Hope — A Necessary Virtue for Health Care

by Kevin Wildes, SJ

This article explores the feasibility of using an appeal to the virtues in bioethical analyses, and the difficulties posed by the fact that most virtues and especially hope, are embedded in particular traditions. Whose virtues, then, shall focus our analyses? A brief description of Christian hope is used to argue that hope does play a major role in various health care venues and to suggest that the common elements in a secular account of the virtues can be found in an unbiased sharing of one's religious background or way of life.

Moral character has been the talk of the nation for some time now. But talk about character, virtue, and vice is not new for our time. Since Alasdair MacIntyre published *After Virtue* in 1984, a renewal of interest in virtue ethics and character ethics has appeared in the philosophical and theological literature. This renewed interest in virtue ethics is also — and not surprisingly — found in the literature in bioethics (e.g., Pellegrino and Thomasma 1988). Traditional health care ethics has often focused on the virtues of the professional. The turn toward virtue ethics also fits well with the development of an "ethics of care," with its focus on interpersonal relationships and character (Little and Veatch, 1998).

The interest in character and virtue is an approach to framing and discussing questions in ethics. In character or virtue ethics, moral analysis moves beyond a focus on the outcomes of actions (utilitarianism) or the rules and principles that characterize and define actions (principlism). The language of virtue and character shifts the discussion from actions to agents. Many ethicists would argue that virtue theory gives a more complete account of the moral life than simply looking at rules, duties, or outcomes. Indeed one can argue that the lens of virtue and character can include these other concerns (i.e., actions, outcomes, and rules) in the rich fabric of the intentional life of the moral agent. The focus on character and virtue also leads to a wider concern about how we think about teaching morality and ethics in terms of the formation of character. Character formation is not an easy topic in a society that is morally pluralistic and respectful of differences. It is often difficult to make character assessments.

Virtues amid Diversity

One crucial problem for any appeal to virtues is the question of how to give an account of the virtues. That is, it is not hard to imagine that many people would agree that character and virtue are important for ethical analysis. However, beyond this general agreement one might ask, to paraphrase Alasdair MacIntyre, "Whose virtues? Which character?" (MacIntyre 1988). The moral virtues are tied to a way of life so it is not surprising that different ways of life, different cultures, frequently offer different accounts of virtue. Humility, for example, is an important virtue to Christians yet it is not a virtue found on Aristotle's list of virtues. Different cultural contexts and ideals, especially in a secular society, lead to different accounts of the virtues. This pluralism would seem to derail any talk of virtue theory in bioethics. Which account of the virtues should be used? Many controversies in bioethics can be understood as conflicting views of virtues. Yet, notwithstanding important differences, we can

find common moral ground that men and women share. This ground makes us moral acquaintances; that is, more than strangers, if not outright friends (Wildes 1999).

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One way to sidestep the difficulties of secular diversity is to focus on common social practices. Medicine is a social practice. And a certain account of the virtues can be developed by looking to the practice of medicine. While medicine and health care are areas of sharp moral disagreements, one can argue, nevertheless, that there are certain practices (e.g., informed consent) and certain conditions (e.g., treatment needs, family relationships, dependency, hope) that cut across the differences.

For some observers, hope as the expectation of a happy outcome is a sine qua non for medical practice. If one is truly without hope of a cure, or prevention, or amelioration, there would be no reason for medical intervention; and the practice of medicine would make no sense. In this view, hope is a virtue that brings together the present and the future. In hope, the limits and crises of the present — illness, for example — are understood and lived through the lens of the future. Thus, the assumption is widespread that hope forms a necessary condition for the practice of medicine. Nevertheless, because hope has been tied to religious virtues and visions of life, it has not received much attention in bioethics.

Historically, hope has its roots in the Hebrew Bible and early Christianity, and it plays a central role among the theological virtues (Pellegrino and Thomasma 1996). Hope has also been part of western philosophy and theology in general, with mixed results. Though many have acknowledged its usefulness, many more philosophers and dramatists from Plato to Albert Camus have distrusted hope as an illusion more likely to foster apathy than action. These conflicting beliefs inform our concept of hope; viewed singly, they give us several views of hope, taken together they present various strands that can be woven into a common pattern.

