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SCIENTIFIC CONTRIBUTION

Hope for health and health care

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Abstract Virtually all activities of health care are motivated at some level by hope. Patients hope for a cure; for relief from pain; for a return home. Physicians hope to prevent illness in their patients; to make the correct diagnosis when illness presents itself; that their prescribed treatments will be effective. Researchers hope to learn more about the causes of illness; to discover new and more effective treatments; to understand how treatments work. Ultimately, all who work in health care hope to offer their patients hope. In this paper, I offer a brief analysis of hope, considering the definitions of Hobbes, Locke, Hume and Thomas Aquinas. I then differentiate shallow and deep hope and show how hope in health care can remain shallow. Next, I explore what a philosophy of deep hope in health care might look like, drawing important points from Ernst Bloch and Gabriel Marcel. Finally, I suggest some implications of this philosophy of hope for patients, physicians, and researchers.

Keywords Hope · Health care · Medicine · Philosophy · Ernst Bloch · Gabriel Marcel · Thomas Aquinas

Introduction

Virtually all the activities involved in health care are motivated at some level by hope. Patients hope for a cure; for relief from pain; for a return home. Physicians and other health care providers hope to prevent illness in their patients; to make the correct diagnosis when illness presents itself; that their prescribed treatments will be effective. Researchers hope to learn more about the causes of illness; to understand how treatments work; to discover new and more effective treatments. Ultimately, all who work in health care hope to offer their patients hope.

Sometimes "hope" indicates no more than a desire; for example, "I hope the weather warms up by next week." This type of hope is an example of what I call "shallow hope." Hope may also be shallow when it is unrealistic. When this type of shallow hope is thwarted, the result is often a feeling of disappointment; if the disappointment is serious enough, it might even escalate to a feeling of hopelessness. Having this kind of hope might then actually be counterproductive. To insist on maintaining these sorts of hopes can lead to disillusionment and resentment against those who might be perceived to be responsible for thwarting the hope. Patients may put themselves at great risk chasing shallow hopes in therapies that physicians know are nothing more than modern-day snake oil.

Physicians sometimes resist talking to patients about hope. Clinicians can worry about not "taking away" or "destroying" hope when they have to deliver bad news to patients. As a result, they might be less than forthright in informing patients about the extent of their illness. While it is true that receiving bad news can strain a patient's hope and engender great suffering, patients have a right to accurate and compassionate disclosure of information from their physicians. It may still be possible to help people maintain realistic hopes even in the face of bad news that forces the abandonment of other hopes (Feudtner 2009, 2307).

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Physicians can resist talking to terminally ill patients about hope because they do not want to engender unrealistic hope in their patients. Ironically, physicians might unwittingly contribute to unrealistic hope by offering last-ditch treatments that have little chance of success instead of exploring just what a patient is hoping for. Chris Feudtner (2009, 2307), in advocating "an ethic respecting the breadth of hopes," reports that his gentle probing about patients' hopes reveals that patients hope for a range of things: e.g., miracles, relief of suffering, going home, finding meaning, and even surviving, not in a physical but a spiritual sense. When hope can be articulated in this way, physicians may be able to muster resources to help in ways they had not considered.

Physicians will be most effective at healing and relieving suffering if they can promote what I will call "deep hope." Deep hope includes a search for meaning and will often have a spiritual or transcendental element. There is much to learn about deep hope from religious traditions, theological scholarship and literature, but my approach here is philosophical. I shall first consider the nature of hope, shallow and deep. My review of the philosophy of hope is not exhaustive; my purpose is merely to highlight a few of the important elements that make a hope deep. I shall next consider several of the ways that hope can remain shallow. Then, I shall turn to explicating deep hope, drawing on the philosophy of Ernst Bloch and Gabriel Marcel. I highlight Marcel's emphasis on a supernatural dimension of hope but also explore how Bloch's atheistic view gives us insight into the nature of deep hope. Finally, I suggest some implications of this philosophy of hope for patients, physicians, and researchers.

Hope, shallow and deep

A brief analysis of hope

I begin with the "great dead philosophers" (Smith 2008, 8).[1] The ancient Greeks and Romans sometimes judged hope to be good, the Romans speaking of *bona spes*. They were cautious, however. They also recognized danger in hope, for hope can lead to disappointment.

