THOSE of us who talk about ethical issues in medicine have our spiel on "truth-telling" down pat. We talk about the historical background of the policy of benign deception; about data that show that patients generally suspect the truth anyway; about recent changes in physician behavior in the direction of complete disclosure of unwelcome diagnostic news; and finally, about the important ethical principles of autonomy and individual self-determination. But sooner or later comes the rejoinder, delivered with the air of laying down the trump card: "All of that sounds very good. But how can you possibly justify ever taking away the patient’s hope?"

In debates on medical ethics, this question is all too often left unanswered. I believe that there is a satisfactory answer and that it has more to do, as Norman Cousins very correctly pointed out, with the "art of medicine" rather than the ethics of medicine. It is possible to tell the patient his true diagnosis in such a way as to leave him and his family emotionally devastated. It is also possible to prescribe the wrong dose of digoxin or to operate on the left knee for an arthropathy present on the right. We should not confuse botching our jobs with adhering to an erroneous ethical principle.

We know from placebo research how potent the patient’s emotions and ideas can be in healing the body. We also know that the physician is placed in a pivotal role to influence the patient’s ideas and emotions for better or for worse. Since hope is such a powerful medicine, we ought to manage our therapeutic relationships so as to maximize its effects. But to do so, we ought to have a more precise idea of hope’s psychopharmacological properties than is commonly gained from the truth-telling debate.

I would like to offer two rather rash observations about hope in this attempt to advance our understanding. The first is that, while we talk with great facility about the dangers of taking away the patient’s hope, I am not sure that we really have the power to do so except in very rare instances.

One does not have to practice medicine for long before one becomes aware of the profound emotional impact that our most innocent, off-handed remarks can have on our patients. As most of us would not have become physicians if we did not have the desire, at some level, to wield power over our fellow creatures, these incidents tend to confirm our satisfying myths of omnipotence. We may forget the much greater numbers of our patients who go on smoking despite our dire warnings, or who always seem to have a few extra penicillin pills in the medicine cabinet despite our firm admonishments to "take the pills four times a day until the prescription is completely gone."

Anecdotes have been told of patients who die of their terminal cancer, firmly convinced that they are in perfect health and that the slides must have been mixed up in the laboratory. I have had an elderly man tell me with great gusto how ten years ago his physicians had told him that he had only six months to live with his prostate carcinoma. Certainly, anecdotes can be offered to support the opposing view also; but I think that in general hope may be more resilient than we realize. The most callous pronouncement of doom may prompt not despair, but rather an intense commitment to proving that SOB wrong. And, if more sophisticated defense mechanisms fail, denial is not a bad thing to fall back on.

The second rash observation is that it is almost always possible to combine frank and accurate disclosure of the truth with an invigorating infusion of hope. For one thing, in many cases, the actual facts are not as grim as we think, if the patient is motivated to hear the good news along with the bad. We can truthfully tell the patient with terminal cancer, along with, "Statistically I would say that your life span is more likely to be measured in months rather than years," the additional message, "Somehow a few lucky or highly motivated patients seem to beat the odds and live much longer than we expect." The patient, depending on his or her own needs at the time, can choose to hear that the glass is 95% empty or that it is 5% full.

But there is a more important reason why we can almost always give hope even along with the direst tidings. It is suggested in a poem by Emily Dickinson:

The heart asks pleasure first,
And then escape from pain,
And then those little anodynes
That deaden suffering,
And then to go to sleep,
And then if it should be
The will of its inquisitor
The privilege to die.

If we were as good at listening to our patients as we are at telling them things, we would learn that hope is not automatically equated with survival. Hope means different things to different people; and hope means different things to the same person as he moves through different stages of his illness and his emotional reaction to it. The man who last year hoped for a cure for his arthritis may now hope that, on a good day, he can get in nine holes of
golf. And, for those unfortunates for whom those who would keep them alive have become truly the “inquisitor” instead of the savior, hope may mean a pain-free and oblivious death.

Giving hope, then, need not consist of, “You really don’t have cancer after all,” or, “We removed all the cancer surgically and your ten-year survival prognosis is excellent.” Giving hope can be: “We will be able to give you medicines to keep you free of pain,” or, “You will still be around this weekend to visit with your grandchildren when they come,” or, “I will not abandon you.” (Which in turn makes us wonder, when patients “lose hope” after being told the truth in a callous, brutal manner, if they are not responding to the unspoken message of the physician’s detachment and abandonment rather than to the spoken words.) When we talk to patients and find out what is really worrying them, we can almost always give some realistic assurances.

If we understand the psychopharmacological features of hope in this way, we realize that setting hope-maintaining against truth-telling is to create a false dichotomy. There is no fundamental conflict between our moral duty to preserve hope—to heal our patients with our words and not just with our medicines—and our moral duty to respect our patients as adult human beings who should be given the information they need to make their own free choices about their lives. We as physicians can maintain the demeanor that calms and reassures our patients—the positive sense of “arrogance” described by Franz Ingelfinger—and still take the initiative in disclosing truth. And once we realize that this is possible, we can turn our attention to the real question, which is how to learn and how to teach the skills necessary to do it as well as possible.

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