Palliating Uncertainty:

Tools from the Pragmatism of William James, MD

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ACKNOWLEDGEMENTS

Thank you to all those who have supported me through the uncertainties of writing a DPhil.

First, I wish to thank my advisers, Dr Alister McGrath and Dr Matthew Kirkpatrick, for their guidance, encouragement, and unwavering belief in me. I am profoundly grateful to my mentor in philosophy, Dr Kelly Clark, who pointed me towards William James, and my mentor in medicine, Dr John Mulder, who taught me about palliative care.

I sincerely appreciate the Rotary International Foundation's generous support through the Global Grant Scholarships. The financial assistance has been invaluable, but the sense of community among Rotarians, particularly from Dr Jackie Taylor, has been equally important. Your faith in my potential and your steadfast support has meant so much to me.

I also want to express my gratitude to the physicians, philosophers, theologians, chaplains, and patients who have kindly met with me to discuss the ideas of this dissertation. I treasure these conversations. Thank you for sharing your stories, wisdom, and lessons learned from your experiences in practice. Thank you for your perspectives, which have informed and greatly enriched this project, and for your encouragement regarding the importance of this work. I would like to express my heartfelt appreciation to Dr Robert Twycross, Dr Max Watson, Dr Matt Dore, Dr Harvey Chochinov, Dr Richard Lawes, Dr Paul Han, Dr Kathryn Mannix, Dr Joshua Hordern, Dr Bill Fulford, Dr Ashok Handa, Dr Elaine Sugden, Dr Mary Miller, Dr Kathryn Mannix, Dr Bee Wee, Dr Farr Curlin, Dr Warren Kinghorn, Dr Harold Koenig, Dr Christina Puchalski, Rev. George Handzo, Dr Karen Steinhauser, Dr Laurence Leaver, Dr Trisha Greenhalgh, Dr Basilio Hernandez, Dr Richard Lehman, Dr Brent Beckman, Dr Daniel Maughan, Dr Gweneth Doane, Dr Matthew Carey, Dr Gina Hadley, Dr Ashley Moyse, Dr Victoria Bradley, Dr Trudo Lemmons, Dr Frank Cole, Dr Jeremy Howick, Dr Michael Lloyd, Dr Brian McLaren, Dr Emma Sutton, Dr NT Wright, Dr Nicholas Wolterstorff, Dr Steve Wykstra, Dr Jen Zamzow, Dr Micah Hester, Dr Arthur Petersen, Dr Joel Rasmussen, Dr Peter Zachar, Dr Rush Stewart, Dr Martin Davie, Fred Stella, Tony Himmelspach, Brian & Kathy Coughlin, Julie Phillips, Ryan Shinkel, Dr Brian Malley, Dr Tim McGrew, Dr Karen Campbell, Dr Paul Shrimpton, Dr Rolf Bouma, Dr Mark Wynn, Dr Bethany Sollerdeer, Dr Andrew Pinsent, Dr Shaun Henson, Dr Saad Ismail, Sam Chaloner, Jay Foy and others.

Thank you to the physicians who have exemplified the palliation of uncertainty to me and to the dear friends and family, and community, (such as Joe Welford, and Michael Lloyd, Wycliffe Hall) who held uncertainty with me in the times of my own medical challenges.

Thank you to my circus friends for the love, encouragement, and dance breaks. Thank you to my family: my father, who inspires me; my mother, who proofreads my work with meticulous care; my grandfather, who cheers me on; and my grandmother, who taught me to love libraries and to never give up.

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Abbreviations

CT	Computed Tomography
EBM	Evidence-Based Medicine
IOM	Institute of Medicine
"ILWL"	"Is Life Worth Living"
NHS	National Health Service
PDQ	Patient Dignity Question
PoP	*Principles of Psychology*
"PM"	"A Pluralistic Mystic"
PU	*A Pluralistic Universe*
"RA&T"	"Reflex Action and Theism"
RCT	Randomized controlled trial
SOAP	Subjective, Objective, Assessment, and Plan Note
"SoR"	"The Sentiment of Rationality"
SPP	*Some Problems of Philosophy*
TTT&S	*Talks to Teachers on Psychology and to Students on Some of Life's Ideals*
UK	United Kingdom
UM:FT	*Uncertainty in Medicine: A Framework for Tolerance*
US	United States
VRE	*The Varieties of Religious Experience*
WHO	World Health Organization
WJ,MD	*William James, MD: Philosopher, Psychologist, Physician*
"WtB"	"The Will to Believe" (essay)

Palliating Uncertainty:

Tools from the Pragmatism of William James, MD

"To teach how to live without certainty, and yet without being paralysed by hesitation, is perhaps the chief thing that philosophy, in our age, can still do for those who study it."[1]

~Bertrand Russell, *History of Western Philosophy*

Short Abstract

William Osler, the father of modern medicine, said, "Medicine is a science of uncertainty…" In palliative (end-of-life) care, uncertainty extends through biological, psychological, sociological, and spiritual domains and is felt by patients, caregivers, and healthcare providers. Yet, in the experience of many, uncertainty remains inadequately addressed. Traditional responses to uncertainty often involve overtreatment, over-investigation, and overmedicalization, and these approaches to uncertainty result in much suffering. This dissertation proposes an approach that I call "Palliating Uncertainty." I draw on William James' pragmatism to reframe uncertainty not always as a problem to be solved with more knowledge and technology, but as an experience to be palliated.

James, a nineteenth-century physician and philosopher, developed pragmatism as a philosophy of action rather than absolute truth. I engage with his pragmatism as an "attitude of orientation" that shifts attention away from futile quests for certainty and towards meaningful action. The goals of Palliating Uncertainty are to alleviate the suffering caused by uncertainty and enable individuals to live—and even flourish—amidst uncertainty.

Part I: Managing Expectations About Uncertainty examines taxonomies of medical uncertainty, critiques the assumption that more knowledge cures uncertainty, situates James' pragmatism within his struggles with the uncertainty of illness, and constructs the approach of Palliating Uncertainty by uniting pragmatism with the ethos of palliative care. *Part II: Turning Attention to Action* develops this approach in the context of five cases of uncertainty in end-of-life care. *Part III: Living with Uncertainty* draws on spiritual/religious notions of mystery and relationality in James' work to connect three key themes that run throughout this dissertation: acknowledging uncertainty, taking action, and seeking support in relationships. The conclusion emphasizes the holding of uncertainty together in community and suggests uncertainty is solved (or, rather, "salved") in the act of living. I close with some practical steps forward for integrating the approach of Palliating Uncertainty into practice.

[1] (Russell, 2004, p.2)

Long Abstract

William Osler, the father of modern medicine, said, “Medicine is a science of uncertainty…” Though Osler practiced medicine over a century ago, his words remain true of medicine today. In palliative care, uncertainty is not confined to any one domain; it courses through the biological, psychological, sociological, and spiritual layers of life and is felt by patients, families, caregivers, and healthcare providers. Yet, in the experience of many, uncertainty remains inadequately addressed. Uncertainty is commonly dealt with through avoidance, denial, disregard, indecision, inaction, overtreatment, over-investigation, and overmedicalization. Palliative care is a specialty that aims to alleviate suffering, and much suffering is caused by medical uncertainty and by inadequate ways of dealing with it. This dissertation offers an approach to uncertainty I call “Palliating Uncertainty,” which brings together William James’ pragmatism with the ethos of palliative (end-of-life) care. In this perspective, uncertainty is not always something to “cure” with more knowledge and technology, but something to palliate and live with.

If medicine is a “science of uncertainty,” James’ pragmatism is a philosophy for uncertainty. James, a nineteenth-century medical doctor who was the father of modern psychology, developed a philosophy called American pragmatism. James is commonly known as a physiologist, psychologist, philosopher, and mystic. It is less commonly recognized that he was also a medical doctor. Moreover, he was also a patient who suffered from serious illness, and his pragmatism was part of how he dealt with the uncertainty of his medical conditions. Pragmatism is heralded as a philosophy for life. It is also a philosophy that emerged from a life entangled with uncertainty and suffering. James wrote for himself but also for others facing suffering and trying to cope with uncertainty.