I propose, therefore, to use a specific tradition, namely, Christianity, as a heuristic model for understanding hope. By looking into the rich context of this particular tradition, we will perhaps identify some common themes in hope that may help us understand how hope as a virtue functions in health care and the ethical implications it carries in that setting. If, in order to make these connections, we succeed in casting an unbiased look at this tradition, we may also point the way for looking at other traditions and so develop an even broader account of hope than appears in this general framework.

Hope in the Christian Tradition

The roots of the Christian tradition, and perhaps especially its hope, begin deep within the Hebrew Bible, where to be hopeful is to be confident, secure, expectant, and trusting. In ancient Israel, hope was intimately connected with faith. From the patriarchs to the prophets, God is the source of Israel's trust. God calls and a people responds, following the leading strings of love (in Jewish tradition, the Torah) from the margins of the known to the promised land, then into the second exile, the return, and hoped-for restoration (the building of the second temple, the promise of Messiah). In all their wandering, God was ever before them, never a fixed point, but a "Thou," keeping them even in sight and luring them out of complacency and comfort to the place of divine dwelling, where God is with the poor—with those who act justly, love loyalty, and walk humbly with their God (Micah 6:8).

In the New Testament (i.e., the Gospels, the Acts of the Apostles, and the letters of Paul), the fulfillment of God's reign begins in Christ's life,

death, and resurrection. These religious images are metaphors and symbols that can be stretched in different directions by those who meditate on them. They elaborate a tradition that encapsulates (in theological terms) a formative faith event. To explain exactly what that event was, and the various ways it can be entered into by subsequent generations, is not my objective. I hope only to explain what some Christians mean when they say that the cross is the hope of the world. For these Christians, God, the father of Jesus and the God who raised Jesus from the dead, is the same God who called Israel into being, who sent the prophets to disturb the status quo, who calls into being the things that are not (Colossians 1:16).

In the New Testament as in the Hebrew Bible, God is the One who goes before us (Genesis 12:1; Exodus 3:12; see also Mark 16:7), who turns dry land into springs of water (Isaiah 41:17-18), who will not let God's holy one see corruption (Isaiah 53:10-11; Psalm 22; Acts 2:22-28). The hope that God will be faithful and keep God's promises is, then, rooted in God's fidelity in the past. As Christians hope, so they believe. Faith in God's promise of redemption, particularly in the resurrection of Jesus, is the basis of hope for universal resurrection (which is, e.g., forgiveness, justification, eternal life, bodily resurrection, and/or life after death). But Christians do not see that in which their hope abides. Its fulfillment is — for them as for other God-seekers past and present — dependent on steadfast love. Trust in God's fidelity is tied to the ancient covenant: "I will be your God and you — whoever you may be, who are made in my image and likeness — will be my people." One's trust in God, and one's hope in God's fidelity is a bonded relationship.

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Christians borrowed heavily from the Hebrew Bible to tell their story, and some later historians have argued that humanism and other secular creeds borrowed again from both traditions. Nevertheless, Christian hope, according to Jürgen Moltmann (1967), has little in common with the idea that human progress is inevitable — even if that idea has been given a Christian gloss. The characteristic that most distinguishes Christian hope from utopian ideologies, critical theory, or liberal optimism is this: hope becomes most imperative precisely at the point that no further progress is possible. Hope is not, according to Moltmann, a belief that this world will gradually improve; hope is the "condition for the possibility of *any* new experience" — when decay is all that is left. Moltmann underscores the point by quoting Calvin's comments on Hebrews 11:1.

> To us is given the promise of eternal life — but to us the dead. A blessed resurrection is proclaimed to us — meantime we are surrounded by decay. We are called righteous — and yet sin lives in us. We hear of ineffable blessedness — but meanwhile we are here oppressed by infinite misery. We are promised abundance of all good things — yet we are rich only in hunger and thirst. What would become of us if we did not take our stand on hope, and if our heart did not hasten beyond this world through the midst of the darkness upon the path illumined by the word and Spirit of God (p. 19).

