to ensure a good outcome.¹⁰

⁸ 'Social Deceptions', in *Perspectives on Self-Deception*, edited by B.P. McLaughlin and A.O.Rorty. University of California Press, 1988. Cf. fn. 11 below.

⁹ 'Yet there was one thing that comforted her — the fact that they had brought her to this clinic: she had an exaggerated notion of its excellence. 'At the Boucicaut they would have operated on me yesterday! It appears that *this* is the best clinic in Paris.' Simone de Beauvoir, writing of her mother after a stroke and broken leg. *A Very Easy Death* (New York: Pantheon 1985), p. 17.

¹⁰ Shlomo Breznitz makes a similar contrast in 'Denial Versus Hope: Concluding Remarks', *Handbook of Stress*, 2nd edition, edited by Shlomo Breznitz and Leo Goldberger. New York: Free Press 1993, pp. 297–302.

Physicians, of course, may have similar tendencies to evade, deny, or select and discount evidence to maintain their own self-esteem and hopes. They may thereby be able to regard low cure rates as the work of physicians or hospitals of inferior ability, and so to be largely irrelevant to the prospects of their patients. They may even dismiss their own dismal cure rates on the ground that each failure has been instructive and increases the likelihood of future success. Thereby they support their patients' self-deceptive hopes — and their own.

Generally, self-deception is morally preferable to deception. In most deception, one person uses another 'as a mere means' to the deceiver's distinct and often competing ends. In self-deception, there is no such Kantian abuse. Although, as noted, self-deception often requires assistance to avoid encounters with evidence or people who would challenge one's false pet beliefs, those assistants often want the self-deceivers to retain those false beliefs, for similar ends or compatible ends of their own. Just so, physicians often abet patients' self-deception to secure hopeful compliance whatever its therapeutic benefits for the patient.¹¹

There is, however, an indirect moral issue. Even if not misusing others, physicians who abet self-deceivers may be harming them, if self-deception is as irrational as some critics claim. But is it? In that hope often requires self-deception and uncertain projects require typically hope, then I would want to defend self-deception as a useful and beneficial human trait, and to that extent it *may be* at least an adjunct of rationality. But let us turn to hopefulness apart from self-deception and deception. How irrational is hopefulness *per se*?

HOPE AND PROBABILITY

Most distinctively, hopeful people tend to focus on possibilities, not on evidence or probabilities. Hence they do not need, like self-deceivers, to evade counter-evidence or, like deniers to ignore

¹¹ (Philosophic aside) Nor do self-deceivers engage in Kantian abuse of themselves, somehow cognitively splitting themselves into deceiver and deceived. Contrary to the misleading syntactical form of the term, the logical form of self-deception is not 'xDx.' Self-deceivers do not have to perform paradoxical feats of persuading themselves to believe what they believe to be false. Accordingly, they do not use themselves, let alone use themselves to pursue aims at odds with their own. Rather, they engage in activities that have some, but not all of the techniques and consequences of deception. Hence, it is *semi*-deception, just as self-teaching is semi-teaching. Whether self-deception is imprudent or irrational is another and complex question.

it. Hopeful people may not even need, like ordinary, small-scale optimists, to find shreds of positive evidence among the negative. Hopefulness does, however, often draw on large-scale religious or scientific optimism. On the grand scale satirized in Voltaire's Dr. Pangloss, optimists claim that any and all desirable possibilities will be realized sooner or later, thanks to God's benevolent omnipotence. More limited is the optimistic belief that Modern Medicine will find cures to any malady, sooner or later, thanks to the Scientific Method. For such robust optimists, their hope is that the outcome they desire will be sooner rather than later.