I engage with James’ pragmatism not as a theory of truth but as an attitude of orientation. The aspect of pragmatism central to this dissertation is a turn of attention. James describes the pragmatic method as “the attitude of looking away from first things, principles, 'categories' supposed necessities; and of looking towards last things, fruits, consequences, facts.” In this dissertation, I propose that James responds to uncertainty by shifting attention to action—away from the uncertainty, towards what we can actually do. The following quote from Osler serves as an apt example of an attitude of pragmatism: “Our task is not to see what lies dimly at a distance but to do what lies clearly at hand.”

In the approach of “Palliating Uncertainty,” I argue that turning attention towards action does not “cure” uncertainty but “palliates,” i.e., cloaks it—not just in the sense of “conceal” or “hide,” but in the sense of “cover,” “comfort,” and “alleviate the suffering” caused by uncertainty so that one can get on and live a life that is meaningful according to what they value. The approach of Palliating Uncertainty seeks to limit the uncertainty, but the goal is not always to remove it. The goals of Palliating Uncertainty are to alleviate the suffering caused by uncertainty and to help people live—even flourish—in the midst of uncertainty.

Part I: Managing Expectations About Uncertainty attempts to manage expectations by acknowledging uncertainty that is experienced in medical practice. Chapter 1 outlines taxonomies of uncertainty in medicine and questions the assumption that more knowledge always cures uncertainty. I suggest that, like a terminal condition, uncertainty might not be curable but can be palliated. Chapter 2 introduces James' pragmatism in the context of his life. I show that his philosophy emerged *from* dealing with the uncertainty of serious illness and was written *for* dealing with that uncertainty. Chapter 3 explains James' theory of attention, explores his pragmatism as a shift in attention from uncertainty towards action, and develops the approach of Palliating Uncertainty by uniting James' pragmatism with the ethos and values of palliative care.

As the dissertation develops, the idea of shifting attention from uncertainty towards action is expanded and further nuanced: "attention" is understood dynamically, so that, depending on circumstances, attention can quite properly move back and forth between uncertainty and action; "action" is conceived as taking a stance in the world, which may in some cases mean not actively doing anything; and "uncertainty" is read with sensitivity to context, recognizing, with James, that sometimes attending to uncertainty can be productively action-enabling. Furthermore, just as shifting attention towards action does not simply mean taking action, shifting attention away from uncertainty does not necessarily mean ignoring it. In other words, attention and action are not mutually exclusive; the contrast between them is not absolute.

Part II: Turning Attention to Action discusses the approach of Palliating Uncertainty in the context of five typical cases of uncertainty experienced in end-of-life care. The cases are based on true stories and are more than illustrative; they are primarily constructive. Different cases exhibit different types of uncertainty and different ways in which James' pragmatism can be used to turn attention to action. The use of case studies to advance argumentation is standard practice in medical literature and is the approach James takes in his writing of *Pragmatism.* As is standard practice in medical literature, all cases are anonymized with identifying factors removed, or publicly available, or used with permission.

Part III: Living with Uncertainty seeks a place that acknowledges uncertainty yet still enables a meaningful life. Chapter 4 explores religious/spiritual notions of relationality and mystery in James' thought. I use James' reflections on mysticism and his image of the "anaesthetic revelation" to draw together the three key themes that run throughout this dissertation:

> 1) Managing expectations about uncertainty (embracing the uncertainty inherent in life's mysteries);
> 2) Turning attention to action (recognizing the ability to act in relation to that which is not fully understood);
> 3) Living with uncertainty (through relationship with others).

Chapter 5 culminates in the conclusion that "living with uncertainty" requires "holding uncertainty together" in community, with our patients, with each other, and with communities that extend beyond hospitals and hospices. I suggest that each medical specialty with its own

unique dispositions may have something to contribute to holding uncertainty together. I conclude by suggesting that uncertainty is solved (or, rather, "salved") in the act of living, and I point towards some practical steps forward for integrating Palliating Uncertainty into practice.

Although medicine is heralded as a pragmatic science, little work has been done to apply James' pragmatism to palliative care. In medical literature, the term "pragmatism" is used to refer not to a complex and nuanced philosophy but rather to practical considerations. This is not the case, however, for palliative care physician and uncertainty researcher Paul Han. I respect much in Han and find in him a companion who recognizes the need to find a better way to deal with uncertainty in medicine and sees the potential to use James' philosophy to ground that paradigm shift. His book *Uncertainty in Medicine: A Framework for Tolerance* is based on James' worldview rather than on explicit exegesis, and he limits his most direct engagement with James to a brief section in the conclusion. My work collaborates with Han's in an important way. Based on empirical study, Han has developed useful taxonomies of uncertainty, categorized regulatory responses to uncertainty, and proposed guidelines for managing it. My work on James provides a philosophical groundwork for Han's and justification for the turning of attention towards actions that Han has taxonomized. Han intuits that James' philosophy can provide an important philosophical foundation for his work, and this is what I have set out to do.

This dissertation contributes to 1) medical practice, 2) the field of science and religion, 3) theology, and 4) Jamesian scholarship.

1) My primary objective is to contribute to a cultural shift in medicine by reshaping how we approach and manage uncertainty. I seek to make a practical impact by enhancing the practice of physicians and care of patients, especially those at the end of life. Although primarily written in the context of palliative care, the insights of this dissertation address medicine more broadly. James calls pragmatism "a new name for old ways of thinking" and names tendencies that were always present in philosophy but previously lacked a collective name. In some ways, his pragmatism is also a new name for old ways of thinking in palliative care. His pragmatism articulates its philosophy, highlights effective ways physicians manage uncertainty, serves as a valuable corrective, and offers a practical guide for taking action amid uncertainty. The approach of Palliating Uncertainty is a contribution that is uniquely my own, and my hope is that these tools from the pragmatism of James will help medical practitioners palliate uncertainty in practice.

2) This dissertation, on the whole, is a contribution to the field of science and religion in its medical and pragmatic emphasis. Medicine is underrepresented in the dialogue between science and religion. Most engagement consists of empirical studies on religion/spirituality and health, and even these have been largely neglected by theologians. Many traditional discussions of science and religion gravitate towards the philosophy of physics and epistemological concerns. Uncertainty is a rich field for exploration in science and religion, and this dissertation is a continuous interplay between these fields. Theologian Alister McGrath, in *Why We Believe,*

writes that there is "a long tradition of scientific and philosophic reflection and religious faith which are deeply attuned to the problem of uncertainty, both as a cognitive and existential concern." Of this tradition, James is a significant part. He is a pivotal figure in the field of science and religion. He offers pragmatism as a mediator between science and religion; pragmatism is a philosophy that emerges from his engagement with science and religion, as well as living with the uncertainty of both. Although this dissertation predominantly refers to James' "philosophy," it is important to recognize that religion and spirituality permeate James' thought—and, likewise, this dissertation. In this task of Palliating Uncertainty, I find James' writings that pertain to religion/spirituality extraordinarily helpful, and deep engagement with James' reflections on religion/spirituality opens up useful and often-overlooked relational aspects of his philosophy. Finally, there is an emerging intersection between science and religion in the context of "medical humanities," which involves collaboration among patients, artists, humanities scholars, and health professionals to develop ethical, professional, and humane practice. This dissertation builds bridges between the medical and theological and hence demonstrates the value of theological and religious/spiritual exploration in medical humanities.

3) This dissertation makes a theological contribution in two ways. First, it shows that religion/spirituality has pragmatic utility in a way that is not traditionally approached. One way James describes religion is as "the manner of our acceptance of the universe," meaning a disposition towards the world and its mystery. James' way of engaging with uncertainty recognizes the importance of a form of spiritual openness that resonates profoundly with the dynamics of faith, yet can be shared by religious and non-religious alike. I show how this disposition towards the world, oriented towards relationship and humble before mystery, can make a practical difference to the structures and habits of medical practice, as it can be used to critique, inform, and improve how uncertainty is handled in medicine. After all, recognition of the pragmatic utility of spiritual/religious discourse is something that James appreciated very much. Second, through this shared disposition, this project draws awareness to how uncertainty makes room for the religious/spiritual and the secular to occupy the same space and interact in fruitful and practical dialogue. Many theological projects emphasize certainty, evidence, and proofs in attempts to justify their place in a secular context. I show that uncertainty creates an important space that theology and medicine can share. Finding ways to live with uncertainty is important in both medicine and theology, and both have valuable insights on uncertainty to offer each other.