And Moltmann adds, "It is in this contradiction that hope must prove its power."

Applying Hope in the Medical Context

In light of these Christian and theological parameters, what can be said of hope in the medical context or within the broader context of a secular society? There are at least three lessons that medicine and health care can learn from these reflections on hope. I will put them in the simplest way possible.

Hope is necessary

To live with illness is to be a newly constituted human being (Cassell 1977). When one becomes

afflicted with illness — no matter how minor — one's life is altered. Illness can easily come to dominate a person's life. Consider how even the irritation of the common cold, a surely minor illness, affects our lives. More serious illnesses and diseases bring even greater uncertainties, and the regime of therapy. Pellegrino and Thomasma (1996) write:

> To be healed in the face of these [medical] uncertainties, we must be motivated by hope. To set out on the sometimes perilous and uncertain journey of medical treatment, we must have hope that the goal of health will be attained. Without hope few would embark on what may be an arduous, painful, and unsuccessful venture (p. 59).

Hope is not an illusion, but a goad to action

What exactly does the ill person hope for, and how does one's illness affect one's hope? Is one's hope always and primarily that one will be cured? Kay Tombs (1992) argues persuasively that there is deep complexity in the meanings of illness. Illness not only affects the individual who is ill, but also the patient's relationships with others — and how one is seen by others. So then, hope as a goad to action can help patients set their minds on getting well, no matter how onerous their treatment regimes may be. More important, however, it can help them redirect their actions when cure is impossible. Hope is the virtue that helps one cling to the good even when the good is threatened and seems least possible of attainment. Hope, we can say, helps us hold on; and then hope helps us find a way out.

Of course, this discovery is not easy. To go back to Cassell's article: illness affects not only the body, but the person we are, therefore also our virtues and character. It attacks our independence, undermines our autonomy, and makes free choice almost impossible. And that, I would add, makes hope so much more important. The person who lives in hope recognizes difficulties and lacks certitude but is still willing to pursue the good, no matter what happens. Hope is not a naive view of the world but one born in realism. Without such realism, hope becomes mere fantasy or wishful thinking or denial. Hope is not simply about the future. It ties together past and future to define the present. Hope sees difficulties and possibilities. It helps us order the goods we desire. Living in the virtue of hope, one examines what is desired and why one might hope for it realistically.

The hoped for future impinges on the present and colors our present. The "already" (present) is seen for what is "yet to come." But hope also involves risk. Here the past is important. For it is the trust we learned in the past that teaches us what to hope for. We can distinguish fanciful daydreams from realistic hopes. The present is understood and illumined by past and future. Hope is especially important in the care of patients who are dying. We hope that suffering will be alleviated, and that men and women will end their lives peacefully and fulfilled.

We do not hope alone

Through hope, we can, if we will, live and die in each other's company. Any sense of hope involves some notion of trust. Hope is built on the experience of trust, which is to say on another's promise of help. Hope is the type of knowledge that we gain in our relationships with others. We ground our hopes in those who are trustworthy and watchful — who truly see us and our deepest needs; and we confide our future to them or to the institutions they represent. Contemporary institutions, however, like education or health care seem less and less worthy of trust. This barrier to hope must be a moral concern for health providers and their colleagues. In our organizational structure and training, do we attend sufficiently to the virtue of hope and its vices? Hope requires that we present an honest, realistic view of what is possible.

Experiences of honesty and candor help build levels of trust and help patients live with "true" hope. This hope, in turn, will help guide patients in their decision making. If physicians and other health care professionals view the situation differently from the patient, they have a duty to help the patient understand the situation. Hope

for the future is grounded in a realistic understanding of the present.

We must begin to think about making hope a central virtue for health care providers and institutions. Patients and their families make decisions in the present that are future oriented. The hoped-for future helps us to know and understand the present. Realistic hope is part of the decision-making process. If there is to be realistic hope then patients must be able to trust their providers and institutions. In this ultimate context, to hope is to believe in one's own experience and value even when no further progress is possible. This "not yet, but certain" hope is elusive but not an illusion.

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