Jamesian Overbelief and the Therapy of Hope

Andrew Flescher

"The true survivor is the one who has finally learned that survival itself is beyond the point," the best-selling author and survivor of domestic violence, Hannah Nyala, once said. In this paper I want to explore not only the extent to which this thesis is true in the context of dire prognoses following illness or injury, but also whether its de-prioritization of the straightforward fact of survival in favor of emphasizing one's attitude towards surviving ironically leads to the best sorts of medical outcomes. In the process, I intend to connect hope to healing in a tangible way, distinguish genuine from false forms of hope, and, this distinction established, finally suggest realistic strategies for conceiving of hope as sound medical therapy. I maintain that hope, according to Jerome Groopman and others a virtue of healing, is, broadly construed, an example of Jamesian "overbelief," that is, a belief that is adopted without sufficient evidence but by virtue of whose adoption is made more likely to be true. This categorization in place, a question about hope, which is really a question about overbelief, arises: Does *believing* one's condition will improve, when the existing evidence does not suggest as much, itself con-stitute new evidence that needs to be taken into consideration? Does hoping make healing more likely? It does a great deal, I argue, and is in addition something worth pursuing for its own sake, so long as hope is understood as a subjective state which the hoper freely inhabits, rather than a set of expectations provided for the hoper by another party (even dear loved ones).

Romantic Love, Religious Faith, and Hope's Promise

In order to appreciate James's influence on the link that would medically be established a century later between belief and well-being one must first understand the epistemological dominance "evidentialism" had enjoyed through much of the modern era as well as the challenge to this standard view posed by the notion of overbelief. James's principal insight from "The Will to Believe" – "faith in a fact can help create that

fact" (25) – flew in the face of Enlightenment epistemological orthodoxy by suggesting that belief in advance of a hypothesis actually creates evidence *in support* of that hypothesis. This was James's distinctive innovation in the burgeoning pragmatist movement: beliefs gained validity not on the basis of the set of known certainties in support of them, but in proportion to the positive effects that ensue following their introduction into the world by their holders. James argued that we have the right to harbor beliefs in unlikely propositions and even whole doubtful futures the actuality of which no one as of yet has the objective confirmation to refute. Thus characterized, "overbelief" is not delusion. The former imbues hope into the existing sphere of what is known, while the latter perniciously denies reality. Overbelief coheres with our excavation of the undiscovered universe, a process which delusion derails.

This is not to suggest that overbelief is without its risks. Imagining a hitherto unexperienced future, the overbeliever might fail to manage her expectations, or adversely impact others by not preparing for what is, if not inevitable, the most plausible unfolding of events. If hope is given a blank check, one risks being seduced by delusion, even though in themselves hope and delusion are very different things. Thus, it is important to bear in mind what one stands to gain by overbelieving. Doors close when another one opens. Beyond a certain threshold, the skeptic is inclined to press the believer to justify ignoring the predictive success of the thing in which the believer has claimed her right to believe, especially if she forgoes a real and significant good in favor of a fictitious or insignificant one. Fantasies that temporarily console often amount to costly distractions. In lieu of an airtight proof that something is *not* so, there are still reasons to be cautious to believing that it *could be* so.

James anticipates objections from the camp of skepticism by honing in on a specific sort of hoped-for good, namely a good (1) that is a *real* option for the one choosing it; (2) which *must* either be chosen or lost and (3) in which something very *significant*, indeed, life-altering, hangs in the balance. In James's parlance, "overbelieving" makes rational sense when the good to be gained is "live," "forced," and "momentous" (3). A flourishing romantic relationship between two individuals – this is to say the *fact* of whether the individuals relate to one another in a flourishing relationship – exemplifies just this sort of good on behalf of which it behooves one to overbelieve. The prospective relationship remains a real possibility for the two lovers; if it is not acted upon and subsequently nurtured it will dissipate; and it is plausibly the sort of relationship on

which the rest of their lives could hang in the balance. In the case of a romantic relationship, the good to be gained depends on the attitude with which the good is pursued. What character will such a relationship take? On what do the traits by which it is to be characterized depend? Does it contain good-will? Trust? Love? Asks James:

> *Do you like me or not?* [...] Whether you do or not depends, in countless instances, on whether I meet you half-way, am willing to assume that you must like me, and show you trust and expectation. The previous faith on my part in your liking's existence is in such cases what makes your liking come. But if I stand aloof, and refuse to budge an inch until I have objective evidence [...] ten to one your liking never comes. How many women's hearts are vanquished by the mere sanguine insistence of some man that they *must* love him? (24)

In matters romantic, the "fact of the matter" is reliant on a *desire* for the fact to turn out to be true, a desire rendered moot without the desirer's displaying the additional risk to convert her desire into something actionable. Any insistence on evidence undermines the romantic objective. The very gesture of the request helps to ensure that that evidence will *not* be forthcoming, for it will be interpreted as a sign that one is not willing to back up the desired outcome with a faith in that outcome. And this brings us just to the point about certain sorts of outcomes we experience in the world: they in part *are*, already, substantively the faith that precipitates them. With regard to some things in this world, the most important things, faith in something *is* that something already, not entirely, but partially.

The good of romantic love is, for James, analogous to religious faith. Like trusting that the one you love loves you back, believing represents a subjective mental state that corresponds to a reality that transcends its subjectivity. With respect to those for whom religion is a "live" option to begin with, i.e., one for which my existing set of beliefs makes me eligible, the objective pay-off goes hand in hand with a subjective leap, so much so that vetoing faith in lieu of sufficient evidence becomes "illogical:"

> The more perfect and more eternal aspect of the universe is represented in our religions as having a personal form. The universe is no longer a mere *It* to us, but a *Thou* [...] and any relation that may be possible from person to person might be possible here. For instance, although in one sense we are passive portions of the universe, in another we show a curious autonomy, as if we were small active centres on our own account. We feel, too, as if the appeal of religion to us were made to our own active good-will, as if evidence might be forever withheld from us unless we met the hypothesis half-way. (27-28)

With regard to this and similarly momentous relational states, ontological existence and human access to that existence are irretrievably intertwined. It is not merely that we have the right to believe in God or Nirvana; belief becomes the avenue for ascertaining these transcendent referents. In the case of love, religion, and other similar states that relational activities precipitate, truth-seeking is *ipso facto* passional. It involves a prior commitment to, not mere discovery of, beliefs in truths that, in turn, make other beliefs true. Hoping for the reality of a certain sort of relationship becomes a key feature of that relationship.

Despite James's insistence on the superfluity of evidence in advance of believing, it turns out that in the area of medicine it looks like there *is*, after all, evidence to support the hypothesis that overbelief helps to create a fact. The relation in question in the case of medicine occurs between a patient and a patient's well-being, where "well-being" often, but not always, pertains to bodily well-being. In patients who are afflicted with devastating diseases, many of whom are formally diagnosed as "terminal," the direst prognosis becomes less dire, the evidence suggests, when that prognosis is supplemented with hope. In what shortly follows, I will delve into the biology of how the act of hoping stimulates brain circuits that release hormones shown to have physiological benefits for the ailing patient. For now what is important to emphasize is that this finding, if true, calls attention to the critical but still underemphasized role of patient subjectivity in the patient-physician relationship. The convention is to see the patient as the *object* of a physician's attention, where the physician not only presents the patient with the options that are available, but, in effect, decides for the patient (or leads the patient to decide) which of these options make the most sense to pursue. In the conventional view, the physician sometimes becomes the patient's proxy, determining for her a path to well-being that should be hers alone to declare. Certainly a decision on which a physician weighs in, for example whether or not to administer the most aggressive regimen of chemotherapy, or whether an elderly patient ought to undergo a risky orthopedic surgery, is one that should also be significantly governed by the advice that is rendered. It bears noting, however, that the exact same treatments yield different outcomes depending on the extent to which the patient is involved in the decision making process. The data shows that a physician who promotes agency sees better results (cf. Snyder 259-261). A patient fares better when given the space within which to *choose* to hope.