4) There are many ways to frame James' pragmatism. Reading his pragmatism as a turning of attention from uncertainty towards action is a contribution uniquely my own. Attention is a significant theme in James' psychology and philosophy. He describes his pragmatism as an attitude that changes where one is "looking," and his philosophy repeatedly demonstrates a turn of attention. Yet, to date, there are no Jamesian scholars I am aware of who pick up on this theme and understand his pragmatism as a change in attention. I further contribute to Jamesian scholarship by understanding his philosophy towards uncertainty as a palliative measure. Though James' work has palliative characteristics, this concept has not been employed

previously and is brought out helpfully through engagement between James' philosophy and the practice of palliative care.

Finally, this work holds significance beyond medicine, science and religion, or James' scholarship, because living with uncertainty is a shared part of human experience.

INTRODUCTION

"Medicine is a science of uncertainty…"[2]

William Osler, Father of Modern Medicine (1849-1919)

Though Osler practiced medicine over a century ago, his words remain true of medicine today, especially in palliative (end-of-life) care.[3] As a medical specialty that cares for patients with life-defining (often life-threatening) serious illness, uncertainty is felt acutely because the matters at stake are those of life and death.[4] In palliative care, uncertainty is not confined to any one domain; it courses through the biological, psychological, sociological, and spiritual layers of life and is felt by patients, families, caregivers, and healthcare providers.[5] Yet, in the experience of many, uncertainty is not adequately addressed. Uncertainty is commonly dealt with through avoidance, denial, disregard, indecision, inaction, overtreatment, over-investigation, and overmedicalization.[6] Palliative care is a specialty that aims to alleviate suffering, and much suffering is caused by medical uncertainty and especially by inadequate ways of dealing with it.[7]

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[2] (Osler 1961, p.129)
[3] (Ford, 1998; Greenhalgh, 2013; Han, Klein, & Arora, 2011; Kasper, Geiger, Freiberger, & Schmidt, 2008; Kim & Lee, 2018; McCormick, 2002; McKechnie, MacLeod, & Keeling, 2007; Mishel, 1983; Wittenberg-Lyles, 2016, p.242)
[4] (Karlsson, Friberg, Wallengren, & Öhlén, 2014)
[5] (Arias-Rojas, Carreño-Moreno, & Posada-López, 2019; Brashers et al., 2003; Connolly, Coats, DeSanto, & Jones, 2021; Etkind, Bristowe, Bailey, Selman, & Murtagh, 2017; Etkind et al., 2022; Kimbell, Murray, Macpherson, & Boyd, 2016; Mishel, 1999; Robinson et al., 2021)
[6] (Brashers, 2001; Etkind & Koffman, 2016; Fox, 1980; Fox, 2000; Katz, 1984; Kim & Lee, 2018; Montgomery, 2019; Murray, Boyd, & Sheikh, 2005; Scott, Doust, Keijzers, & Wallis, 2023)
[7] (Brashers, 2001; Donovan, Brown, LeFebvre, Tardif, & Love, 2015; Gramling et al., 2018; Han, 2021; Ngwenya et al., 2021; Ogden et al., 2002; Robinson et al., 2021; Rock, 2025; Simpkin & Schwartzstein, 2016)

The *Textbook of Palliative Care Communication* states that "strategies [to] manage uncertainties are poorly understood" and that "managing uncertainty is one of the most understudied and problematic elements of patient-centered communication" and patient-centered care.[8] Paul Han, a palliative care physician and health-services researcher who specializes in uncertainty, emphasizes the need for a paradigm in medicine that helps patients and healthcare professionals live with uncertainty. Han's quote below highlights the problem that this dissertation seeks to address.

> The ultimate and most challenging task in managing uncertainty is…to help each party cope with uncertainty. We know the least about how to accomplish this task, since past work on this issue has been sparse and largely focused on the provision of information…the real problem is one of managing uncertainty arising from irreducible ignorance, and that this entails much more than filling in knowledge gaps. It requires helping patients—and health professionals—cope with the consciousness of ignorance that cannot be remediated. Such coping implies a deeper, broader acceptance of irreducible uncertainty in life…[9]

Han points to the need for a philosophy in medicine that helps people to live with uncertainty which cannot be "cured." If medicine is a "science of uncertainty," William James' pragmatism is a philosophy for coping and living with uncertainty. James was a nineteenth-century medical doctor who was the father of modern psychology and American pragmatism. Moreover, he was also a patient, and his pragmatism was part of how he dealt with the uncertainty of his medical conditions. How can his pragmatism contribute to an approach to uncertainty in medicine that alleviates the suffering that is caused by uncertainty and helps people to live courageously with it?

[8] (Wittenberg et al., 2015, p.242) references (Decker, Haase, & Bell, 2007; Epstein & Street, 2007; Mishel, 1999; Politi & Street, 2011)
[9] (Han et al., 2011, p.836)

Bringing together James' pragmatism and the ethos of palliative care, I offer an approach to uncertainty that I call "Palliating Uncertainty." In this perspective, uncertainty is not always something to "cure" with more knowledge and technology, but something to palliate and live with.

Background & Context

Personal Context

I am a physician from the United States. I earned my MD at Michigan State University College of Human Medicine, and after completion of this DPhil, I plan to return to the States for residency training with a fellowship in palliative care. Behind this project are questions that my colleagues and I face as physicians, countless conversations about uncertainty with healthcare workers, patients, and families/caregivers, personal experiences of walking alongside those at the end of their lives, and the experience of living with a life-threatening diagnosis myself.[10] In James' pragmatism, I have found resources that offer helpful guidance for living with uncertainty, and I have written this dissertation to share these with other medical practitioners.

Key Concepts & Definitions

Palliative care, according to the World Health Organization (WHO), is a medical specialty that "improves the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether physical, psychological, social or spiritual…"[11] I focus on end-of-life care, even though palliative care covers more than that (for example, pain management). Palliative care involves "active total care" of both patients and

[10] (Dempsey, 2020; Fox, 1980, p.2)
[11] (WHO, 2020)

their families by multidisciplinary teams.[12] Relationships are recognized as central to healing, and non-abandonment in the midst of that which cannot be cured is one of its pillars.[13] The spirit of palliative care is captured in the words of its founder, Dame Cicely Saunders: "You matter because you are you. You matter to the last moment of your life, and we will do all we can to help you not only to die peacefully, but also to live until you die."[14] This quote describes palliative care at its best. In the complexities of healthcare, there are times when palliative care falls woefully short of its aims. What is of note, however, is the specialty's distinctive ethos. In palliative care, there is less attention on "curing" disease, since this is not possible, and more on the patient and what can be done to alleviate their symptoms and help them live meaningfully with their incurable conditions. This ethos of palliative care has an important contribution to how we approach uncertainty in medicine.

Pragmatism is a philosophy that is oriented towards practice and action.[15] Contrary to what is commonly assumed in medical literature, "pragmatism" is not synonymous with the word "practical." Pragmatism emerged in America at the end of the nineteenth-century among a group of thinkers (Charles Peirce, William James, John Dewey, etc.) and received renewed interest at the end of the twentieth century among neo-pragmatists (Richard Rorty, Hilary Putnam, etc.).[16] In this dissertation, I engage with James' pragmatism, not as a theory of truth, but as an attitude of orientation.[17] The aspect of pragmatism that is central to this dissertation is a shift in the direction of attention. James describes the pragmatic method as "the attitude of looking away from first things, principles, 'categories' supposed necessities; and of looking

[12] (Twycross, 2003, p.9)
[13] (Twycross, 2008, 2022a; Twycross, Wilcock, & Toller, 2021, pp.11-12)
[14] (Saunders, 2006, p.137)
[15] (Malachowski, 2013, pp.1, 11)
[16] (Bacon, 2012)
[17] (James, 2008ai, pp.32-33; Putnam & Putnam, 2017, p.108-120)

towards last things, fruits, consequences, facts."[18] In this dissertation, I propose that James responds to uncertainty by turning attention to action—from uncertainty towards what we can actually do. The following quote from Osler serves as an apt example of the attitude of pragmatism: "Our task is not to see what lies dimly at a distance but to do what lies clearly at hand" (Chapter 3).

