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Healthcare Policy and Hope Part II
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Your Life Your Health
The Examiner
June 28, 2007

If hope is essential for health; if we understand what hope is; if a successful healthcare policy will require that health be generated and sustained in others, how can healthcare providers help people find hope?

Why do so many do so little so often about their health? Recently, as I walked around a major Midwestern city, I was taken with how many people continue to practice self-destructive habits -- smoking, drinking alcohol, overeating, and not exercising, using illicit drugs -- and the list could go on and on. How do you help people who lack the discipline, the decision, or the determination to live healthily?

Programs don't meet their needs. Publicizing the dangers of self-destructive behavior does not seem to help. Scare tactics don't help, because even though people acknowledge intellectually that their behavior is self destructive, they fundamentally believe that they will be the exception to the rule. This "unrealistic optimism" may be at the root of much of the inconsistency in choices about healthy habits. "It'll happen for sure, but surely not to me," may be a major part of the problem.

Often people will say, "I hope I'll be OK." Here, they use the concept of "hope" as a wish or as a talisman, as a lucky rabbit's foot which will help defy the odds and the realities we all face. Yet, hope is also at the root of potential success, I think. It is not wishful hope, but it is true hope. Webster's defines "hope" in several ways:

1. An archaic definition of the word is given as "trust, reliance." This is how the Bible uses the word.
2. To cherish a desire with anticipation
3. To desire with expectation of obtainment
4. To expect with confidence

The third definition is how we use the concept of hope in regard to health issues; although the Christian view of "hope," as expressed in the first definition, and which is declared by *Webster's* to be "ancient or primitive," also underlies our understanding of hope. Yet, hope often appears to be a socio-economical phenomenon. Even religious people often associate "hope" -- a sense of optimism and positive attitude -- with the bills being paid, the kids being healthy and having a secure job.

For health care providers, who are dealing daily with people with chronic, debilitating and often devastating conditions, hope -- to desire with expectation of obtainment -- often is missing in patients. Yes, without hope, as we have discussed, people will not make the changes necessary to retain or regain their health. The question is then, “How does a healthcare provider help someone who has no hope; who has given up, or who is not willing to help himself?”

Is it possible to create hope in others? Is it possible to "hope" for others? What is the foundation of hope? Why do some have it, in spite of their circumstances and others do not? How do you help someone who either consciously or unconsciously doesn't make the connection that their modifying behavior can make a difference in their future?

Value

To answer these and other questions, we have to understand the foundation of hope. Where does hope come from? How is hope created? First, hope is founded upon the intrinsic value of the individual. "Intrinsic" means "belonging to the essential nature or constitution of a thing." In other words, a person's value it is not a result of what they have, what they do, or who they are; the value of a person is as a result of their being a "person."

This is a foundational principle of western civilization and particularly of the value system of the United States of America. It is not the state which is of ultimate value; it is the individual and it is not the individual as a "concept," but as a person. There is no doubt that some are honored more than others because of what they have and/or of what they have accomplished, but objectively in our culture, we do not value the life of one above another.

How then, do healthcare providers instill in others the sense of their value and of their worth? How does this practically operate every day? Perhaps no other group can so readily and directly communicate the value of life to others as can health care providers. And this is done first by the respect, dignity and compassion with which each person is treated in the clinical setting, whether hospital, clinic, emergency room, nursing home or other location. Simple things like shaking the hand of a person while looking them in the eye and greeting them by name are the beginning of this exercise. In the healthcare setting, each individual, whether a bank president, or not, can be addressed by their title -- Mr. or Mrs. or Miss -- until and unless the relationship is such that addressing a person by their first name is appropriate.

It may be that the respect and dignity with which an individual is approached in the clinical setting instills a greater sense of the personal worth of an individual than even the excellence of the care they receive. This is not to suggest that inferior care is balanced by compassion, but it is a fact that excellent care given in a negative environment will not benefit the patient as much as that given in a caring, affirming relationship.