This said, it follows that a medically therapeutic utilization of hope is volitional. It is not the static assertion of optimism. There is a balance to

strike. The afflicted sufferer must tread between a Scylla of agency abdication – accepting another's vision of what is one's own well-being to determine – and a Charybdis of resignation, the premature denial of possibility of hope even in the face of the most restrictive sorts of situations (cf. Groopman 52-53). *Productive* hope, i.e., a hope that is medically "prescribable," represents a way of preserving control over one's life when it is precisely control that seems to be slipping away. This "way" is comprised of two aspects of how overbelief functions in a medical context. The first is reflected in the link between hope and good medical outcomes. The second, which is decisively Jamesian in character, moves from evidence to faith in lieu of evidence. These two aspects of overbelief, the pragmatic and the spiritual if you will, reinforce one another. Hope's immediate physiological benefits not only make the body better; they also propel a patient to a stable state of hopefulness, which, in turn, renews the positive thoughts that precipitate the body's organic, recuperative processes. Moreover, the pragmatic and spiritual aspects of hope, both of which are agency enhancing, combine to give warrant to discard, or at least sidestep, the conventional protocol that currently governs how physicians confer with their patients about what course of action to pursue in fighting serious disease by making the patient a more active participant in her own recovery.[1] Finally, in the instances in which dying does turn out to be the eventual outcome, I want to suggest, with James, that the right kind of hope makes dying better than it would have been without it.

[1] Eric Kodish and Stephen Post make the shrewd point that patient agency is also important because the physician does not always have every resource at her disposal to ignite hope within the patient. Spirituality is an example of a hope-promoting resource that is possibly outside the physician's purview, but which might have the best chance of being effectuated if the patient is encouraged to participate to a greater extent in her own recovery (by, perhaps, seeking resources within her community to help her through her ordeal). Kodish and Post lay the grounds for an "obligation" to promote hope for patients with cancer that should dovetail disclosure of all medical information based on a principle of "respect for the remarkable healing powers of the human spirit, responsibility for promoting the psychologic and physical health of patients, and humility in understanding the limitations of the clinician's ability to predict the future with certainty" (1821). See Eric Kodish and Stephen G. Post. "Oncology and Hope." *Journal of Clinical Oncology* 13.7 (1995): 1817-1822.

Some Evidence on Behalf of the Physiological Effects of Hope

The various ways in which hope improves the condition of an ailing patient is by now well-documented in the case of a number of medical diagnoses. Hopefulness about one's predicament dampens one's pain and amplifies one's immune response. It can reverse the irreversible in ways that are otherwise statistically inexplicable. How hope works at the physiological level, however, is just beginning to be understood.

One way in which hope concretely impacts well-being is with regard to the "placebo effect," the subjectively felt but also objectively measurable improvement in health attributable to inactive substances thought by the one ingesting them to be actual medicine. In a landmark study in 1998 on the effectiveness of medication for depression, Irving Kirsch and Guy Sapirstein of the University of Connecticut compared the improvements in 3,000 depressed individuals who were taking prescribed medications for their conditions with those taking placebos. They found that patients in the latter category, some suicidal, demonstrated improved conditions almost to the same degree as those on medication (75%). In a 2002 report that reanalyzed this data looking only at the highest doses of the medications that were prescribed, placebos were determined to be 82% as effective (cf. Kirsch, Moore, Scoboria, and Nicholls). The conclusion that is to be drawn from this investigation is not that antidepressants do not work – although their continued use may not be quite as supportable as was previously thought – but rather that placebos work about as well, without the expense and side-effects of their alternative.

Hope and Overbelief

Hope, then, is not a superstition or a magical healing potion but the genesis of a series of physiological interactions in the brain that mitigate almost intolerable symptoms caused by real diseases and injuries. Hope has a recuperative effect on musculoskeletal maladies, nerve damage and nervous system disorders, heart disease, autoimmune disorders, cancer, and a host of other conditions.[2] However, hope, I want to go on to suggest, also imbues the sufferer with a meaningfulness that is itself recuperative even when its direct impact on the body is minimal or absent. This is to say, hope furnishes its adherent with a new worldview, one in which the victim of a disease or injury is no longer bound by the typical criteria by which quality of life measurements are generally assessed.

[2] See especially Groopman, chapter 7.

Hope has a spiritual upside that complements its physiological one. It is here where James's notion of overbelief becomes critically relevant. Committing to a *future* for which one will work hard to realize, one improves one's lot here in the *present*. Hope is beneficial to the patient not only because of the physiological process it precipitates, but also because of the passional life with which it is at once, in the immediate, perpetuating. In this respect hope offers the self a way of living differently and better than the skeptic might not have thought possible. James's classical refutation of the skeptic, correspondingly, is significant because it confers upon the prospective hoper a certain freedom and purpose which would otherwise seem unavailable.