Uncertainty is far more easily recognized than defined. The *Oxford English Dictionary* defines uncertainty as "the state of being uncertain,"[19] and "uncertain" is defined as something "about which one cannot be certain or assured,"[20] a "feeling doubt about something, not sure."[21] Uncertainty is sometimes characterized as a known unknown.[22] Oncologist and medical philosopher Benjamin Djulbegovic, for example, describes uncertainty as a "lack of information."[23] In "Uncertainty and Medicine: An Active Definition," Erman Sozudogru defines uncertainty as a "subjective experience of the gaps in our knowledge" and makes the important point that uncertainty is felt strongly when it affects our ability to act or to know what to do.[24] Like Sozudogru, I focus on the experience of uncertainty (especially as it relates to action), but I think uncertainty is more than an experience of "gaps in knowledge."

Many definitions of uncertainty show an overly cognitive emphasis. Han, for example, defines uncertainty as "metacognitive awareness of ignorance."[25] Although James does not explicitly define uncertainty, he does present a more complicated, embodied, and affective picture in which "our deepest organ of communication with nature of things" is far more than cognitive.[26] Uncertainty is embodied in actions, affections, and (for James) even in the subconscious and

[18] (James, 2008ai, p.32)
[19] (OED, 2024)
[20] Ibid.
[21] (OLD, 2024)
[22] (Han, 2021, p.15)
[23] (Djulbegovic, Hozo, & Greenland, 2011, p.302) quotes (Zimmermann, 2000, p.192).
[24] (Sozudogru, 2022, p.329)
[25] (Han, 2021, pp.24, 12-30)
[26] (James, 2008q, p.55)

the soul, and as such, its management requires a more than metacognitive solution. In defining uncertainty, Han references a comment by James in his essay "The Will to Believe" (WtB). "Of some things, we feel that we are certain: we know, and we know that we do know."[27] Han inverts James' comment and reasons that if certainty is "knowing that we know," then uncertainty must be "knowing that we don't know."[28] In the quote above, Han emphasizes the word "know," whereas I emphasize the word "feel." I place less attention on constructing a definition of uncertainty and, following the move that James makes in "The Sentiment of Rationality (SoR)," look more to recognizing uncertainty by its effects. In "SoR," James depicts rationality as elusive to definition but recognizable by "certain subjective marks." A person "recognize[s] [the rationality of a conception] as he recognizes everything else, by certain subjective marks with which it affects him. When he gets the marks, he may know that he has got the rationality."[29] Similarly, I think uncertainty, whatever the definition, is also recognized by subjective marks. Some of these marks James describes as strong feelings of dis-ease, un-peace, and unrest.[30] Positive experiences could be added to this list, such as excitement and hope.[31]

There are many taxonomies of uncertainty in clinical medicine. Some types of uncertainty can be approached as theoretical quantifications of unpredictability and risk through the application of probability—for instance, various decision theories, Bayesian probabilities, predictive algorithms, statistical methods, and risk calculators.[32] However, given the diverse sources and types of uncertainty, the increasing realizations of the limitations of scientific evidence, and

[27] (James, 2008ax, p.21)
[28] (Han, 2021, p.15)
[29] (James, 2008ao, p.57)
[30] (Ibid., p.57)
[31] (Han, 2021, pp.5-6)
[32] (Albert, 1978; Ashby & Smith, 2000; Cohen et al., 1987; Djulbegovic et al., 2011, pp.302-303; Dziadzko, Gajic, Pickering, & Herasevich, 2016; Manuel, Rosella, Hennessy, Sanmartin, & Wilson, 2012; Medow & Lucey, 2011)

the plurality of alternative care options, communicating uncertainty in terms of probabilistic risk is not always appropriate.[33] Furthermore, my interest is in experiences of uncertainty that are often elusive to such tools. Practically speaking, there is uncertainty that can be reduced through the acquisition of more knowledge and uncertainty that cannot. I am interested in uncertainty that cannot be "fixed" but can be accepted and lived with (Chapter 1).

Historical Context

In her pioneering studies on medical uncertainty, sociologist Renée Fox outlined three basic types of uncertainty: one that results from "incomplete or imperfect mastery of available knowledge," another from "questions to which no physician, however well trained, can as yet provide answers," and the third from the difficulty of distinguishing between the two.[34] Since Fox's work in 1957, there have been many developments in taxonomies of uncertainty. For instance, through studies in nursing, Merle Mishel identified four dimensions of patients' experiences of uncertainty in illness: ambiguity, complexity, deficient information, and unpredictability.[35] General practitioner Trisha Greenhalgh offers a four-part taxonomy based on her experiences in primary care: uncertainty regarding evidence-based medicine (EBM), narrative medicine, case-based reasoning, and multi-professional care.[36] Han synthesizes many uncertainty taxonomies by visualizing uncertainty across three fundamental dimensions: source (informational or conceptual), issue (scientific, practical, or personal), and locus (the person in whose mind the uncertainty resides).[37]

[33] (Scott et al., 2023, p.424)
[34] (Fox, 1957, pp.208-209)
[35] (Mishel, 1983, p.361)
[36] (Greenhalgh, 2013)
[37] (Han, 2021, pp.31-58)

The taxonomies acknowledge types of uncertainty that can be reduced through the acquisition of knowledge, such as Fox's "incomplete or imperfect mastery of available knowledge." However, as discussed in depth in Chapter 1, in each taxonomy, there are also instances of uncertainty that are unresolvable because their root is the finitude of being human. Han's taxonomy, for instance, lists inevitable ontological and epistemic root causes of uncertainty:[38] indeterminacy—lack of a definitive or fixed outcome or result;[39] intractability—resistance of a problem to human comprehension and control;[40] and indeterminability—inability to establish a definitive or fixed outcome, result, or answer.[41] As palliative care comes to the finitude of human mortality, so uncertainty comes to the finitude of human knowledge. Some types of uncertainty run deep. Like a life-defining illness, these uncertainties cannot be cured but can be palliated and lived with.

Paul Ramsey, theologian and a founding figure in the field of medical ethics, once said, "The function of medicine is not to relieve the human of the human condition."[42] When the only framework of medicine is one of problem-solving and "fixing," uncertainty becomes characterized as a problem to be solved. Harvey Chochinov, a psychiatrist who specializes in care for cancer patients, points out that in the standard medical paradigm, we "examine, diagnose, and fix."[43] If the pathology is found, then maybe the cure can be found, too. But what if the pathology ends up being the human condition itself? James' philosophy does not "fix" uncertainty with more knowledge and certitude. Like those who undertake palliative care, he shifts attention to what we can do even when the underlying problem cannot be resolved. Palliative care challenges dominant medical paradigms and reframes death as a normal part of

[38] (Ibid., p.39)
[39] (Ibid., p.41)
[40] (Ibid., p.45)
[41] (Ibid., p.43)
[42] (Sulmasy, 1997, p.33) quotes Paul Ramsey
[43] (Chochinov, 2023c, p.2885)

human life that must be adapted to.[44] James likewise reframes uncertainty as a normal and vital part of life.[45] His pragmatism is an invitation to be honest about uncertainty, to act in the midst of it, and to live courageously with it.