Thomas Hobbes (1996, Part I, Chap. 6, Par. 14) called hope "appetite with an opinion of attaining." John Locke (1975, Bk. II, Chap. XX, Par. 9) held that "hope is that pleasure of the mind, which everyone finds in himself upon thought of a probable future enjoyment of a thing which is apt to delight him." David Hume (1978, Part III, Sect. IX) saw hope as produced by an event that, if certain, would produce joy. Hope arises in us when the anticipated event is "only probable and uncertain." Hope has a *cognitive* aspect, regarding belief about a future object and a logical connection with probability. Hope also has a *conative* aspect, having to do with desire (Day 1991, 17–20).

Smith (2008, 10–12) finds three important insights that follow from Joseph Patrick Day's (1991, 29–38) analysis of the position of Hobbes, Locke and Hume (HLH).[2] First, hope is a matter of more or less. Any plausible analysis of hope has to account for our experience of holding hopes with varying degrees of strength. With respect to the conative aspect, we know that our desires vary in intensity. Desires also vary over time. With respect to the cognitive aspect, HLH demands that the object of hope be probable. Probability varies for different objects of hope and can also vary over time with respect to the same object. These matters all contribute to my analysis of the depth of hope.

Second, HLH provides a schema for interpreting phenomena related to hope. It may not have all the resources necessary to make fine distinctions, but it does at least tell us that there are distinctions. Desire, for instance, is necessary for hope, but not sufficient. Hope may be related to fear of losing something. Hope and optimism are often difficult to distinguish. I shall later argue that this last distinction if important for identifying deep hope.

Third, Day's analysis of HLH provides a framework for evaluating hope and related phenomena. It can help us to see where hope and its related phenomena "go wrong." Hopes can go wrong in the conative realm; they may be based on malicious or unrealistic desires. Hopes can go wrong in the cognitive realm; they may be based on false beliefs about probability. Hope might even go wrong in both realms at once; for example, a hope for a long life without growing old (Smith 2008, 12). "Going wrong" is a matter of degree, however, and is important in judging the depth of hope.

HLH also has limitations. It seems reasonable to say that one can hope even in the face of very low or even near-zero probability. Furthermore, we hope not only when the future is uncertain; we sometimes hope when we have no idea what the future will bring (Smith 2008, 15).

Jayne Waterworth's (2004, 8–14) distinction between expectation and anticipation is telling here. She follows Wittgenstein's (1973, #583) observation about hope as a uniquely human phenomenon that reflects the significance attributed to the object of hope. Olympic athletes hope to win a race, but greyhounds do not (Waterworth 2004, 5–6).

[1] I am indebted to Nicholas Smith (2008) for the structure of analysis in this section. Smith acknowledges his own debt to Joseph Patrick Day (1991).

[2] I here follow Smith's accounting of the critique, which he applies to all three philosophers. Day confines his own critique to Hume. It does, however, seem plausible to extend the critique to Hobbes and Locke as Smith does.

Waterworth argues that it is anticipation and not expectation that plays a part in the phenomenology of hope. The experience of hope carries a feeling of uncertainly quite unlike the experience of expectation, which seems closely related to the belief that what is expected will occur with some degree of probability. Although one cannot hope without desire, one can hope without expectation (Waterworth 2004, 9). Expectation can refer to simply a passive observation and awaiting, a "looking out for"; it can also refer to degrees of probability.

Anticipation is different. Anticipation involves taking a stance, a "projection of one's *self* into the future, with a "readiness for action." It is the "taking up of a stance" that shows the subject's engagement with what is hoped for (Smith 2008, 17). In anticipating, one "reaches out towards that which is anticipated and unites oneself with the objective, phenomenologically speaking" (Waterworth 2004, 9). It seems quite reasonable to say that I expect the sun to rise in the morning, but I experience that expectation as hope only in rare and perhaps even dire circumstances.

The analysis of Thomas Aquinas (1948, S.T., I–II, q. 40, a. 1) fits these kinds of situations better than does HLH. Thomas argues that the object of hope has four conditions: (1) It is something good; (2) It is future, for hope does not regard that which is present and already possessed; hence it differs from joy, which regards a present good; (3) It must be something difficult to obtain and not something which is in one's power to have at any time; hence it is different from desire; (4) The thing that is difficult to obtain is something possible to obtain.