In "The Will to Believe" James emphasizes the usefulness of overbelief to the kinds of decisions that need to be made in the real world. What we know for certain admittedly represents the most secure sort of information upon which to base beliefs, but such information rarely amounts to the kinds of choices that make us happy, manifest our values, or develop our characters for the better:

> Objective evidence and certitude are doubtless very fine ideals to play with, but where on this moonlit and dream-visited planet are they found? I am, therefore, myself a complete empiricist so far as my theory of human knowledge goes. [...] [W]e must go on experiencing and thinking over our experience, for only thus can our opinions grow more true; but to hold any one of them – I absolutely do not care which – as if it could be reinterpretable or corrigible, I believe to be a tremendously mistaken attitude, and I think that the whole history of philosophy will bear me out. [...] Apart from abstract propositions of comparison (such as two and two are the same as four), propositions which tell us nothing by themselves about concrete reality, we find no proposition ever regarded by anyone as evidently certain that has not either been called a falsehood, or at least had its truth sincerely questioned by someone else. [...] No concrete test of what is really true has ever been agreed upon. (14-15)

Objective certitude is simply not ascertainable with regard to decisions that take place in the real world, but by virtue of its elusiveness we should not, according to James, insist any less vociferously on the search for truth. It is virtually a criterion of the most important decisions in life that they are made on the basis of the decider's *not* having enough information at the outset of these decisions. Moreover, if this observation about "truth" holds for experiential knowledge in the present, then how much more it is plausible for states that pertain to the future. Short of denying that "two plus two equals four," or other comparable truisms the comprehension of which influence no real world outcomes, the one de-

ciding what to believe, particularly when deciding about what to believe *will happen*, has no choice but to engage in passional decision-making.

It is thus a condition of gaining *new* truths, which include some of the most important truths, that one forego the skeptic's maxim of 'shunning error.' To remain cautious and "wait for more light" is to lose the thing one stands to gain. This is because waiting is not inaction but a different sort of action, one which in its conspicuous absence of conviction contravenes the arrival of the unlikely but desirable outcome. Not only is exercising the freedom to believe in an uncertainty therefore not absurd, *never* to so believe is tantamount to assuring that outcome's not coming to pass. As James notes, "if we believe that no bell in us tolls to let us know for certain when truth is in our grasp, then it seems a piece of idle fantastically to preach so solemnly our duty of waiting for the bell" (30). By implication, we should live our lives so as at least occasionally to have faith in the improbable; in not doing so the improbable becomes impossible. Emboldened by the confidence that we are not exploited in our embrace of the improbable, the door is now opened for experiencing what I above identify as the "deeper," or "spiritual" sense of hope: the passional claiming of jurisdiction over our destiny.

Hope is empowering because it allows its possessor to choose among viable courses of action (despite the panoply of options that no longer seem available), proactively anticipating trials that must soon be endured (cf. Groopman 199). It braces one for danger by safeguarding all that which *is* within one's control. More than an expectation of how successful a course of medical treatment will be, hope offers its possessor a mental freedom in general which continues to operate in the face of all potential outcomes, even death. Having established the *right* for one to believe, James illuminates for the one otherwise poised to despair the *dignity* of one's believing will. Hope assures that no matter what the prognosis, one lives and dies in this world on one's own terms, allows one to recognize rather than deny threats that are real, and furnishes its possessor with the courage to overcome a fear of the unknown. Spiritually, hope brings one back to the world by introducing avenues to find meaning in experiences that had previously seemed empty or unfruitful. Hope is not an escape. It aids one to manage reality. In hope, one learns to cope with that which one could formerly not accept. Finally, hope furnishes its possessor with humility, first in the form of a frank acknowledgement that however sure one is, one, in fact, does not know the future, and second in its implicit endorsement of human finitude, the acceptance of which goes hand in hand with the insight that whatever happens to us individually is not the most important thing. Hope, in this respect, puts our place within humanity in its proper context.