Research Problem & Objectives

Problem Statement

Physician David Eddy writes,

> Uncertainty creeps into medical practice through every pore. Whether a physician is defining a disease, making a diagnosis, selecting a procedure, observing outcomes, assessing probabilities, assigning preferences, or putting it all together, he is walking on very slippery terrain. It is difficult for nonphysicians, and for many physicians, to appreciate how complex these tasks are, how poorly we understand them, and how easy it is for honest people to come to different conclusions.[46]

Despite the constancy of uncertainty in medical practice, uncertainty is rarely spoken about or acknowledged. We spend a lot of time in end-of-life care talking about doses of opiates and pregabalins and how to help patients and families find meaning at the end of life, but we do not talk about uncertainty and how we deal with it. In the words of palliative care physician Sunita Puri in her book, *That Good Night,* "medicine must find new language to discuss and destigmatize this experience that all of humanity shares; our silence and avoidance have resulted in much unnecessary anguish."[47]

[44] (Merino, 2018; Watson, 2019, pp.xxv-xxxii)
[45] (Croce, 1995, pp.225-231; Han, 2021, pp.135-139)
[46] (Eddy, 1984, p.75)
[47] (Puri, 2020, p.xiii)

I wish to address the need for a paradigm in medicine that helps patients and healthcare professionals to live with uncertainty, especially uncertainty that cannot be "cured." Han writes,

> Although medical uncertainty is an extremely important problem to understand and manage, its pervasiveness, complexity, and ambiguity lead us to disregard it. We focus our attention on the objective gaps in our knowledge rather than our subjective experience of these gaps...This systemic disregard has important self-reinforcing consequences. It leads us to treat medical uncertainty as a pathological condition to be eradicated through the pursuit of knowledge, rather than a normal state of being to be accepted and managed through other means. It focuses our efforts on curing uncertainty, rather than palliating its effects.[48]

Three points emerge from the quote above regarding medical uncertainty:

- Uncertainty is often denied and disregarded even though it is pervasive and a source of much suffering.
- People manage medical uncertainty by focusing on gaps in knowledge and attempting to "fix" uncertainty through the acquisition of more knowledge. Other approaches for dealing with uncertainty may be disregarded or ranked as of secondary importance.
- Many medical professionals view uncertainty is often viewed as a "pathological condition to be eradicated." Attention is on "curing" uncertainty through knowledge and technology rather than palliating its effects and helping people to live with irreducible uncertainty.

James' pragmatism speaks directly to these three points, which lead to three key themes that run throughout this dissertation (see discussion of structure).

[48] (Han, 2021, p.7)

1) Managing expectations about uncertainty: James' pragmatism is a philosophy in which uncertainty, rather than certainty, is the starting point. His pragmatism challenges medicine to normalize uncertainty with honesty and humble acknowledgement.

2) Turning attention to action: James challenges the assumption that having more knowledge "fixes" uncertainty and that evidence and certainty must be guaranteed before action. Addressing gaps in medical knowledge is important but does not always alleviate the suffering of uncertainty. In a pragmatic approach to uncertainty, efforts are focused on palliating the effects of uncertainty in a plurality of ways. James' pragmatism turns attention from uncertainty towards action. The Latin root of the word "palliate" is to cloak.[49] This turn towards action does not "cure" uncertainty but "palliates," i.e., cloaks it—not just in the sense of "conceal" or "hide," but in the sense of "cover," "comfort," and alleviate the suffering caused by uncertainty so that a person can get on and live a life that is meaningful according to their values.

3) Living with uncertainty: James provides a paradigm in which uncertainty is to be accepted and lived with courageously.[50] He acknowledges, however, that response to uncertainty is largely a matter of temperament[51] and that a person cannot be asked to be courageous all the time.[52] In James' pragmatism (and especially in the spiritual/religious elements of his thought), uncertainty is not carried alone but held together in community.[53] For James, uncertainty is not just something to fight; indeed, it can even be part of what makes life worth living.

[49] (Twycross, 2003, p.9)
[50] (James, 2008q, pp.55-56)
[51] (James, 2008ai, pp.11-13)
[52] (Gavin, 2013, pp.109, 113; James, 2008p, pp.61-63; 2008ab, p.124)
[53] (James, 2008ai, pp.142-145; 2008ap, pp.115-116)

Research Questions & Hypotheses

"What can James' pragmatism teach us about uncertainty? How can we better deal with it, how can we help our patients deal with it, and how can we learn to accept it and even live with it ourselves?"[54] These were the questions that the Association of Palliative Medicine asked me to address as the plenary speaker for the 2023 UK Palliative Care Congress.[55]

Palliating Uncertainty, which is an approach developed through this dissertation, emerges from James' pragmatism and is modelled after the ethos of palliative care. The approach can be used to address the three themes listed above.

1) Managing expectations about uncertainty: This approach humbly and honestly acknowledges uncertainty, expects it, and accepts it as a normal part of medical practice (Chapter 1).

2) Turning attention to action: In this approach, we do what we can to limit uncertainty, but the goal is not to remove uncertainty. The goals of Palliating Uncertainty are to alleviate the suffering that uncertainty causes and help people to live—even flourish—in the midst of it. Attention shifts from uncertainty to the person and the diverse ways we can care for them. In practice, it might look like saying, "Honestly, here is what we don't know." "Here is what we can do." "I and my team will be with you through this." After all, accepting that there are things we cannot fix and staying alongside our patients is at the heart of end-of-life care (Chapter 3).

[54] Personal records
[55] (Dempsey & Mulder, 2023a)

3) Living with uncertainty: Like James' pragmatism, this approach to uncertainty is deeply relational. Yes, uncertainty causes suffering, but as we step into uncertainty with our patients, the uncertainty can become transformed to become part of the healing. We do not carry the weight of uncertainty alone but hold uncertainty together with our patients and their families, multidisciplinary teams, other healthcare practitioners, medical systems, and with communities beyond hospitals and hospices (Chapter 5).

Objective

My objective is to bring together James' pragmatism and palliative care to help transform how uncertainty is approached in medicine, on the whole. This is not to say that palliative care is the only specialty that deals with uncertainty or has insights to offer. Each specialty with its own temperamental dispositions has something to contribute to the better management of uncertainty. This, too, is part of holding uncertainty together (Conclusion).

Significance of the Study

Rationale

This work has significant implications for medicine and, if put into practice, will have practical outcomes in patient care. My hope is to support healthcare practitioners as they navigate uncertainty, help alleviate the suffering experienced by patients and their families, and inspire a shift in how uncertainty is approached in medicine more broadly. Already, this work has been well received and is making a difference in medical care.

James writes, "Pragmatism asks its usual question. 'Grant an idea or belief to be true,' it says, 'what concrete difference will its being true make in anyone's actual life?'"[56] This work

[56] (James, 2008ai, p.97)

addresses a widely felt yet unaddressed issue and has the potential to make a concrete difference in medical practice and in the "actual lives" of patients and practitioners. James sought to craft a philosophy that was useful for life.[57] This project, which draws on pragmatism to make a concrete difference, in some ways, is a continuation of James' work.[58]

In the last three years of his life, James greatly supported the cause of Clifford Beers, a young man who suffered from mental illness and was campaigning for the reform of mental asylums and for the transformation of how mental health was understood in society.[59] In a letter of praise to Beers, James writes,

> [I]t 'sets me up' immensely to be treated by a practical man on practical grounds as you treat me. I inhabit such a realm of abstractions that I only get credit for what I do in that spectral empire…and to have actually done anything that the like of you can regard as having helped him is an unwonted ground with me for self-gratulation.[60]

Beers drew on James' work to campaign for practical reforms in the medical care of the mentally ill. I hope to draw on James' work to make practical reforms in the medical care of the terminally ill and thereby continue James' project of constructing a philosophy that is useful for life.

[57] (Putnam & Putnam, 2017, pp.108-120, 225-231)
[58] (James, 2008j, p.81; 2008ai, p.30)
[59] (Sutton, 2023, pp.160-166)
[60] (bid., p.164)

Contributions

Contributions to Medicine

My primary objective is to contribute to a cultural shift in medicine by reshaping how we approach and manage uncertainty. I seek to make a practical impact by enhancing the practice of physicians and the care of patients, especially the care of those at the end of life.

