Hope and the Medical Encounter

James T. C. Li, MD, PhD

A patient told me a compelling story about her health problems. She was articulate about providing important details about her symptoms but also shared her experience of living with a medical problem. She ended the story (history) by saying, "...so I hope you will be able to help me."

The medical encounter begins with elicitation of the medical history. This medical history must contain sufficient information and detail for the physician to make a correct diagnosis and to formulate an appropriate therapeutic plan. Alongside the medical history is the patient's history, the history of the experience of illness. This "other" history may contain elements of fear, anger, or regret. There may be an underlying sense of hopelessness or despair. The patient may be searching for the "cause" or the meaning of illness.

The experience of illness varies widely among patients. However, virtually all patients come to the clinical encounter with some fear or uncertainty about the future. As the patient relates her story from the past to the present (the medical history), there is uncertainty about how the story ends, about the future. The work of the physician is to offer a vision of an alternative future, to change how the story ends. This work is accomplished by addressing the plea "...I hope you will be able to help me."

The work of shaping the patient’s hope for the future begins with an understanding of the patient’s hopes and fears in the present. Does she hope for a cure? Does she hope to continue working? Does she hope to see her 50th wedding anniversary? Is she afraid of losing her home? Does she fear disfiguring surgery? Does she dread a neglected, painful death? These hopes and fears may be carefully guarded and revealed only to a trustworthy person.

The Transformation of Hope

The 10th edition of Merriam-Webster’s Collegiate Dictionary defines hope as a “desire accompanied by expectation of or belief in fulfillment.” In the medical setting, the physician may have a role in shaping a patient’s desires and in providing a context for the expectation that these desires might be fulfilled.

An understanding of the patient’s present hopes affords the physician an opportunity to reshape these hopes. Of course, this reshaping should not be grounded simply on facts or numbers. This reshaping is an invitation to reimagine the possibilities of the future. For example, usually it is inappropriate to dash all hope of a complete recovery, even if recovery is highly unlikely.

The transformation of hope is essential to the healing and recovering process. Through education, encouragement, and empowerment, the physician may enable the patient to find realistic ways of perceiving an entirely new set of possibilities. In redefining hope, the physician is offering a promise for a new future, where the unthinkable becomes thinkable and the thinkable becomes unthinkable!

For patients with chronic diseases such as diabetes, asthma, or congestive heart failure, the physician can deliberately transform the false hope of cure into the realistic hope of a full and active life. This provision of hope might involve the physician guiding the patient through a reimagining of life with a chronic illness (eg, “I know you can’t walk up a flight of stairs now, but you may be able to climb several flights of stairs very soon”). Or the physician may focus on freeing the patient from the captivity of unrealistic fears (eg, “This problem does not turn into lung cancer”).

The power of giving hope has been misused in the past. Physicians no longer mislead or deceive patients in an attempt to provide deceptive hope. However, physicians can balance the science of the probable (probabilistic thinking) with the hope of the possible (anything is possible) to keep a patient’s hope alive.

Most medical therapy is mediated through the physician. In the medical encounter, the effectiveness of treatment is closely related to the therapeutic nature of the patient-physician relationship. At a minimum, the physician can promise quality medical care, an honest relationship, and a steadfast presence. The physician can describe a future that has meaning. Through these promises, the hidden future announces itself and enters the present. To be effective, a promise must be believed. For
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a promise to be believed, the one offering the promise must be trusted. Herein lies the power of the patient-physician relationship.

Hope is the inseparable companion of trust. The power of hope to transform and transcend depends in large part on the confidence, trust, and faith the patient has in her physician. Hope allows the patient to look beyond (to transcend) the present. The skillful physician creates and nurtures trust with the patient. Whether trust-building behaviors can be taught is an open issue.

Hope and Hopelessness

Identify Hope.—The assessment of hope begins with the medical history. This history is the story of the patient’s life and the intrusion of illness into that life. This history has great bearing on the “hope status” of the patient (and thus the physician’s response to it). For example, the meaning of a headache in a 50-year-old person whose father died of a stroke at age 50 years differs from the meaning of a headache in a 20-year-old person who is studying for examinations.