Such optimisms are probably more common among patients than physicians. Even if some surgeons still regard themselves as 'the hands of God', they are unlikely to hold such global religious optimism. Nor are they likely to share patients' optimistic faith in Medical Progress. They know that medical progress is sporadic and that 'medical miracles' are long in the making and usually come as no surprise to physicians in the field. Their hopes are more likely to rest on probabilities than on possibilities. And yet, they cannot depend on probabilities alone, for there are too few established probabilities in Medicine, and those few are often too low to be used with much confidence. When prescribing drugs, physicians often bolster their own hopes with the possibilities implied by such addages as, 'Each patient is unique' and 'Each treatment is experimental'. Accordingly, they allow for unexpected, even if not miraculous cures.¹²

How much hope or possibility-supplementation is needed varies somewhat with the disease and medical specialty, as well as the patient. Oncologists need more hope than internists, and internists need more hope when treating a patient with multi-drug resistant tuberculosis than a patient with acute bronchitis. Nonetheless, in every medical setting conflicts can arise between physicians or patients whose hopes are largely possibility-based and physicians or patients whose hopes are probability-based. For simplicity, let us speak about 'possibility-hopes' and 'probability-hopes', while allowing that in the medical context the hopes of both physicians and patients are usually hybrid.

¹² Some philosophers have tried to provide a probability-analysis of hopes, but with limited success. See J.P. Day, 'The Anatomy of Hope and Fear', *Mind* LXXIX (1970). He allows hope to range from a subjective probability lower limit of 0.001 to an upper limit less than 1.0. I think these are both too high. Any value greater than 0 could express a possibility-hope, but any value very close to 1 will not reflect the uncertainty (or fear, according to Spinoza) that is presupposed by hope. Perhaps the upper limit should be dropped to 0.945 to reflect the use of 0.5 confidence levels in statistical studies in medicine.

How are such conflicts to be reduced or resolved?

CONFLICTING HOPES

Among the sharpest such conflicts may be those in which parents insist on continuing treatment that pediatricians judge futile. Parents may cling to hope by insisting that the diagnosis, prognosis, or dosage could be in error, or that new remedies or God's interventions are possible. The pediatricians may regard these beliefs as irrational, self-deceptive forms of denial, yet want to address them tactfully. But how?

Direct rebuttal may be unavailing. Calling in colleagues may not shake parents' belief in the possibility of medical error or ignorance. ('Haven't doctors all been wrong in the past?') And, even if a drug has proven ineffective in the last 100 documented similar cases, they may insist (correctly) that those results do not prove that it will not work in this case. ('My child may make medical history!').¹³ An alternative tack would be religious argument. ('Surely, an omnipotent, loving God would have intervened by now, even if He had been testing your faith.')

Or, the pediatricians could try to substitute more realistic hopes for the high hopes to which parents are clinging. Physicians often do gradually shift dying adult patients from hopes for cure or remission to hopes for an 'easy death' or 'death with dignity'. It may, however, be much harder for parents to down-shift, since the prospect of losing a child may be far worse than the prospect of their own death.

Suppose the parents will not accept lesser hopes for their child. Are there any other ways of resolving the impasse? Could pediatricians shift their own hopes to accommodate those of the parents? Could they, for example, give up their hope to make the child's dying as easy as possible for the child (and staff) in favor of the hope to make the child's dying easier for the parents?

VITAL AND SURVIVAL HOPES

In discussing the harms of deceptive hopes, we ignored harms to family members due to collusion with physicians in deception. To preserve a dying patient's false hopes, family members often must avoid topics that might raise patient's doubts or suspicions, for

¹³ Failure in the last 100 cases is the criterion for medically futile treatments proposed by Lawrence J. Schneiderman and Nancy S. Jecker in *Wrong Medicine* (Baltimore: Johns Hopkins University Press, 1995).

example, questions about organ donation, coma care, provision for survivors and heirs. Likewise, they often must avoid any unusual expressions of love, gratitude, and grief, and they must postpone, or even forego (if the patient remains conscious and deceived to the end) certain pre-mortem rites dictated by their religion. Unable to discuss certain matters or give the care that their love or religion favors, they may suffer greater remorse and guilt during or after the patient's death than they otherwise would. In short, deceiving the patient prevents them from putting *their* affairs in order, perhaps for a long time.