Although written primarily in the context of palliative care, the insights of this dissertation address medicine more broadly. James calls pragmatism "a new name for old ways of thinking," as he names tendencies that have always been present in philosophy but previously lacked a collective name.[61] In some ways, his pragmatism is also a new name for old ways of thinking in palliative care. His pragmatism articulates its philosophy, highlights effective ways physicians manage uncertainty, serves as a valuable corrective, and offers a practical guide for taking action amid uncertainty. The approach of Palliating Uncertainty is a contribution uniquely my own, and my aim is that these tools from the pragmatism of James will help medical practitioners palliate uncertainty in practice.

Han writes the phrase "palliating uncertainty" in his book *Uncertainty in Medicine: A Framework for Tolerance* (*UM:FT*), but I did not derive this phrase from him and use it in a different sense. For Han, "palliating uncertainty" means "ameliorating the negative psychological effects of uncertainty."[62] By "Palliating Uncertainty," I mean shifting the paradigm for approaching uncertainty to one modelled on the ethos of palliative care and the pragmatism of James.

[61] (James, 2008ai, pp.5, 29)
[62] (Han, 2021, pp.126-129)

Contributions to Science & Religion

Many consider the relationship between science and religion problematic. A 2015 public opinion survey by the Pew Research Center reported that nearly 60% of American adults said that science and religion were often in conflict.[63] A similar narrative of conflict between science and religion exists in medicine. In a study entitled "When Patients Choose Faith Over Medicine: Physician Perspectives on Religiously Related Conflict in the Medical Encounter," palliative care physician Farr Curlin et al. found three settings in which there was a perceived conflict between medicine and religion. These were: settings in which religious doctrines directly conflicted with medical recommendations, e.g., a Jehovah's Witness refusing a blood transfusion on religious grounds; those that involved an area in which there was extensive controversy within broader society, e.g., different worldviews between physicians and patients in controversial areas such as end of life; and those in which there was relative medical uncertainty and patients "choose faith over medicine."[64] Importantly, the study revealed that conflicts between medicine and religion occurred most often in the context of the end of life and in the context of uncertainty. Yet a pragmatic shift in attention would turn the focus from the question "Do science and religion conflict?" to the question "How can science and religion be brought together in a fruitful way?" How can science and religion enhance life at a nexus of their conflict, in the uncertainty of end-of-life care?

Medicine is a field that is underrepresented in the dialogue between science and religion. Most engagement has consisted of empirical studies on religion/spirituality and health,[65] and even these have been largely neglected by theologians.[66] Medicine has a rich religious and philosophical tradition, as well as a unique perspective from the standpoints of practical

[63] (Pew, 2015)
[64] (Curlin, Roach, Gorawara-Bhat, Lantos, & Chin, 2005)
[65] E.g., (Koenig, King, & Carson, 2012)
[66] (Oviedo, 2023, p.85)

engagement and lived experience. Many traditional discussions in the field of science and religion gravitate towards the philosophy of physics and epistemological concerns (for instance, John Polkinghorne and his notion of verisimilitude).[67] This dissertation is a contribution to the field of science and religion in its medical and pragmatic emphasis.

This dissertation explores uncertainty through a continuous interplay between both science and religion. Alister McGrath, emeritus Andreas Idreos Chair of Science and Religion at the University of Oxford, reflects that there is "a long tradition of scientific and philosophic reflection and religious faith which are deeply attuned to the problem of uncertainty, both as a cognitive and existential concern."[68] James stands as a key figure within this tradition, playing a crucial role in the intersection of science and religion. His philosophy of pragmatism functions as a bridge between the two, emerging from his deep engagement with both disciplines and the uncertainties they entail.

Finally, an important contemporary intersection of science and religion can be found in the field of medical humanities, which fosters collaboration among patients, artists, humanities scholars, and healthcare professionals to cultivate ethical, professional, and compassionate medical practice.[69] This dissertation builds connections between medicine and theology, demonstrating the significant contributions of theological and religious/spiritual inquiry to the field of medical humanities.

[67] (Polkinghorne, 2005, pp.3-4)
[68] (McGrath, 2025, p.218)
[69] (Bleakley, 2015). See (FI, 2024)

Contributions to Theology

This dissertation makes a theological contribution in two ways. First, it shows that religion/spirituality has pragmatic utility in a way that is not traditionally approached. One way James describes religion is as "the manner of our acceptance of the universe," meaning a disposition towards the world and its mystery.[70] James' way of engaging with uncertainty recognizes the importance of a form of spiritual openness that resonates profoundly with the dynamics of faith, yet can be shared by religious and non-religious alike. I demonstrate how this relational and humble disposition towards mystery can make a practical difference to the structures and habits of medical practice, as it can be used to critique, inform, and improve how uncertainty is handled in medicine. After all, recognition of the pragmatic utility of spiritual/religious discourse is something that James appreciated very much.[71]

Second, through this shared disposition, this project increases awareness of how uncertainty enables the religious/spiritual and the secular to occupy the same space to interact in fruitful and practical dialogue. Above, I asked how science and religion could come together in a fruitful way. James critiques dogmatic claims to certainty in both science and theology.[72] In contrast to a tendency in theology to find critical grounding in certainty, evidence, and proof,[73] this dissertation demonstrates, through the use of James' philosophy, how uncertainty resides at the heart of theological faith and lived experience and creates a space in which religious and nonreligious faith can share a common ground. Philosopher Richard Swinburne's exploration of the philosophy of science led him to apply the inductive method and Bayesian probabilities to religious questions, believing they offered the strongest foundation for confidence.[74] In

[70] (Jamesav, 2008av, p.42)
[71] (Ibid.)
[72] (Carrette, 2013, pp.164, 168-174)
[73] See (Lennox, 2024)
[74] (Swinburne, 2004)

contrast, my study of medical science has led me in the opposite direction—towards an appreciation of the inherent uncertainty in both science and religion and the recognition that, even in uncertainty, life can still be lived meaningfully. Finding ways to live with uncertainty is important in both medicine and theology, and both have valuable insights to offer each other.

Although this dissertation primarily engages with James' philosophy, it is essential to acknowledge the pervasive influence of religion and spirituality in his thought—and, by extension, in this work.[75] James' writings on religion and spirituality are particularly valuable for addressing uncertainty, and a close examination of these reflections reveals often-overlooked relational dimensions of his philosophy. James also highlights the significance of faith, both secular and religious, as a fundamental aspect of human experience. He explores how reflections on religion/spirituality can contribute to a deepened understanding of faith in the secular world while also showing how secular perspectives can, in turn, enrich insights into the dynamics of faith. McGrath concludes his work *Why We Believe: Finding Meaning in Uncertain Times* with a chapter entitled "Living in a World of Uncertainty," and highlights the potential of the pragmatist tradition—specifically invoking James—as a way forward for navigating the uncertainty of life and faith.[76] (See also "Why Faculty of Theology: Science and Religion?").

Contributions to Jamesian Scholarship

There are many ways of framing James' pragmatism. Understanding his pragmatism as a turn of attention from uncertainty towards action is a contribution uniquely my own. Attention is a significant theme in James' psychology and philosophy. James describes his pragmatism as an

[75] (Carrette, 2013; Hollinger, 2004, 2014; Levinson, 2016; Oliver, 2001; Zehnder, 2010)
[76] (McGrath, 2025, pp.215-230)

attitude which changes where one is “looking,” and repeatedly, his philosophy demonstrates a change in the direction of attention. Yet to date, no Jamesian scholars that I am aware of have picked up on this theme and understood his pragmatism as a change in attention. I also contribute to Jamesian scholarship by understanding his philosophy towards uncertainty in terms of palliation. Although James’ work has palliative characteristics, this concept has not been employed, and it is brought out helpfully through engagement between James’ philosophy and the practice of palliative care.