False Hope

Given this deeper sense of hope according to which it is not only reasonable, but also dignified to anticipate future betterment, the question naturally arises: in hope are we insulated from the bad? Is hope a catch-all remedy for any malady? Conversely, can the rhetoric of hope lead to the exploitation of a prospective hoper?

"He that lives on hope will die fasting," Benjamin Franklin once wrote. There are some who have rhetorically abused the notion of hope to shift the burden of healing entirely to the patient. For such thinkers, such as the surgeon Bernie Siegel, recuperation so rests in the purity of one's positive attitude that speculation about bad outcomes constitutes blasphemy. If one's cancer does not go into remission, it could only be a result of an insufficiently hopeful outlook. This sort of optimism is offensive to the patient who is doing all she can to cope with her affliction, and it deflects the urgent, time-sensitive measures that we all must often take in the face of a crisis. To read Siegel, one sometimes gets the impression that one's affliction should be seen as a "gift." The well-known author Barbara Ehrenreich recounts her encounter with Siegel and company after she herself was diagnosed with breast cancer. Seeking on-line support among fellow sufferers, Ehrenreich discovered to her dismay a surprising percentage of victims that had come to develop a love of their illness ("If I had to do it over, would I want breast cancer? Absolutely," said one. "I am happier now than I have ever been in my life," said another).[3] Of special concern to Ehrenreich was Siegel's well-known claim, first articulated in his best selling *Love, Medicine, and Miracles*, that cancer itself is something that arises from negative feelings. The implication is if one fails to hope, one brings about one's disease. By extension, one has the power, through hope, to undo that which one has brought upon oneself. Very quickly, the logic of such an analysis becomes a version of "blaming the victim." In such a view, the evil of cancer is understated, the subjective capacity to will cancer away is overstated, and in the meantime the precious time one has left is in danger of being squandered due to both false impressions. Clearly, hope ought not

[3] Ehrenreich, Barbara. *Welcome to Cancerland.* Nov. 2001. 7 Mar. 2011. <http://www.barbaraehrenreich.com/cancerland.htm>.

to replace criticism, sober reflection, and a realism that protects rather than spoils the resources one still does have at one's disposal.

How does this criticism square with the virtue of a subjectivity that is hypothesized to trump skepticism in "The Will to Believe"? Does not Ehrenreich's critique of Siegel – that it is well taken can be in no doubt – press us to consider the extent to which radical subjectivity is the equivalent of doubt issuing faith a blank check? Whether the case in point happens to be romantic love, religion, or hope about one's prognosis, one might be inclined to acknowledge a threshold beyond which faith overstays its welcome. Otherwise the Jamesian does not merely tolerate but gives safe haven to evils such as exploitation and domestic abuse within the context of a relationship, a religious cultishness that can result in mass suicide or even murder, or, in the case of medicine, the cruel abandonment to delusion in our worst moments. How do we know when to trust hope? That hope will not mislead?

Jerome Groopman has this to say about the distinction between true hope and the sort of daft rosiness that fails to recognize real threats and dangers: The former

> does not cast a veil over perception and thought. In this way, it is different from blind optimism: It brings reality into sharp focus. In the setting of illness, hope helps us weigh highly charged and often frightening information about the malady and its therapies. Hope incorporates fear in the process of rational deliberation and tempers it so we can think and choose without panic. (198-199)

Echoing James's justification for the right of one to believe without being accused of irrationality, Groopman calls our attention to the sobriety of hope. Hope invokes not a denial of but rather a working within a set of given facts. Unlike overbelief, the source of false hope is often external. In order to overbelieve one must take measure of all one knows about one's situation and subsequently assume the responsibility of resetting one's expectations. False hope, by contrast, represents the indulgent acceptance of a gift which the giver is not really in a position to bestow. False hope is a short cut. Genuine hope entails a leap of faith. It is an existential venture, not something one can be told to do by someone else.