What responsibility and care, if any, should physicians take for such family harms? Some physicians regard a death in the family as simply a monitored biological event, however it occurs. But for physicians who regard patient deaths as 'bio-social' events in the lives of a patient's kith and kin (including devoted nurses), the circumstances of a patient's death — the manner, timing, place, and declared cause of death — are of professional concern.¹⁴

But what weight should concern for a patient's family have when deciding how best to maintain a patient's hopes, or when best to discontinue treatment? Should harms to a family ever preclude hope-giving deceptions, even if they would be beneficial to the patient or protect autonomy (in the life-leading sense suggested)?

It may help here to introduce two further categories of hope, namely, 'vital hopes' and 'survival hopes'. *Vital hopes* are hopes akin to those hopes mentioned in discussing autonomy, namely, hopes that they give shape and meaning to a life. For many people, their children (or hopes for children) are such vital, life-defining hopes. The death of a child deprives parents of those vital hopes and rationale for living. If they are to go on living, they must find or renew other vital hopes. We might call these 'survival hopes' in that are needed to survive the loss of people who have been our *raison d'être*, or the basis of our most important vital hopes.

How a child dies may influence those *survival hopes*. For example, parents who have lied to maintain a child's hopes may long be haunted by their sense of betrayal of the child's trust. Along with other regrets or guilts, this thought may obsessively bind them to the child's death. Arguably, a pediatrician who has involved them in this deception incurs responsibility for reducing

¹⁴ Briefly sketched in an IAB IV panel on brain death, this 'bio-social' concept of death is developed in an essay, 'Death and Discretion' posted in draft on the web at <http://www.nyu.edu/gsas/dept/philo/faculty/ruddick>.

such guilt. This may mean continuing treatment well past the point of medical futility to reassure them that 'everything possible was done' to save their child. That extra effort may well be crucial for any new vital hopes to take root following the loss of a child who has been a parent's principal joy and motive for leading the life they embrace.

Of course, had the pediatrician been concerned with parental hopes from the outset, s/he might never have involved the parents in deception and thereby avoided subsequent responsibility for their guilt. Indeed, perhaps s/he should have misled the parents themselves from the outset as to the child's prospects. She would thereby have kept the circle of colluding deceivers small and hence reduced the risk of disclosure. Moreover, the parents' false hopes would have strengthened the child's own hopes and thereby reduced the need for deception altogether. And when the parents learn the truth either before or after the death of the child, they are likely to see the benefits of the double deception. Or, at least they are unlikely to feel the kind of betrayal a child might feel upon discovering that parents as well as physicians had been lying all along.

Taking responsibility for parents' hopes would come naturally to pediatricians who view parents as co-patients with their children. Giving the parents hope, even false hope, would fall under duties of Beneficence (subject, of course, to the complexities of risk/benefit calculation I mentioned earlier). This view of parents as co-patients does, however, pose a problem when their hopes would require the physician to continue futile treatment burdensome for the child.

The solution may lie in regarding parents as secondary patients whose welfare cannot override that of the primary patient, the child. But this has two shortcomings. The parents' sufferings may be much greater and last much longer than the child's, a moral consideration on most consequentialist ethical theories. Moreover, there is the practical paradox of these 'secondary' patients having a proxy's authority over the primary patient's treatments. As proxies, they cannot demand treatment that physicians or courts would consider inhumane and cruel, but the continued treatment I have in mind does not reach that level of suffering for the child.

It may help the pediatrician to think of parents not as patients, but rather *as parents*. Even young pediatricians have close second-hand experience of parents' incomparable suffering with the prospect and subsequent loss of a child. Likewise, pediatricians might reflect on first-hand experience of losing a beloved friend

or relative through death, or on the anxiety such that an imagined loss inspires. From an early age we know the anxiety that mortality arouses — not our own mortality, but that of others. We easily imagine the loss of parents or sibling long before we may be able to imagine or understand our own mortality. We learn fearfully and perhaps catastrophically what it means to love and depend on mortal others.¹⁵ This common sense of mortality, especially acute with regard to the possible death of children, may be a physician's most helpful guide in decisions about parents' vital and survival hopes.