This work is primarily intended for medical professionals, but I anticipate that it will also interest James scholars, as it makes a significant contribution to the practical application of James' thought. When James scholar and historian Emma Sutton was asked to recommend a recent work for the Society for the Advancement of American Philosophy, she recommended mine on the application of James’ pragmatism to palliative care.[77] In personal correspondence, Phil Oliver, president of the William James Society, comments on this work, “It's so gratifying to see WJ's philosophy being applied widely and creatively. *He* would be gratified.”[78] I hope that this project will inspire others to apply James’ rich work on uncertainty in other fields.

Finally, this work holds significance beyond medicine, science and religion, or Jamesian scholarship, as living with uncertainty is a shared part of human experience.

[77] (Sutton, 2024)
[78] Personal records

Literature Review Summary

A cursory skim of the *Oxford Handbook of William James*[79] or the *Cambridge Companion to William James*[80] reveals the extent to which uncertainty is a central motif of James' work. Paul Croce explores the decline of certainty in science and religion in the nineteenth-century through the lens of James' thought. He highlights how the application of James' pragmatism provides ways to navigate uncertainty in an increasingly uncertain world.[81] W. Leonhirth expounds on the "uncertain universe" of James' philosophy and how his pragmatism embraces uncertainty as an inherent and constructive part of the human experience.[82] Similarly, Andrea Knutson speaks of the "uncertain universe" of James' theology and the dynamic relationships between science, theology, and human experience in *The Varieties of Religious Experience* (*VRE).*[83] Arthur Petersen, in an article entitled "Uncertainty and God: A Jamesian pragmatist approach to uncertainty and ignorance in science and religion,"[84] emphasizes that uncertainty is central to both scientific and religious practices, particularly in fostering creative agency and evoking emotions of wonder. John Kaag, in *Sick Souls and Healthy Minds: How William James Can Save Your Life,* reveals pragmatism's practical utility for daily life and usefulness for decision-making in conditions of distress and uncertainty.[85] James' philosophy regarding uncertainty has been applied in scientific fields such as quantum mechanics, particularly with a focus on indeterminacy, chance, and free-will.[86] John Bishop highlights how James' approach to uncertainty has theological applications. He argues for a pragmatic approach to belief and suggests that commitment, even in the absence of certainty, is rational and justified, and that

[79] (Klein, 2024)
[80] (R. Putnam, 1997)
[81] (Croce, 1995)
[82] (Leonhirth, 2001)
[83] (Knutson, 2010)
[84] (Petersen, 2014)
[85] (Kaag, 2020b)
[86] (Doyle, 2010; Kožnjak, 2018)

beliefs can provide meaningful frameworks for navigating life's uncertainties.[87] McGrath also appeals to James and reaches a similar conclusion in *Why We Believe: Finding Meaning in Uncertain Times.*[88]

In Jamesian scholarship, little attention is drawn to James' identity as a medical doctor and how suffering, illness, and health shaped his approach towards uncertainty.[89] Sutton's groundbreaking biographical work, *William James, MD: Philosopher, Psychologist, Physician (WJ,MD),* demonstrates the centrality of medical interests in James' thought.[90] James' insights in this field, however, still require integration into clinical practice.

Few medical scholars refer to pragmatism as a complex and nuanced philosophy; rather, they tend to conflate the words "pragmatic" and "practical."[91] There is some discussion of pragmatism within the philosophy of medicine, specifically in debates about nosological realism/antirealism (study of the classification of disease),[92] as well as in research paradigms,[93] health policy,[94] nursing,[95] social work,[96] and bioethics.[97] There has been little application of the distinctive contours of James' pragmatism to medicine, and most of what does exist has been limited to psychiatry—a specialty with a well-developed philosophy of medicine and a particular interest in James as a psychologist.[98] Although most references to James pertain to

[87] (Bishop, 2007) See (Grube, 2004)
[88] (McGrath, 2025, pp.216-230)
[89] (Sutton, 2023, pp.14, fn.14)
[90] (Ibid., pp.1-3)
[91] (Greenhalgh & Engebretsen, 2022, p.2) E.g., (Dal-Ré, Janiaud, & Ioannidis, 2018; Duenk et al., 2017; Farris et al., 2023; Sage, 2001; Stiefel, Trill, Berney, Olarte, & Razavi, 2001; D. R. Sullivan, Iyer, & Reinke, 2023; Wiles, Payne, & Jarrett, 1999)
[92] (Ghaemi, 2012; Livingstone-Banks, 2018; Zachar, 2012)
[93] (Allemang, Sitter, & Dimitropoulos, 2022; Biddle & Schafft, 2014; Goldenberg, 2009; Karanicolas, Montori, Devereaux, Schünemann, & Guyatt, 2009; Long, McDermott, & Meadows, 2018; Morgan, 2014)
[94] (Ansell & Boin, 2019; Greenhalgh & Engebretsen, 2022; Wolf, 2018)
[95] (Doane & Varcoe, 2005)
[96] (Berringer, 2019)
[97] (Arras, 2003; Bellantoni, 2003a; Inguaggiato, Metselaar, Porz, & Widdershoven, 2019; Johnson, 2021; Mallia & Have, 2005; McGee, 2003; Tollefsen & Cherry, 2003)
[98] (Fulford, Davies, et al., 2013) See (Borden, 2021; McWilliams, 2009; Paulus, 2017; Zachar, 2014)

the fields of psychiatry and psychotherapy, bioethicist Micah Hester has applied James' radical empiricism to ethical questions of physician-assisted suicide.[99] Few sources, however, apply James' thoughts to end-of-life care.

Han sees the potential for James' philosophy to ground a paradigm shift in the approach to uncertainty in medicine. His book, *UM:FT*, is based on James' worldview rather than on explicit exegesis, and he limits his most direct engagement with James to a brief section in the conclusion.[100] Han contributed a chapter titled "Uncertainty in Healthcare" to *A Pragmatic Agenda for Healthcare,* by Sarah Bigi and Maria Grazia Rossi.[101] Notably, this work focuses on *pragmatics*—the study of speech acts and the interpretation of meaning in communication contexts—rather than *pragmatism*.[102] The book does not reference pragmatism as a philosophical tradition or James. Instead, it emphasizes "pragmatic meaning and interpretation within healthcare communication."[103]

Han is a significant dialogue partner throughout this dissertation, and it is worth briefly highlighting some continuities and discontinuities between his thoughts and mine. Han's extensive empirical research provides a foundation for my work. I highly respect Han and consider him a companion who also recognizes the need to find a better way to deal with uncertainty in medicine and who sees the potential to use James' philosophy to ground that paradigm shift.[104] Through our separate readings of James and experiences in palliative care, we have both independently come to the conclusion that the paradigm in medicine can be expanded from one that is focused solely on "curing" uncertainty by pursuing knowledge to

[99] (Hester, 2009)
[100] (Han, 2021, pp.131-136)
[101] (Han, 2023b)
[102] (Bigi & Rossi, 2023, p.2)
[103] (Ibid., p.398)
[104] (Han 2021, p.131-136)

one that also palliates uncertainty and is focused on helping people to live with uncertainty.[105] Han and I both draw themes of humility and courage from James' work, although we arrived at these separately.

My work collaborates with and adds to Han's in an important way. Based on empirical study, Han has developed useful taxonomies of uncertainty, categorized regulatory responses to uncertainty, and proposed guidelines for managing it.[106] My work on James provides philosophical groundwork to direct attention towards actions that Han has taxonomized. Han intuits that James' philosophy can provide an important philosophical foundation for his work, and this is exactly what my work sets out to do.

UM:FT is based on the worldview of James. Han interacts with James through passing quotes, broad sketches, and underlying influence, explicitly engaging with James at the end of his concluding chapter.[107] For the purposes and audience for which Han wrote his book, this level of engagement with James is sufficient; however, there is opportunity for more rigorous philosophical investigation. I respect the provisionality with which Han puts forth his framework as fallible and open to revision. My critique is that his work could be more pragmatic and more palliative.

