

# Hope: A Double-Edged Sword

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Let me begin with a story.

I visited my younger brother in his hospital room at 11:00 a.m. on a Friday. He had been admitted the night before after falling in his home. When I arrived, he had just returned from a CT scan of his head.

“What happened?” I asked, both concerned and bewildered.

“I lost strength in my legs, causing me to fall, and now I can’t feel them,” he said calmly.

“Have the doctors mentioned a cause yet?”

“They told me this morning they found a ‘shadow’ in my spine, but they need more tests before they can say anything else.”

“Did they explain why they scanned your head?” I asked, still trying to piece things together.

He did not answer. Instead, knowing my background in healthcare, he turned the question back on me.

“What are you thinking? You probably know more than what they’ve told me. Just tell me what you think is happening.”

I examined him, did a head-to-toe assessment, asked about his symptoms, when they started, what he could and could not feel. I touched his toes. Nothing. I asked him to wiggle them. He did, but with effort. I asked him to lift his feet. He could not.

“I have suspicions,” I finally said.

“If you want **hope**,” I added gently, “listen to the clinicians here, and the clinicians who will be added to your care in the near future. What I’m thinking may not give you that.”

“I want you to tell me everything,” he insisted. “Don’t hold anything back!” he commanded.

So I gave him four scenarios, warning him that none of them were good.

“Just tell me,” he said, bracing himself.

“One: the shadow on your spine is non-cancerous. They can remove it surgically, but you will never walk again.

Two: it’s cancerous but confined to your spine. They can remove it, then you’ll need chemo or radiation, or both. You still won’t walk again, and the treatments will leave lasting damage.

Three: they find additional tumors in nearby areas, lymph nodes, organs, tissues. Surgery might help, but chemo and radiation will be unavoidable. It will be a massive battle with a long recovery and a very poor quality of life.

Four: they find a tumor in your brain. You don’t want to hear the words glioblastoma or astrocytoma. If it’s in your brain, the best thing you can do is go home, spend your remaining months, not years, months with family, and get your affairs in order. No one survives that, and those who prolong their lives with treatments suffer greatly.”

Just as I finished, the doctor walked in.

“Labs look amazing! Everything is great. Your back surgery is scheduled for Monday morning. We’ll keep you admitted until then. We’re looking good!” he said clapping once as he finished making those assertions. “Any questions?”

My brother asked the one question the doctor was not expecting.

“Did they find anything in my brain?”

The doctor’s smile thinned, then collapsed altogether. “Hmm... ah... let me just check your chart.” His voice tripped over itself as he backed toward the door. I observed a slight hesitation right before he stepped out.

The moment the door clicked shut behind him, I turned to my brother. “He already knows.”

Ten minutes later, the doctor returned, fidgeting, avoiding eye contact.

“Well, um, ah, so... there is a tiny, pea-sized spot on your CT scan. It may just be an artifact, and it’s really small, so we shouldn’t make much of it at this time. Right now, what we need to focus is on your surgery and **hope** for a full recovery.”

My brother looked at me, and I knew he was thinking of scenario four.

“You don’t have to do the back surgery,” I said softly.

Before I could finish, the doctor cut in. “Oh no, the surgery is necessary to relieve the pressure on the nerves. This is to help him walk again with some rehabilitation.”

My brother nodded at me. “I’ll do the surgery. It gives me a chance to regain strength on my legs. Then I’ll worry about the brain tumor.”

The surgery lasted fourteen hours, nearly twice what the doctors had anticipated. In the end, they were able to remove only ten percent of the spinal tumor. Rehabilitation brought no improvement. After placing his hope in the operation and finding that it only worsened his condition, my brother refused any further treatment. The recovery from surgery was grueling, and he never regained the ability to walk.

My brother made peace with the probable.

He did not flee from the truth that approached him; he turned toward it. He looked death in the face and, with a steadiness I will forever admire, accepted that it was coming for him.

There was no surrender in him, only a kind of lucid courage, the courage of someone who chooses real life over illusion.

In that acceptance, he found a strange, solemn freedom.

He died three months later at the age of forty, peacefully, without agony, without pain. Full hair. Full mind. Full of love. Had he pursued every treatment offered to him, each one wrapped in the promise of a maybe, each one marketed as the newest, brightest possibility, had he clung to the wish of a miracle at any cost, that peaceful ending, that dignity...I say this with a high degree of certainty, would not have been possible.

Had my brother clung to the belief that he might be the one to outrun that kind of brain cancer, the far more likely outcome is that he would have died in torment, his final days consumed by the side effects of dreams turned desperate. And the rest of us would be left with those memories, haunting, unbearable, instead of the last beautiful days and hours we were given to say goodbye.

Two hours before he died, he spoke clearly and lovingly to every member of our family.

Hope is often praised as if it were a universal medicine.

Quotes about this optimistic state of mind multiply like lanterns in the dark, each one urging us toward goals, toward perseverance, toward some imagined horizon. In these

sayings, hope becomes a kind of moral engine, the force that keeps humanity moving forward, the sworn enemy of despair.

But few speak of the other side. The one that wounds. The one that binds. The one that keeps us tethered to what no longer serves us.

There are moments when hope ceases to be a companion and becomes a captor, when it asks us to wait instead of acting, to endure instead of releasing, to cling instead of seeing reality. In such moments, it is not a virtue but a weight. It becomes the very thing that prevents healing, acceptance, or change.

Yes, hope moves some people forward. This cannot be denied.

But for others, it becomes the very thing that causes increased suffering, a promise that keeps renewing itself while life quietly slips by.