Nor, furthermore, does hope succeed by *contradicting* a set of known facts. Hope represents a decision to embrace the possibly improbable, not a distortion of the probabilities. When in hope one chooses to fight on, one knows what the statistics say. An informed hoper builds into her psychological budget an awareness of death as the likely outcome. If she

has been fully informed and chooses to fight death anyway, therefore, her decision cannot be dismissed as insane or absurd. The case of George Griffin, a seasoned pathologist Groopman discusses who had been diagnosed as terminal with stomach cancer, serves as a good example of the critical difference between the likelihood and certainty of a terminal prognosis. When he was practicing, Dr. Griffin had the reputation of a staunch realist. No one knew better than he did the odds against chemotherapy having a positive effect in a case of metastatic cancer as advanced as his. Groopman and the senior oncologists who had been called in to confer on Dr. Griffin's case concurred that aggressive treatment was tantamount to irresponsible "iatrogenic denial" (58-59). "He risked hastening his demise, or at least robbing himself of the last tranquil days at home with his wife, his children, his friends," writes Groopman. "What [Griffin's oncologist] termed 'madness' seemed rather a sad, self-defeating loss of judgment" (59-60). Yet, Griffin survived. No one can be sure what combination of a barrage of the most toxic chemotherapy, dumb luck, and positive thinking led to the staying of a disease diagnosed as fatal. However, that survival was known to be an improbability that was nevertheless possible, and not an outright impossibility, transformed a fight against a terminal disease into a meaningful endeavor regardless of its outcome. Had George Griffin died, he would have died on his terms, with dignity.

There is an inherent uncertainty in even the worst diseases. We are not merely justified in believing in the improbable, we *must* do so if we want to increase our chances. This is the lesson that Dr. Griffin brought to the very sick cancer patients he visited following his ordeal (78). Dr. Griffin's hope was not false because, once informed, he was permitted to govern the terms of his fate. False hope, by contrast, represents an abdication of agency in which one either forgoes or is stripped of one's ability to choose for oneself. What is at stake here is not the rudderless principle of autonomy for autonomy's sake, but the preservation of the right to form existential commitments to possible, if improbable, futures.

Conclusion

On April 3, 2009, The New York Times featured a front page exposé on a well-known palliative care physician, Dr. Desiree Pardi, who had recently succumbed to breast cancer after battling the disease for nearly eleven years. Pardi, a pillar in her field, was renowned for her compassionate demeanor but also for her tenacious ability to persuade patients

with terminal diseases very near to the end of their lives to come to terms with their predicaments and stop battling death. The article, entitled "Helping Patients Face Death, She Fought to Live," reveals that when her time came to deal with metastatic cancer, Pardi rejected the wisdom she so often dispensed to her patients. But its point was not to brand Dr. Pardi a hypocrite but rather to convey the indispensible virtue of trust, and in particular of trusting the patient: trusting that *she* will know when to hope and what it is appropriate to hope for. As hope is about retaining meaningful control over one's future, it is ultimately not outcomes-based but decisions-based. Hope is a positive thing in one's life – it has a medical upside – because it envelops its possessor not as some foreign imposition from the outside but organically, from within. One hopes genuinely on one's own terms. One is persuaded to hope against the odds because, as James points out, one existentially summons the *will* to do so.

Keeping in mind this critical feature of hope – that it is the summoning of courage and resolve whose source is internal – one can begin to suggest practical recommendations for ensuring that hope is prescribed in a way that is medically sound. First, as hope is garnered existentially, it ought never to be foisted upon the prospective hoper as a mandate that emanates from some external source. The "cowboy" oncologist who under the pretext of leaving no stone unturned fails to respect a terminal patient's repeated attempts to express that she no longer wishes to have treatment prevents his patient from pursuing the goals she has deemed more pressing. A physician ought always to suggest further options, but never force those options on a patient once the patient has understood and considered them reflectively. Agency critically remains a necessary component of authentic hoping. Physicians, family members, friends, and other concerned parties can have faith in the future health of the ones they love, and they can of course do much good transferring their positivity by interacting with their loved ones, but hope itself cannot be transferred by a surrogate.[4] While hope can be communally expressed, it is individually engendered.

Second, hoping well involves an emphasis on the decision, and each successive moment of decision, not on the outcomes or expectations of

[4] The reader will note that I have nowhere made an argument in favor of the causative or even correlational connection between what might loosely be termed "faith-healing" and patient well-being. In this paper I have restricted my discussion to the effect of hope on the hoper's own recovery from illness and injury. If there is an argument to be made about the effect of praying for a loved one on that loved one's improved health, I do not believe it is suggested in James or on the basis of an argument that proceeds from an analysis of overbelief. This is consistent with my assertion that hope is dependent on establishing agency.

outcomes to which these decisions correspond. When we hope we steel ourselves for realities over which we do not have full control and form the attitude that we will take our shot at overcoming them nonetheless. Construed in this way, hope's glory, if such is to be identified, is a subjective victory to be found in the brave decision to stay death, whether or not we live or die. Just as hope cannot be true if it is passively received, it cannot be false when it comes into being by virtue of the active decision of an informed and lucid patient.

