Hope is variously defined, but seems to pertain to a confidence in future events and circumstances. What are the characteristics of hope? Is it different than optimism? What is it and how does it impact health, well-being, and even the will to live? How do patients gain, sustain, or lose hope? Is hope rooted in community, spirituality, evolved cognitive structures, environment, past experience, etc.? Should physicians cultivate hope in their patients? How so? What is the relationship between hope and truth telling? Is there a biology of hope and of despair that impacts health outcomes? How does “hope” play out in the contexts of patients with dementia and their families? How does it play out in individuals with severe spinal cord injuries? Patients with metastatic cancer?

**Instructors**

Stephen G. Post  [Stephen.Post@StonyBrook.edu](mailto:Stephen.Post@StonyBrook.edu)  
Brooke M. Ellison  [BrookeMEllison@gmail.com](mailto:BrookeMEllison@gmail.com)

**Syllabus**

**Detailed Description:**

How can you as a physician respect the dynamic of hope in patients, and why is this important? Harvard hematologist-oncologist Jerome Groopman, in his *The Anatomy of Hope*, writes that hope is “the elevated feeling we experience when we see – in the mind’s eye – a path to a better future. Hope acknowledges the significant obstacles and pitfalls along the path. True hope has no room for delusion” (p. xivi). Groopman notes that belief and expectation, two aspects of hope, are fundamental to the placebo effect, and activate brain circuits that release endorphins (natural opiates) and dopamine (a feel good chemical). A careful assessment of the existing research compels Groopman to conclude, “Hope, I have come to believe, is as vital to our lives as the very oxygen that we breathe” (p. 208). Current researchers focus on the neurobiology of optimism, psychological resilience, physical health and optimism, and the promotion of optimism and hope. Significant NIH-funded investigations link hope/optimism to longevity, enhanced wound healing, stress reduction, dopamine release, and endorphin release.

Hope for a patient is about the uncertain expectations around which they constitute their lives in time of serious diagnosis or illness. It is a passion for the possible and a way of staying afloat in uncertain times. Hope is often thought of as deeper than optimism, and may be grounded in spirituality and religion for many patients. Hope is deemed a virtue in hard times, while optimism is a dispositional personality trait more conditioned by circumstances. The opposite of hope is despair – an unhappy resignation, an admission of defeat, a giving up of expectations. The skilled clinician must handle hope empathically, and be able to help shift patient and family hopes from one goal to another, for in a general sense, there is always hope if we see it. There can be shifts in hope from the possibility of recovery to the comfort care of hospice, from an earlier vision of a flourishing life to a modified vision, etc. Redirecting hope can be challenging in a high-tech era with real possibilities for miraculous new cures.
Perspective matters in the ethics of hope. The oncologist may believe that a last-chance new chemotherapy like the plant alkaloid taxol will work, while the ICU intensivist feels that this is an unwelcome manipulation of the patient in the name of false hope. It turned out that taxol really was a miracle drug for women with gynecological cancer. In one study of women who participated in the early taxol trials (1990), they gave reasons such as, “My husband passed away last year and I cannot bear the idea of our two young daughters not having one of us around,” or “I know that this is keeping my hopes alive.” Yet hope can be manipulated in destructive ways that harm rather than help patients, and that burden them with expensive but ineffective treatments. Is there really anything such as “false hope”? Persons with major spinal injuries navigate the choppy waters of hope and despair. Often physicians who care for such individuals will not allow the patient who wishes to throw in the towel to do so.

Christopher Reeve, for example, initially wanted to give up on treatment, but with the encouragement of many friends and loved ones, over time, he came to accept his new life and even became an outspoken advocate for persons with such massive injuries. He spoke up for stem cell research at the Democratic National Convention in 2004.

**Educational Objectives**

At the conclusion of this course you will have the ability to:

1. Be more aware of the subjective and objective significance of hope in the care of patients
2. Be able to follow a growing literature on the clinical management of patient hope
3. Reflect on hope and despair in patients in specific categories, such as those with a diagnosis of Alzheimer’s disease, or with major spinal cord injuries, or with metastatic cancer.

**Topics and Dates**

**Reading Material**


**Topics:**

**Week 1**

**Hope and the Deeply Forgetful** (Raymundo Santiago)

Video: Alive Inside – Music, Memory and Glimpses of Continuing Selfhood

Reading: S.G. Post, “Hope in Caring for the Deeply Forgetful”

**Week 2**

**Conceptual Development and Prognosis in the Context of the Patient with Metastatic Cancer**

Discussion of Jerome Groopman, *The Anatomy of Hope*

Discussion of student written reflections

**Week 3**

**Hope and Individuals with Major Spinal Cord Injuries**

Video: The Brooke Ellison Story

**Week 4**

Discussion with Brooke Ellison & SG Post – What Does It Mean to Have Hope?

Last updated on: 7/11/2015
Evaluation

Attendance is required, and each student will make a case presentation of their experience(s) with hope in clinical encounters as a medical student, a patient, or as a friend to someone navigating illness. Students will be asked to write a 4-page essay, weaving together experience and thoughts from the course. Students will be graded (Honors, Pass, Fail) based on class participation (70%, including their presentation) and their paper (30%). The class will meet once a week for five weeks, for a total of 10 hours.

Feedback:
The standard evaluation form includes a faculty feedback section. Student papers will receive written comments.

Number of Students

Minimum 6
Maximum 12