But mustn't such sympathetic feelings be disciplined by principles of medical ethics, including a possible principle of hope-giving?

A PRINCIPLE OF HOPE-GIVING?

In general, we should be Occamists when it comes to principles: the fewer, the better. In general, the more principles, the more potential conflicts of principle and the more indecisive their practical guidance. On the other hand, with the help of theory, definition, and exaggeration, principles help keep in mind moral factors we might otherwise neglect. Is hope-giving in need of such high-lighting?

Were it simply subsumable under a Principle of Beneficence, it would need no principle of its own: In thinking about beneficent acts, we would almost certainly think of hope-giving. But I tried to show at the outset that hope is not so subsumable. Perhaps the best reason for a principle of Hope-giving is the prejudice against it arising from the demands for candor and rationality that the Principle of Autonomy is thought to require. Often enough, hope-giving ignores those demands and hence is thought to violate that principle (wrongly in my view).

But before adopting a Principle of Hope-giving, we need to give it and Hope a lot more careful philosophical analysis and psychological study than I have provided here. Only then would we have a proper sense of what the scope, limits, and rationale of such a principle would be. Given the apparent importance of hope-giving in physicians' practice and maxims, this is obviously a worthwhile project. Given the surprising

¹⁵ In Western philosophy almost all discussions of death are about the consequences for the person who dies. There is almost no mention of the survivors who must try to live with the death. I regard this as striking evidence for the charge that Western philosophy is highly individualistic.

neglect of the topic except in religiously motivated writing, it will be no easy task.¹⁶

Let me summarize these remarks, by way of providing possible points for further examination in this Project Hope:

Contrary to the standard accounts of lying to patients,

1. Hope's benefits must be weighed against the harms of having and then losing hope, especially when hope has been based on deception. Losing hope, however, is not always as harmful as physicians assume. Rather than fostering despair, losing hope may liberate a patient from burdens of treatment and allow lesser, more realistic hopes to take root. Or, even if no lesser hopes replace the lost hope, patients may still continue treatment to please their still hopeful family and physicians.
2. Deceptive hope may sometimes serve rather than subvert patient autonomy. Nonetheless, deception often separates patients and family in ways harmful to both. Patients may get less attention; families may forgo saying and doing what would make the patient's dying more bearable, for the patient and for them, especially.
3. When patients and physicians are optimistic, there may be little need for deception, especially when their optimistic hopes are jointly maintained by ignoring discouraging facts (cure rates, progress of the disease) and by other techniques of self-deception.
4. On the other hand, physicians may tend to have hopes more sensitive to discouraging evidence than patients or their families. Hence, physicians' ('probability') hopes for cure or remission may fade long before the ('possibility') hopes to which patients or their families cling, either through their trust in God or their distrust of statistical and other medical data.
5. When physicians cannot alter a family's possibility-hopes, they must decide whether to accommodate them by shifting their own initial hopes from solely patient-focused to more inclusively family-focused hopes. This shift is called for when

¹⁶ Apart from Aquinas and Spinoza, the most helpful writing I have found is that of James Muyskens, *The Sufficiency of Hope: The Conceptual Foundations of Religion*. (Philadelphia, Pennsylvania: Temple University Press Philosophical Monographs, 1979.) Although a work in philosophy of religion, the first three chapters analyze hopes and beliefs, whatever their objects.

Discussions with Jeffrey Blustein, Bengt Brülde, Carsten Hansen, and Frances Kamm have been very helpful, as well.

these continuing family hopes for a cure or remission reflect their broader 'vital hopes' and 'survival hopes'. If well-defined, a principle of hope-giving might help better assess such vital and survival hopes, as well as the possibility- and probability-hopes that physicians, patients, and their families hold.

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