Finally, hope involves the humility to accept that life is bigger than we are, that we are part of something larger, something redeeming if you will, that furnishes us with meaning even when the obvious pathways seem to lead to dead-ends. Humility, however, also refers to an ever-present uncertainty in medicine that leaves room for improbabilities, experimental strategies, and, on rare occasion, inexplicable miracles. As James reminds us, unless what one proposes to chase is the denial of two plus two equals four, nothing that has not yet occurred can *pejoratively* be labeled "absurd." Physicians ought never to deprive patients of the ability *to choose* to hope before the issue of their recovery is fully settled.

Responsible hopefulness sets the stage for deliberate living and converts the frequent capriciousness of the universe into a series of meaningful events. It is not a distraction that deflects attention away from terminal patients getting their affairs in order. To the contrary, hope imbues these activities with a sober clear-mindedness and determination and assures that we do not abdicate our values and ambitions during any phase of life. In this sense, there is yet a final benefit to hoping when the chips are down: hope links temporal stages of life and preserves the narrative continuity of our sense of where we are and where we are going. Here, the wisdom of the theologian Paul Tillich, quite sensitive to the importance of distinguishing genuine from foolish hope, seems apt:

> Where there is genuine hope, there that for which we hope already has some presence. In some way, the hoped for is at the same time here and not here. It is not yet fulfilled, and it may remain unfulfilled. But it is here, in the situation and in ourselves, as a power which drive those who hope into the future. There is a beginning here and now. And this beginning drives toward an end.

If hope is rooted in a reality, even if that reality is a faint possibility, then hopefulness itself is a state worth pursuing. And in this case it cannot be a mistake.

Works Cited

Amanzio, M., et al. "Response Variability to Analgesics: A Role for Non-Specific Activation of Endogenous Opiods." *Pain* 90 (2001): 205-215.

Ehrenreich, Barbara. *Welcome to Cancerland*. Nov. 2001. 7 Mar. 2011. <http://www.barbaraehrenreich.com/cancerland.htm>.

Groopman, Jerome. *The Anatomy of Hope: How People Prevail in the Face of Illness*. New York: Random House, 2004.

James, William. "The Will to Believe." *The Will to Believe and other Essays in Popular Philosophy*. New York: Dover Publications, 1956.

Kirsch, Irving, and Guy Sapirstein. "Listening to Prozac but Hearing Placebo: A Meta-Analysis of Antidepressant Medication." *Prevention and Treatment* 1.2 (1998): Article 0002a.

Kirsch, Irving, et al. "The Emperor's New Drugs: An Analysis of Antidepressant Medication Data Submitted to the U.S. Food and Drug Administration." *Prevention and Treatment* 5 (2002): Article 23.

Kodish, Eric, and Stephen G. Post. "Oncology and Hope." *Journal of Clinical Oncology* 13.7 (1995): 1817-1822.

Siegel, Bernie. *Love, Medicine and Miracles*. New York: Harper Paperbacks, 1990.

Snyder, C. R. "Hope Theory: Rainbows in the Mind." *Psychological Inquiry* 13.4 (2002): 259-261.

Taylor, Shelley E., et al. "Psychological Resources, Positive Illusions and Health." *American Psychologist* 55.1 (2000): 99-109.

Tillich, Paul. *The Right to Hope*. Nov. 1990. 7 Mar. 2011. <http://www.religion-online.org/showarticle.asp?title=62>.

Tindale, Hilary A., et al. "Optimism, Cynical Hostility, and the Incident Coronary Heart Disease and Mortality in the Women's Health Initiative." *Circulation* 120.8 (2009): 656-662.

Sonderdruck aus

SUSANNE ROHR
MIRIAM STRUBE (Eds.)

Revisiting Pragmatism

William James in the New Millennium

Universitätsverlag
WINTER
Heidelberg
2012