There are several points to note here. Hope is related to a future good; hence, it must include a component of evaluation. While HLH draws a sharp distinction between desire (conative) and belief (cognitive), evaluation of what is good requires both emotional and intellectual effort. Aristotle recognized this and Thomas follows. Just how good we judge an object of hope to be will contribute to the depth or shallowness of our hope. Thomas's third and fourth points differentiate him clearly from HLH and support the idea that hope is more than simple expectation of something that is probable. In hope, the effort expended is great, for what is hoped for is not within easy reach. One possible interpretation of this is that Thomas envisions the object of hope as something that is not merely mundane or ordinary, and hence probable. This would well differentiate a deep hope from a shallow one. But there may be another interpretation of Thomas's demand for difficulty. If hope does indeed involve the taking of a stance in which one projects oneself into an uncertain future, then it will "characteristically need to be worked on" (Smith 2008, 20). Deep hope requires effort.

There is, in Thomas's account, no demand that what is hoped for be probable. Indeed, much of what is hoped for in health care is not probable at all, but still not unreasonable. This is not to say there is no need for adequate consideration of the possibility and probability of obtaining what is hoped for. As Thomas recognizes, hope for something impossible is not true hope.

Finally, hope is future-oriented. It involves a future that is not certain but one that is possible. To evaluate possibility in medical matters is not easy, nor is it an exact science; it requires both emotion and intellect.

In summary, hope, as I conceive it, involves a committed stance, which takes effort, of anticipation of some future possibility that is good. It involves both conative and cognitive aspects and draws on both the HLH and Thomist traditions. Depth of hope involves not only the degree of commitment and effort (conative), but also the assessment of possibility and probability (cognitive) and evaluation of the goodness of what is hoped for (conative and cognitive).

My goal is not to provide any sort of quantitative scale by which to measure depth of hope. Neither am I suggesting that all aspects of hope need to be considered equally in judging degrees of hope. Such judgments are inherently normative and may appropriately vary with different individuals in different situations. I do take it, however, that a normative assessment of the *object* of hope plays a major role in determining the depth of the hope. That is, the intensity of the desire is not primarily what determines the depth of the hope. Although shallow hope may not be without value in health care, I will argue that deep hope plays an invaluable role in health care because the object of hope in health care usually involves matter of the very meaning of human life, death and suffering.

How hope can be shallow

The four-point definition of Thomas Aquinas about the object of hope provides a handy framework to show how hopes can be shallow. In this section, I shall suggest some ways that shallow hope deviates from this definition. First, there is shallow hope for what appears to be good but really is not. Second, there is shallow hope that regards the future in a wrong sort of way, by overvaluing the promise of medical innovation; the new is seen to be inherently better than the old. Third, there is shallow hope that attempts to avoid the difficult work necessary for deep hope. Fourth, there is shallow hope that miscalculates possibility and probability.

Hope for what is not really good

The problem here is that what is perceived as good may or may not be what really is good. Setting aside for a moment the difficulty in knowing whether a proposed means to an end has a particular probability of success, we are faced

with the question of whether the apparent good is really a good. We might plausibly claim that relief of suffering is a good, but there are cases where suffering is a necessary means to some further good (e.g., painful surgery that will almost certainly result in a complete cure). Judging when suffering is necessary for a greater good is not always easy. Extending life is an apparent good, but it may not be a true good when it only serves to prolong a painful road to certain death. These sorts of judgments about what is good involve both conative and cognitive considerations in that they involve conforming our desires to what is properly judged to be good. For this, the Aristotelian intellectual virtue of *phronēsis*, or practical wisdom, is needed. I will consider further the nature of the good in health care in my discussion of deep hope.