The value of life and the personal value of the individual are the root of our healthcare decisions. The choice to live rather than to die is the first choice based on that value. The choice to make healthy decisions about behavior, access of care, follow-up and follow through on treatment recommendations are all founded upon the value a person places on life and on their own life. Because these judgments of value are often not cognitive -- they are often not things we consciously think about -- a person may be unaware that they are making a decision about their personal, intrinsic value, but they are nonetheless.

Instilling Hope in Others

Beyond their personal interaction with patients in the clinical setting, how can healthcare providers contribute to the development of hope in a patient through the affirmation of personal value? An optimistic view is helpful. Optimism is not created by the ignoring of reality, but it is assuming the best while facing other possibilities. If a person has no value, it is possible to be fatalistic and assume the worse; if they are highly valued, optimism with be the intuitive default position.

Next, the healthcare provider builds a sense of the value of the individual when he/she addresses the future of the patient from a perspective of change. "Here is where you are today, but with the following actions, you can change that future," is not only an expression of optimism but it is a result of clinical competence to know what can and what should be done to make things better. Rather than quickly dismissing the patient -- and this is not a function of time spent with the patient but of total focus on the patient's future -- providing the patient with a plan of action for improvement of their health invests in them value.

Follow-up is one of the most important evidences of the value of the individual. When a person is given appropriate interval follow-up, it instills in them a sense that someone else cares, and even if life's experience have diminished their own caring about themselves, that caring can be regenerated through others caring about them. A part of follow-up is access. When the only access a person has to a healthcare provider is when they are in the office, generating a bill, the relationship becomes commercial. When the patient has access to the counsel and attention of a healthcare provider, at an appropriate frequency, at other times, the patient begins to see that he/she has value to someone else and is more likely to begin having a sense of personal value. When a healthcare provider answers telephone calls in a timely fashion, he/she is instilling value, which is the foundation of hope, in the life of the patient. And, while this may not be a conscious transaction in the mind of the patient or provider, it is nevertheless the case.

Virtue

The second foundation of hope, which is actually the "engine," or the power source of hope, is virtue. Like hope, virtue has many definitions. *Webster's* gives one of them as "a capacity to act, potency." This is the sense in which virtue is an aspect of hope. We often, and appropriately, associate "virtue" with morality, but it means more than that. Without the capacity to act, hope has no means of impacting a person's life. However, a person who recognizes the value of their person -- regardless of their education, position, pocketbook or other external trait -- and who has virtue -- the ability to make decisions and act on them -- can change their future. Virtue provides the patient with the courage to make decisions which are uncomfortable but profitable

Virtue allows a person to persist in a decision until the promised benefit is realized. The presence or absence of virtue is often the difference between success and failure. And, the absence of virtue does not mean that a person is evil or immoral in the sense in which we are using the term. The absence of virtue simply means that the person lacks the courage,

the conviction, the consistency, or the capacity to change their behavior for the good of their person.

Here is a more difficult question, "Can a healthcare provider help a patient develop virtue?" Without doubt, it is hard, but it is possible. Virtue is more than the development of habits, but virtue's presence, or absence will result in habits being formed. The healthcare provider can help a patient develop positive habits with accountability and reinforcement of positive conduct. The healthcare provider can promote virtue in the life of the patient by celebrating success however small and by cheering the patient on to success.

In fact, the more successful the healthcare provider is in accomplishing the first element of hope -- instilling value in the life of a patient -- the more success he/she will have in promoting virtue. For the more a patient feels that the healthcare provider "cares" about them -- values their person, intrinsically -- the more "power" the provider will have to promote positive habits in the patient from which will spring virtue -- the capacity to act.

As we continue to work to help patients get control of their lives and health, it is clear that all of the answers will not be found in a test tube. Life's experiences can "beat the life" out of us. How to "re-inflate" our lives is a question which we all must address, but it is a question which is critical to the mission of healthcare providers. While we are striving for clinical competence and excellence, we must never forget that we are not dealing with simple machines, but with complex and complicated individuals, each of which is incredibly important.

Without hope, which is a function of value and virtue, all of the healthcare financing and access in the world will not change a person’s health. Public policy must address this central element to the efficacy of our efforts at improving the administration, financing and distribution of healthcare in the United States.