The deeper question is not whether hope is good or bad, but when it nourishes and when it corrodes. For it is not inherently a blessing; it is a tool. And like any tool, it can build or it can break.

Hopefulness is often treated as a prerequisite for action, a kind of inner sunlight without which nothing grows. Those who speak of this human experience speak of it as breath, as compass, as the very condition for striving.

But there exists another kind of person, less accepted and less understood, the one who moves without hope. Not in despair. Not in resignation.

But in actuality.

These individuals do not rely on wishes or dreams to propel them. They rely on discipline, understanding, skill, or a sober reading of reality. They act because action is needed, not because they are buoyed by a promise of future reward. They improve because improvement is possible. They solve problems because problems require solving. They succeed because they commit to the work, not because they are carried by a feeling.

To the eternally hopeful, this can be confusing, even unsettling. They mistake the absence of hope for the presence of hopelessness. They assume that without it, a person must be lost, defeated, a pessimist, a cynic, or numb.

But this is a misunderstanding.

There is a form of forward motion that does not depend on hope at all, a movement grounded in responsibility, realness, or simply the refusal to abandon agency. It is the movement of those who do not need to believe things will turn out well in order to do what must be done.

Hope is one path.

But it is not the only path.

At times, it is not even the best path.

It is important to recognize that hope is not an overarching virtue, but a temperament, one that some need, and others transcend.

I keep returning to an unorthodox, unofficial definition of hope, one that has followed me for years.

"Hope, it is the quintessential human delusion, simultaneously the source of your greatest strength, and your greatest weakness." – The Architect (The Matrix, Movie)

The Architect's line is striking because it refuses to romanticize a, as he put it, human delusion. It names what most cultures avoid, that delusional force is not purely a strength, but a double-edged mechanism. On one edge, it energizes, uplifts, and sustains. On the other, it distorts, delays, and traps.

The world is saturated with quotes celebrating the first edge. Hope as courage. Hope as resilience. Hope as the spark that keeps humanity moving. These are comforting ideas, and comfort tends to be repeated until it becomes doctrine.

But the second edge, the one that cuts, is rarely acknowledged.

Because to admit that hope can weaken us is to admit that our cherished narratives are incomplete. In many cases, wishes and dreams are just lenses that filter out reality, a tether to what should be released.

Hope becomes a liability when it detaches from feedback.

But the Architect's line points to a deeper truth, hope is not a fundamental human necessity. It is a psychological delusion, powerful for some, perilous for others.

At its best, hope is a motivational resource, it sustains effort, organizes attention, and orients a person toward desirable futures. But when it persists without recalibration, when

new evidence no longer updates the expectation, it shifts from a rational stance to a cognitive distortion.

Hope overrides cost–benefit reasoning. Choices are made not because they are adaptive, but because they preserve the emotional comfort of the hoped-for outcome.

The imagined future becomes insulated from reality. As the probability of success approaches zero, the individual continues to behave as if success were guaranteed. The gap between expectation and reality widens.

Agency becomes compromised. Instead of guiding action, hope begins to dictate it. The person becomes committed to a trajectory that no longer serves their well-being.

The harm emerges at the moment of divergence. When the desired outcome becomes unrealistic, unreachable, or impossible. The individual's continued investment, emotional, financial, relational, turns destructive. What once empowered now misleads.

The weakness is not hope itself but the failure to update hope in response to changing conditions. Delusion arises when the mind protects the desired narrative at the expense of accurate perception.

In science and medicine, one hundred percent certainties do not exist. This absence of absolutes unsettles us, for we live in a culture that treats hope as a kind of currency, something to be invested even in the faintest possibilities.

Yet medicine, perhaps more than any other field, is crowded with treatments that promise a glimmer of salvation. Each new therapy, each experimental protocol, becomes a vessel for our longing to outwit chance, to bend probability toward desire.

But when a society clings too tightly to vanishingly small odds, it risks confusing possibility with inevitability. Hope becomes less a virtue and more a refuge from the discomfort of uncertainty. And in that refuge, we sometimes forget that medicine is not a realm of guarantees, but a discipline of careful wagers, guided by evidence, shaped by limits, and carried forward by the humility to act without ever knowing for sure.

Patients want hope. Doctors, knowing the limits of their art, offer it in the form of small probabilities, fractions of a chance, slivers of possibility. Yet patients often cling to these numbers as if they were promises rather than statistical outliers. The mind quietly edits the equation, a five percent chance becomes “maybe me,” while the ninety five percent likelihood of defeat fades into the background.

This creates a cycle that neither side fully intends. Patients, driven by desires, wishes, dreams, fear, and longing, amplify the faintest glimmer. Doctors, mostly driven by compassion and duty, on few occasions driven by “more treatments mean more money,” continue to offer that glimmer. And together they sustain a loop in which hope is exchanged, but reality is lost.

Hope becomes detached from proportion. When improbable success is treated as destiny, and probable failure is treated as irrelevant, the patient is not empowered but misled. The cycle persists because it soothes everyone involved, yet it rarely serves the one who must ultimately bear the outcome.

I am not opposed to hope; it can be a lantern in dark places, a force that keeps some people moving when nothing else will. What I resist is the kind of faith that is fastened to impossibility, hope that demands we build our choices on infinitesimal chances while ignoring the far greater likelihood of harm. When wishes and dreams become a wager against reality, they stop being nourishment and become a cruelty. In some cases, pure suffering. There are moments when clinging to vanishing odds fractures a person more deeply than accepting the truth that stands before them.

Sometimes the most compassionate act is not to reach for the improbable, but to make peace with the probable.

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