Hope in the inherent benefit of innovation

Medical innovations are developed with the expectation that new treatments will bring about a future that is better than the present. The great number of truly valuable innovations of the recent past can blind us to the fact that not all innovation is inherently good. Some innovation is in fact counterproductive. Ivan Illich (1976) famously argued that our confidence in the power of technological medicine to cure all our ills amounts to *hubris*. As technological innovations in medicine have increased, so have iatrogenic ills and medical expenses. Illich sees this as the response of Nemesis to hubris. He calls for a reining in of technology, but his radical approach hardly seems possible or even desirable. Furthermore, we ought to have hope in medical technology and innovation, for undoubtedly it has brought great good, even among the ills. The argument of Illich does suggest a point worth considering, however. Jon Elster (1983, 22) argues that desires or preferences can be objectionable when they are what he calls "counteradaptive." Obsession with novelty is one such counteradaptive preference (e.g., "the grass is always greener on the other side of the fence"). Blind optimism that the innovative medical technology of the future will be better than what we have now is simply a variant of belief that the neighbor's grass will always be greener. Hope in medical innovation *qua* innovation is a shallow hope because of inadequate evaluation of the belief. Judgments about the depth of hope here will largely be in the cognitive area. A lot of difficult assessment is necessary to judge how deeply we ought to hope in any newly proposed technology.

Hope in what eliminates the hard work

Hoping to be cured of an aggressive form of cancer will serve as a good example to illustrate the third aspect. Such a cure is difficult to achieve and good, competent physicians will not downplay this to patients. Still, some patients will turn away from these physicians and seek "alternative" treatments because they judge such alternative treatments to be less arduous and to offer better hope. For example, people continue to seek laetrile for cancer treatment even though studies have shown its ineffectiveness and possible toxicity and even though the FDA has banned its import since the 1970s (Food and Drug Administration 2004). Taking laetrile is not "easy" in the sense of being readily available; it does take effort to get it. But some who turn to laetrile are hoping for a cure that is easier than the difficult path of engaging in conventional treatments that require even more effort and have known risks of serious side effects.

On the other hand, conventional treatments are sometimes presented in a way that might sound inspiring but really offers only shallow hope. Innovative treatments are increasingly referred to as medical miracles; advertisers tell us that we can expect miracles from their particular product or at a particular hospital. Such language can lead to unrealistic expectations that are nothing more than shallow hopes. Some people might understand miracles simply as great wonders and this might even be a source of hope. Many medical technologies are indeed great wonders. Seeing such wonders as "miracles" might be a source of deep hope for some, provided that they understand "miracle" properly. Hard work might even be necessary for a proper understanding. Other people, however, might understand miracles as David Hume described them: violations of the laws of nature. This is, on the face of things, simply unrealistic, but it raises another complex philosophical issue. Whether nature is so regular as Hume thought or whether is it open to radical chance, as C. S. Peirce thought, is not obvious. Furthermore, whether we adequately understand the laws of nature at this particular time is questionable. The point is merely that using the language of miracles to promote treatments, alternative or conventional, is easily misunderstood and can obfuscate hope. (Stempsey 2002).

Hope for what is not possible or probable

The importance of the cognitive realm is perhaps most evident in the consideration that the object of hope is either probable, according to HLH, or merely possible, for Thomas Aquinas. The one who holds the former will judge more hopes as shallow than will the latter. Although I favor the idea that hope need involve only what is possible, I do recognize that some hopes involve a probability that is so remote that we might deem them "practically impossible." Whichever position one takes, however, the importance of estimating probabilities is essential to judging the depth of a hope. A hope based on a biased estimate of probability or

possibility is shallow, for its cognitive dimension is lacking.

There has been a good amount of analysis, both empirical and philosophical, about what patients hope for when they agree to be subjects in clinical research. A common reason people give for participating in research is hope of receiving a chance for cure (Catania et al. 2008, 181). This hope, however, can blind people to the actual goals of some research, particularly phase 1 drug studies, which do not aim primarily at testing therapies for effectiveness, but rather at determining maximum tolerable dose and toxicity. In a Scottish survey, nearly all people enrolled in such studies said they knew the purpose of the trial and had adequate time to consider their participation, but at the same time cited "possible health benefit" as a "very important" reason for their participation. Over half used words such as "hope of remission," "help me/help others," "improve health," and "reduce tumour." (Nurgat et al. 2005, 1002). In another study of cancer patients, the vast majority (85 %) of patients reported that they decided to participate in the phase 1 study because of possible therapeutic benefit. Curiously, 93 % said they understood all or most of the information given to them about the phase 1 trial, but when asked open-ended questions about their understanding of the researchers' goals, 52 % incorrectly stated that the purpose was either to find out how their tumor responds to the drug or to determine the therapeutic benefit of the drug. Only a third were able to give responses that dealt with the real purpose of the study (Daugherty et al. 1995, 1064–1065).