Sometimes a direct inquiry about the hopes and fears of the patient can be invaluable. A response to the statement “...so I hope you will be able to help me” might be “What did you hope I would be able to do for you?” or “What did you hope to get out of this visit?” Similarly, asking the question “What concerns you about this problem?” or “What do you think may be the problem?” may get to the heart of the patient’s fears.

Other queries into hope and hopelessness might include “If you could identify a source of hope, what would it be?” “What kind of things do you hope for?” “What makes you feel hopeful?” With this approach, the physician may be able to identify the patient’s sources of support and hope. Furthermore, responses to these questions might lead the physician to conclude that the patient has a fragile or non-existent hope for the future. The physician has a responsibility to recognize hopelessness if it exists and to respond in a caring and constructive manner.

Establish Trust.—Experts in medical communication have identified specific behaviors that can build and maintain patient-physician trust. Key physician behaviors include greeting the patient, acknowledging the patient’s response to it, demonstrating thoroughness in elicitation of the history and performance of the examination, negotiating a treatment plan, answering questions, and arranging for follow-up. Important elements in the patient interview include active listening and expressing empathy.

Clinical competence is a major determinant of patient trust. Medical knowledge, procedural skill, and problem solving are all requisites for establishing trust. Building trust in the absence of clinical competence is sheer quackery.

Perhaps the most important principle in building trust is the primacy of the patient. While acknowledging that the physician may have competing interests, the patient must have the confidence that her interests come first. At a minimum, the physician should be a stronger advocate for the patient than for the patient’s payer.

The physician’s unwavering presence is an important demonstration of caring and compassion. From the patient’s view, the physician becomes a trustworthy companion along life’s difficult journey. From the physician’s view, this means answering patient telephone calls, being accessible in the clinic or the hospital, and participating in the longitudinal care of the patient.

Transform Hope.—Just as the patient tells the physician a story, the physician can tell the patient a story. While the patient’s story is primarily about the past, the physician’s story is primarily about the future. Most physicians formulate a picture of what the patient’s future might hold. The challenge is to communicate this vision and to help the patient see new possibilities for the future. Through the transformation of hopelessness into hope, the physician can transform chaos into peace.

This transformation occurs (predominantly but not exclusively) through the spoken word. The physician can explain, describe, even proclaim the hope for an alternative future. For the patient with back pain, this may be a life free of disability. For the patient with end-stage renal disease, this might be the opportunity to continue to work. For the terminally ill cancer patient, this may be a life of peace, without pain. Physicians should be skilled in the use of the spoken word.

Hope can flourish even when the prognosis is poor. Prognosis is simply 1 piece of biomedical information. The prognosis is internalized and interpreted by the patient, sometimes with the help of the physician. The meaning of suffering, life, and death may influence hope more than the prognosis itself. For many, hope does not end at the prospect of death.

For many patients, hope may represent an inherent conflict. The patient’s experience of the present reality may seemingly contradict the hope for the future. The patient must believe the physician (and her message) for hope to be transformed. This ability to believe is the crux of the patient-physician relationship.

If the physician can get to know the patient and identify the patient’s personal values, the physician is better equipped to identify meaningful, attainable goals. For many patients, successful control of symptoms is a source of hope. Involving patients in decision making can be empowering and may drive out hopelessness. If appropri-
ate, the physician can support the patient’s spiritual endeavors and participate in the patient’s search for the meaning of illness and suffering.

There are practical benefits to giving hope. Adherence to complex medical regimens (patient compliance) can be enhanced. The successful follow-up visit can represent a concrete example of hope realized. A bright hope for tomorrow can give the patient the strength to persevere today.

Concluding Remarks

Hope is intrinsic to the clinical interaction. Hope embraces the future, even death. Hope makes it possible to bear pain and suffering in the present. Hope reinterprets the past and redirects the patient’s story to an alternative ending.

The patient-physician relationship is only 1 source of hope. Many sources lie outside this relationship, such as friends, family, and faith. Nevertheless, physicians should identify, shape, and transform hope to the best of their ability. However, a patient’s true hope for life and the meaning of life (and death) lies outside the medical encounter, in the domain of relationships and faith.

REFERENCES