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What Is False Hope?

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Throughout the long history of the doctor-patient relationship, doctors have always had to break bad news to patients. It is only recently, however, that much attention has been devoted to this delicate art. Medical schools run classes on communication skills, and authors have written many books on the theory and practice of breaking bad news.[1] The common guidance is that doctors should be honest without being brutal, whilst all the while maintaining some hope in the patient, however grim the prognosis.[2] A distinction is often made between instilling hope, which is desirable, and instilling "false hope," which is not. But how is hope distinct from false hope?

To understand false hope, we must clarify the related notions of hope and expectation. Hope is typically a combination of two elements: (1) a desire that something will happen and (2) a belief that this desire could be fulfilled. So, although I cannot hope to be the fastest Jamaican sprinter in the world because I am not Jamaican, I can hope to be the fastest sprinter in England. Expectation typically refers to the belief that something is likely to happen. For example, I may hope to win the lottery (that is, I desire that my numbers come up and believe that there is remote possibility that they will), but I may not expect to win (that is, I do not believe this will actually happen). This distinction is encapsulated in the oft-heard advice: "You should hope for the best but expect the worst."

False hope arises when there is a strong dissociation between hope and expectation, when a terminally ill patient hopes for a cure *and* strongly expects that he will be cured, or, less commonly perhaps, when a patient hopes for a realistic outcome and pessimistically expects that it will never happen. The object of a hope — be it a cure for motor neuron disease or a multimillion lottery jackpot — does not determine whether or not the hope is false. What makes the hope false is the accompanying expectation and its relationship with what, objectively, is likely to occur.

In a scene from the comedy *Dumb & Dumber,* the protagonist Lloyd, played by Jim Carrey, asks his dream girl to estimate the chances of a romance between them.[3] With a grimace, she apologetically mutters "one in a million." His face lights up: "So you're telling me there's a chance!" Lloyd's hope is false not because he wants to date the girl, but because his expectation, conveyed by his enthusiastic response, is higher than the situation warrants.

In medicine, talk of hope must thus be supplemented with talk of expectations, in particular managing patients' expectations. In instilling or maintaining hope, doctors should modulate a patient's expectations to avoid sliding into the realm of false hope, which may prevent the patient from exercising his or her autonomy (that is, from making decisions based on his or her own deeply held beliefs and values). This may be difficult when hope and expectation are at opposite extremes. Some patients may be totally unaware of the severity of their illness, waltzing into a consultation with high hopes that a pill or two will resolve the bothersome problem. Yet realigning a patient's hope with reasonable expectations is central to respecting a

patient's autonomy and, although members of the public have no obligation to adjust even the wayward expectations of others, doctors are duty-bound to direct the health-related expectations of their patients.

"To hell with autonomy," one might retort, "and long live beneficence!" True hope might indeed be harmful and, at times, even more so than false hope. Anecdotes abound of patients who rapidly declined after their farfetched hopes and expectations were dashed. However, even on a harm/benefit analysis, true hope usually fares worse than false hope in the short-term only. Lloyd is happy in his fool's paradise for a while but when his *objet d'amour* mentions her husband, his heart sinks: "Husband? Wait a minute . . . what was all that one-in-a-million talk?"

Admittedly, there may be rare cases when it is preferable to raise expectations well beyond what cold reason dictates, and when false hope is kinder than true hope: in the minutes before a major, long-awaited operation, when the terrified patient asks if he or she will be all right, saying reassuringly that all will be fine; when a distraught mother asks if her child suffered in its final moments, saying that the child died peacefully; when a depressed patient contemplates suicide, lifting the patient's spirits with encouraging words.[4] If the two virtues cannot coexist, humanity should always precede sincerity.

In most circumstances, faced with the unenviable task of breaking bad news, one should maintain the all-important hope whilst guiding patients' expectations to a level roughly equal with one's best prediction of what will occur. It is a precarious juggling act, but a profoundly important one.

CONFLICTS OF INTEREST

The author reports no competing interests.

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NOTES

1. R. Fielding, *Clinical Communication Skills* (Hong Kong: Hong Kong University Press, 1995); T. Brewin, *Relating to Relatives: Breaking Bad News, Communication and Support* (Abingdon, U.K.: Radcliffe Medical Press, 1996); R. Corney, ed., *Developing Communication and Counselling Skills in Medicine* (London: Routledge, 1991); M. Lloyd and R. Bor, *Communication Skills for Medicine* (Edinburgh: Churchill Livingstone, 1996).

2. Fielding, see note 1 above.

3. P. Farrelly, *Dumb & Dumber* (New York: New Line Home Video, 1994), ASIN 0780618556.

4. D. Sokol and G. Bergson, *Medical Ethics and Law: Surviving on the Wards and Passing Exams* (London: Trauma Publishing, 2005).