This is the so-called "therapeutic misconception" (Applebaum et al. 1987). In therapeutic misconception, the research subject conflates research with clinical care. A related but distinct sort of error has been called "therapeutic misestimation" (Horng and Grady 2003). In therapeutic misestimation, the research subject underestimates risk, overestimates benefit, or both.

There are many factors that can lead to misestimation of probabilities.[3] Consider just three (Weinfurt et al. 2003, 333–340). (1) The Multiple Speakers Problem: Patients may receive information about potential benefit from several different physicians, from an informed consent form, or from other sources such as the Internet or other patients. Any of these sources can influence a patient's perception through the use of suggestive language. (2) The Semantic Problem: Statements of probability can be of the "belief-type" (I am 90 % certain of a cure occurring within a year) or the "frequency-type" (90 % of cures occur within the first year) (Hacking 1975). Talk about chances of success in a trial is usually frequency-type, which is meaningful only for groups. A particular patient, however, either will or will not have success. The judgments important to patients are of belief-type. So, even if the chance of success is only 5 in 100, the patient may still feel 90 % certain that he or she will be one of the five. The mathematical or scientific error here is obvious. On the other hand, if a physician simply presents a patient with his or her own belief-type probability and the patient holds a different belief-type probability, there are no *scientific* grounds to show that either belief is correct. (3) The Pragmatic Problem: People try to accomplish different things with different kinds of "speech acts." Expressing a high level of confidence that a treatment will be effective might be a statement of belief about what past studies have shown, but it might also be an expression to get oneself "psyched up" in the belief that a positive attitude will foster healing. It might also be a speech act intended to reassure loved ones or to express confidence in the physician. Hence, the expression of one set of words might convey many different meanings and, indeed, several different meanings at the same time.

Misestimating the probability of a desired outcome may weaken the depth of hope but may still be consistent with hope. This idea rejects HLH but is consistent with the definition of Thomas Aquinas as long as the object of hope is at least possible. Lynn Jansen (2006, 14–15) proposes the notion of the "hopeful pessimist." Hopeful people need not necessarily believe that they are more likely to experience positive benefits than available evidence suggests, but may merely be disposed to "accentuate the positive." Other people might underestimate the probability of benefit from a proposed therapy but still be hopeful. Jansen (2006, 15) concludes that it is possible for a person to be both unrealistically pessimistic and hopeful at the same time, a "hopeful pessimist." This notion of the hopeful pessimist clearly distinguishes mere optimism and hope, two ideas that can easily be conflated. It might well serve as a test case (along with other necessary factors) for assessing deep hope, somewhat akin to Kant's example of a man who refrains from committing suicide against all personal inclinations to do so, as a sure indication that he is acting from a moral duty to preserve his life and not from personal inclination. It is not necessary for a hopeful person to be pessimistic, but might be sufficient, when coupled with other factors, such as a correct judgment about the nature of the good hoped for, genuine desire, and heartfelt effort put into hoping, to show a deep hope.

Toward a philosophy of deep hope in health care

Consider the object of hope as oriented toward the future. It may be oriented toward something definite like surviving

[3] For a general discussion of types of uncertainty, emphasizing psychological factors, see Kahneman and Tversky (1982). For a discussion of bias and confounding, see Murphy (1997).

surgery; or toward some type like a seat on a crowded train, where any instance of the type will fulfill the hope. Other kinds of hope might be for a "superabundance" of something such as a better life or world peace (Godfrey 1987, 11–13). This makes evident that there are varying degrees of depth in hope. Hope for a seat on a train is not terribly deep in ordinary circumstances, whereas hope that involves a search for meaning in a terminal illness is.

Hope also has a subjective side with several dimensions. There are many desires corresponding to quite different levels of human needs. Desires can be specific or general, e.g., for a hamburger versus for anything to eat. Here, the desire disappears when it is satisfied. Both general and specific types of desires can arise in health care but this distinction alone will reveal very little about the depth of the desire. Other types are more telling. Some desires, e.g., feeling fulfilled in a career, can present different objects as the subject changes over time. Still other types of desire, like the desire for wisdom, are never satisfied completely; the desires may even increase as more and more wisdom is attained (Godfrey 1987, 15–17). These are more likely contributors to deep hope.

For purposes of evaluating the depth of hope, it is important to remember that the conative and cognitive elements are both important and that the cognitive can influence the conative. The cognitive element is not always simply analytical, like calculating probability; it may involve imagining, not in the sense of pure fantasy, but an imagining directed toward a real possibility. Take, for instance, a disease that is currently cured only by radical surgery. I might well hope for and imagine an innovative non-invasive treatment that would cure the disease with equal effectiveness. William Lynch (1965) equates a life of hope with a life of realistic imagination. Hope refuses to stop imagining; it is always imagining what is not yet, a new way out of difficulty, or a wider perspective on life. Hope not only imagines; it "imagines with." It is not a private desire. Hope cannot be achieved alone but must somehow be an act of community. People hope that they will receive help from other people (Lynch 1965, 23–24).

Consider now how these elements come together. What I want to argue is that deep hope in medicine involves much more than a simple desire for cure and relief of suffering. Deep hope in medicine involves a complex desire for healing in the fullest sense, and truly human healing involves more than physical cure. It involves the deepest elements of the human spirit and the meaning of human existence. Human life, death, and suffering bring us headlong into mystery.

How one conceives of these mysteries depends on one's larger worldview. Although I favor the admittedly theistic stance toward hope that was so nicely articulated by Gabriel Marcel, Ernst Bloch's atheistic, Marxist stance also brought him to show how hope can be deep.

The three volumes of Bloch's (1986) *magnum opus, The Principle of Hope,* address a breadth of philosophical and social topics. The work is an "encylopaedia of hopes," from the most trivial to the mystical. For Bloch (1986, 75), hope is rooted in the most fundamental human impulse of "self-extension"; it is "the most human of all mental feelings" and "refers to the furthest and brightest horizon." He advocates openness to the future and distinguishes two types of possibility. *Objective* possibility refers to what is scientifically expected, or at least cannot be discounted. What is *really* possible, on the other hand, is something radically new, the "not yet fully assembled." *Real* possibility is "dialectically-materialistically mediated newness" (Bloch 1986, 196–197). The highest of this newness is what Bloch calls the "*Ultimum.*" This is not the "Last Thing" of Christianity, which sees the *Ultimum* as a return to the *Primum,* which was lost through sin, but rather a *Novum*, the "Not-Yet-Being" of the "naturalization of man, humanization of nature." It "corresponds to exact anticipation, concrete utopia as objective-real correlate" (Bloch 1986, 203–205). Bloch's thinking, then, is utopian, but his utopia is naturalistic. It is not redemption in the "hereafter" or other such "places," an idea that Bloch sees as easily leading us astray. Rather, it involves a hope ethos that might be characterized as "transcending without transcendence" (Anderson 2006). Bloch (1986, 1375) explains:

> The goal as a whole is and remains still concealed, the Absolute of the will and of hope still unfound, in the agent of existing the light of its Whatness, of its essence, of its intended fundamental content itself has not yet dawned, and yet the nunc stans of the driving moment, of the striving filled with its content, stands ahead, utopian and clear.

Bloch discusses medical, social, technological, architectural, and geographical utopias. He describes medical utopia as a quest against suffering (Bloch 1986, 454–471). One who suffers at first seems not to be missing something, but rather to have something superfluous: an illness. The person wants only to be rid of the illness to return to the state where the body is "comfortably quiet" (454). Doctors have generally been content to confine their labors to this goal because of several historical influences, notably that of Stoicism (464). The result, however, is not ultimate relief of suffering but merely the postponement of death. Doctors hold an "*almost crazy* utopian plan latently in view, … nothing less than the *abolition of death"* (465). Nonetheless, they avoid pursuing the utopian goal, content in trying to restore their patients to their previous state of health, which is seen as removing the superfluous illness.

Hope, however, involves struggling against death, our destiny. Health, for Bloch, is more than a removal of disease. It is something new. Medical utopia is essentially linked to social utopia. It makes little sense to see removal of disease as health when such a life, even without disease, continues to be threatened by war. Bloch concludes that "people cannot walk upright when social life itself still lies crooked" (471).

There is much to admire in this far-reaching analysis of hope in health care. In particular, Bloch moves us toward the question of the ultimate meaning of human existence without resorting to facile justifications or pipe dreams, what are often called hopes but really are not much more than mere desires to be rid of present pains. Health is seen in the context of larger social realities. Hence, it makes sense to think about hoping for health even when the possibility of cure of one's own particular ailment is remote. This kind of hope transcends the hope that is simply a desire to be relieved of one's current illness. Bloch's own hope resides in a Marxist overcoming of capitalistic society, but one need not endorse this goal to see how nicely his analysis illustrates what I am calling deep hope. It is a quest for an ultimate good, a brand new future, which involves projecting oneself into a kind of unity with that future by great intellectual and emotional effort. Bloch shows how deep hope can be held in a completely naturalistic context. There is more for religious people facing suffering and death, however.

And so I turn now to a thinker who sees hope in the context of a theistic worldview. For Gabriel Marcel, hope inhabits the world of mystery, something that is not often spoken about in contemporary health care. A characteristic feature of our age is the "misplacement of the idea of function." Individuals appear both to themselves and to others as an "agglomeration of functions" (Marcel 1963, 10). We allot time to vital functions such as sleep, recreation, and sex, and we tend to see individuals in terms of the work they do. The functionalized, technical world exists primarily to satisfy desire and stave off fears and allows no room for mystery. Events such as birth, love, and death are understood as "purely natural," presenting theoretical and technical puzzles to be solved. Consequently, there is atrophy of the faculty of wonder (Marcel 1963, 12–13). A sense of mystery is lost. Marcel (1963, 19) argues that mystery expresses our "ontological need," the "need of being," which cannot be denied without risking despair, which is the very denial of hope. But ignoring this mystery is precisely the fault of modern philosophers in this technically oriented world of doing (Marcel 1963, 26–27).

For Marcel, true hope is "hope in what does not depend on ourselves, hope springing from humility and not from pride" (Marcel 1963, 31–32). It rejects the hubris that Illich decried. Hope is more than a simple desire to be removed from a trial. Hope allows a greater realization of the sort of integrity we desire to regain than we would have had without the trial. Marcel (1951, 31) gives the example of a sick person for whom the word "health" has a "wealth of associations" that those who are well do not even suspect.

Marcel (1951, 36) takes hope to be the act by which the temptation to despair is overcome. Despair is a capitulation before what we judge to be our inescapable fate. Marcel (1951, 37) illustrates this with a comparison of two sick people. The first says of himself, "I cannot be cured" even when a doctor has told the patient that there is a slight possibility for recovery. What the patient is doing is saying that he is the best judge of his own symptoms and knows that recovery is impossible. The doctor may then judge that the person's pronouncement has made conditions so unfavorable as to preclude any effective resistance to the illness. It comes about that the patient's forecast of his destiny precipitates it. In the second case, the patient is told by her doctor that there is no possibility of recovery. The person does not appear to be precipitating her own demise unless she accepts the doctor's judgment and makes it her own. To capitulate to the prognosis of incurability is not only, and possibly not at all, to recognize the inevitability of the fatality of the illness; it is to "go to pieces under this sentence, to disarm before the inevitable." It is to "renounce the idea of remaining oneself." It is to renounce the ontological need, a sure road to despair. Acceptance, on the other hand, is to "keep a firm hold of oneself." Just because one will not recover from the illness does not mean that one gives up who one is. Yet hope goes even further than acceptance; hope is, in fact, non-acceptance, but positive non-acceptance. It is non-acceptance of being doomed by one's fate; it involves patience, accepting the trial as part of oneself and something that will be transmuted and integrated into the self in a creative process (Marcel 1951, 37–39). This sort of person, who knows that death is near but is somehow able to embrace the fact and integrate it, is a good example of Jansen's "hopeful pessimist." It is precisely the type of deep hope I am claiming is so important in health care—for both those who receive care and those who provide it.

Take another example of a sick person who was expecting to recover by a certain date. The person loses hope because no cure has come about at the expected time, even though there is still time for a cure. The person's initial inclination is that everything is lost if recovery does not arrive on schedule. A timely recovery is equated with ultimate salvation. Marcel (1951, 46) says of this case, that hope allows the very idea of recovery to be "purified and reformed." He explains:

> From the moment when he will have not only recognized in an abstract manner, but understood in the depths of his being, that is to say *seen*, that everything is not necessarily lost if there is no cure, it is more than likely that his inner attitude toward recovery or non-recovery will be radically changed; he will have regained the liberty, the faculty of relaxing.

In this way, hope in health care is something that goes beyond mere desires about physical states. As Marcel (1951, 51) observes, hope is "fundamentally untechnical" for the person who hopes is fundamentally unlike the technician, who does not recognize an end if he does not see approximately how to achieve it. Marcel (1951, 51) says:

> This, however, is not true for the inventor or the discoverer who says, "There must be a way" and who adds: "I am going to find it." He who hopes says simply: It will be found." In hoping, I do not create in the strict sense of the word, but I appeal to the existence of a certain creative power in the world, or rather to the actual resources at the disposal of this creative power.

For Marcel ultimate hope is rooted in religious belief, which is important for many people. Health care providers, then, will do well to recognize this in order to foster hope in their encounters with such patients. But even those who are not overtly religious often still recognize a transcendent element in their lives, especially when they are confronted with suffering.

This understanding of hope as a mystery transcending the functionalized world—a world we increasingly take for granted—depends on a particular metaphysical worldview that goes beyond the idea of the physical world as all of reality. Furthermore, it takes the human person to be more than the objectified biological being that is described by medical science. Human beings search for meaning in life and death and the greatest attempts to describe what has been found in this search transcend the physical world. Medical science has advanced greatly by working within a functionalized worldview. Yet all physicians know that the practice of medicine necessarily goes beyond medical science. The idea of a deep hope affirms this. Deep hope is not concerned exclusively about desires for particular physical ends, but about desires for human persons who are themselves ends that cannot be reduced to what is explained by the physical and even social sciences. Health care comes head-to-head with suffering and it is a person and not a body that suffers (Cassell 2004). Sickness confronts us with ultimate questions about living and dying, issues that are not settled by technological innovations. Hope in medical practice has ultimately to do with healing of persons, in all their complex dimensions.

Implications

Hope in the context of health care is common and often beneficial, but if it remains shallow and unreflective it can lead to disillusionment and even despair. An understanding of the complexity of deep hope on the part of all involved in health care might encourage deep hope and go a long way in fostering good care.

Patients, when they speak of their hopes, need to understand what they are looking for. What sort of healing do they seek in the medical encounter? The range of desires and expectations is enormous. Some may seek education about preventative measures. Some may simply seek relief from a particular pain. Some seek assurance that their pains are not signs of a life-threatening condition. Some have life-threatening conditions and seek cure. Some have life-threatening conditions and seek extra time. Some have life-threatening conditions and seek meaning in their dying and the way they die. In all of these, but especially in this last case, the present analysis of hope shows that careful thought is necessary for patients in order to express exactly what they seek and why. It also shows that even when terminal illnesses cannot be cured, people can still have hope. This is, in my estimation, the deepest kind of hope.

Physicians need to be aware of these various levels of expectations and the different ways they are expressed in the language of hope. The healing role of the doctor requires an understanding of the complexity of hope and this is not something that is learned in studies of medical science alone. Physicians must understand what patients are saying when they speak of hope and be ready to address misconceptions. Physicians need to be truthful to patients. They need not only to be explicit about probabilities of success of various proposed treatments, but also to present these complex data in a way that is understandable to patients. Physicians must know and understand their patients to know how to present options. They ought not withhold or sugarcoat bad news for fear of destroying hope in their patients; neither ought they always present everything they know all at once. Aristotelian practical wisdom is needed to know the manner and timing of breaking news to patients if hope is to be maintained. Physicians must also constantly be aware of their own conceptions of hope in various situations. They may or may not coincide with the conceptions held by their patients.

Researchers largely inhabit Marcel's technical, functionalized world. They solve problems. It is imprudent to suggest that that should change; effective research depends on such a problem-solving model. But researchers are often physicians as well. The hopes they have for their research and the hopes they have for their patients may conflict. Researchers need to be aware of the vast number of ways

therapeutic misconception and therapeutic misestimation can influence the hope of patients become research subjects. Researchers must realize that technical solutions are important but do not tell the whole story in medical innovation.

Understanding the complexity of hope should prove beneficial in our thinking about the best ways to pursue medical innovation. Only when we challenge unreflective presuppositions about hope and begin to see hope as a mystery central to who we are as humans can we begin to understand what a true healing relationship is about. Only then can we discern rational frameworks from which to assess the depth of hope and decide which hopes are worth pursuing and which are ultimately counterproductive. We can begin to see how hope orients us and thrusts us into what is of ultimate importance.

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