Han and I agree that a shift is needed from an exclusive focus on "more knowledge" as a solution to uncertainty. Yet, Han still seems drawn towards a focus on knowledge in his definition of uncertainty and its management. Han defines uncertainty as a cognitive problem and, consequently, his solution inclines towards a cognitive approach. He encourages medical

[105] (Ibid., p.133)
[106] (Han et al., 2011; Medendorp et al., 2021)
[107] (Han 2021, p.131-136)

practitioners to expand their responses to uncertainty to include "response-focused" and "person-focused," "palliative" management strategies, yet his work employs primarily "ignorance-focused" and "uncertainty-focused" strategies such as taxonomies. Han is a physician who has been socialized into a medical culture, and in some ways, his thinking reflects the culture that he critiques.

Han and I both criticize a culture in medicine that "focuses our efforts on curing uncertainty, rather than palliating its effects. "[108] Yet, Han models his framework for managing uncertainty after the medical model of disease management, not after palliative care.[109] I agree with Han that there must be greater emphasis on palliative approaches to uncertainty. I therefore propose to provide a palliative care-based model for the management of uncertainty. In short, Han advocates for "uncertainty tolerance;" I advocate for "uncertainty palliation."

Methodology Overview

Why Palliative Care?

Palliative care revolves around uncertainty (Chapter 1). As a specialty that cares for patients with conditions that cannot be cured, palliative care has a distinctive ethos. The focus is on the person and what can be done to address their symptoms and help them live meaningfully with their condition. Hence, I propose that palliative care can provide insight regarding the alleviation of suffering and ways to live with the incurable but palliatable conditions of uncertainty.

[108] (Ibid., p.7)
[109] (Ibid., p.97-108)

Why James?

James is commonly known as a physiologist, psychologist, philosopher, and even mystic. It is less commonly recognized that he was a doctor. Sutton, in *WJ,MD,* argues that the "element of James' life and work that unites his disparate identities" is his interest in medicine.[110] Her investigation of 9,400 letters, James' unpublished notebooks, his diaries and reading lists led her to the conclusion that "James' medical interests, concerns and values are the threads that bind many of his seemingly unconnected pursuits together. They are the warp and weft of many of his best-known publications and major lines of thought."[111]

Sutton has brought to light the influence of ill-health on James' philosophy. From early adulthood, James self-identified as an "invalid."[112] His private letters contain references to a vast scope of medical problems, neurasthenia, chronic back pain, poor eyesight, chronic gastric and digestive problems, heart problems, melancholia, and depression so severe that he contemplated suicide. James suffered chronically from conditions that could not be cured and the uncertainty of living with such conditions.

Many of James' major publications were written in the last decade of his life when his health was especially poor and his future uncertain. In the autumn of 1899, James began to suffer from severe heart problems with angina, shortness of breath, and fatigue. Much of the 1901-1902 *VRE* was written while James lay sick in bed, and at times, his illness meant that he could only work on the lectures for two or three hours a day.[113] In 1907, he delivered his *Pragmatism* lectures at the Lowell Institute at Columbia University in Boston, US. In the same year, he resigned from Harvard because his health was so poor that he was worried he might die before

[110] (Sutton, 2023, p.1)
[111] (Ibid., pp.1-3) See (Ibid., p.6)
[112] (Sutton, 2011, p.389)
[113] (Putnam & Putnam, 2017, p.202)

he had completed his philosophical work. James passed away three years later. In both James' experiences and philosophy, there is real pain, real suffering, and real uncertainty.[114] Philosopher Charles Taylor calls James "the great philosopher of the cusp. He tells us more than anyone else about what it's like to stand in that open space and feel the winds pulling you now here, now there."[115] Furthermore, for James, such sufferings and uncertainties "may after all be the best key to life's significance, and possibly the only openers of our eyes to the deepest levels of truth."[116]

Pragmatism is heralded as a philosophy for life. James' version is also a philosophy that emerges from a life entangled with uncertainty and suffering. In some ways, James wrote for himself—his philosophy was his therapy.[117] His philosophy not only emerged out of uncertainty but was his way of dealing with it. James wrote for himself, but he also wrote for others facing suffering and trying to cope with uncertainty. As Sutton writes,

> Ultimately,…what mattered to James above all else was the practical efficacy of the ideas he unearthed…and, to a significant extent, their value to the general, nonacademic audience to whom many of his writings were addressed. James's intellectual pursuits were born of everyday experiences and frequently offered as solutions for the everyman. He may never have practiced as a doctor in the traditional sense, but throughout his life James remained, at heart, a public physician.[118]

In 1869, James graduated from Harvard Medical School as an MD, but his ill-health prevented him from practicing.[119] Yet, he was a doctor who left behind a philosophy that is helpful for those who cannot be cured. Perhaps the hard-won insights of his philosophy are not curative

[114] (James, 2008av, p.136)
[115] (Taylor, 2002, p.59)
[116] (James, 2008av, p.136)
[117] (Kaag, 2020b, p.3; Sutton, 2023, p.11)
[118] (Sutton, 2023, p.9) references (Cotkin, 1994)
[119] (Sutton, 2023, p.1)

but palliative. Through his pragmatism, James, the physician, offers a way to palliate uncertainty and to help people live courageously with it.

What can a nineteenth-century philosophy teach modern medicine? It is not uncommon to apply insights from past philosophers to contemporary medical practice. Kathryn Montgomery, for instance, is recognized for recovering the Aristotelian notion of *phronesis* in medical philosophy.[120] Harvey Carel has used the philosophies of Epicurus and Heidegger to develop a medical phenomenology.[121] What I attempt to do with James' pragmatism has precedence in the influential work of Bill Fulford, psychiatrist, philosopher, and founder of Values Based Medicine (VBM).[122] By applying the ordinary language philosophy of JL Austin to debates in psychiatry regarding the concept of a mental disorder, Fulford revealed the significance and complexity of values in both mental and bodily disorders. This philosophical fieldwork provided the theoretical foundation for a philosophy of medicine called VBM, which, alongside EBM, provides a practical approach to work with complex and conflicting values in medicine and has become influential in the philosophy of medicine.[123] As Fulford drew on Austin, I draw on James. As Fulford applied ordinary language philosophy to the problems of values in psychiatry, I applied pragmatism to problems of uncertainty in end-of-life care. As Fulford's work provided a basis for transforming the way in which values were understood in medicine, I hope to provide a basis for transforming the way in which uncertainty is understood (and acted upon) in medicine.

[120] (Montgomery, 2019)
[121] (Carel, 2016)
[122] (Atwell & Fulford, 2007; Fulford, 2012, 2022)
[123] (Fulford, Van Staden, & Crisp, 2013, p.387)

Why Faculty of Theology: Science and Religion?

James is a pivotal figure in the field of science and religion.[124] His work, *VRE,* is regarded by many as the first "science of religion." In his book *Pragmatism*, James presents a framework by which to mediate between science and religion, and much of his work is positioned as a "justification of faith" to those of a scientific temperament.[125] It is widely recognized that uncertainty is fundamental to James' philosophy.[126] His pragmatism, itself, is a philosophy that emerges from science and religion and living with the uncertainty of both.[127]

Although some cast James as a secular humanist,[128] I stand with Lamberth,[129] Hollinger,[130] Croce,[131] and Carrette,[132] who agree that James cannot be understood without relation to spirituality. Some scholars, such as Gale, characterize James as divided between scientific and religious loyalties.[133] Sutton makes the important point that such readings of pragmatism are "shorn of the context within which it is was formed." James' ideas about science and religion are dynamic and "embedded, like so much of his thinking, in matters of a medical nature."[134] Carrette explains that "driven by his increasingly poor health and sense of limited time," James, at the end of his life, felt a need to summarize the motives underlying his philosophy. He explicitly challenged the notion that one point of view could take in all and advocated for "science, philosophy and theology to work…together."[135] Carrette writes, "James offered a resolution to the conflicts between science, philosophy and religion by showing the limitations

[124] (Croce, 1995; Levinson, 2016; Petersen, 2014; Proudfoot, 2004)
[125] (James, 2008ax, p.13)
[126] (Croce, 1995; Knutson, 2010; Leonhirth, 2001; Petersen, 2014)
[127] (Croce, 1995)
[128] (Hollinger, 2014, pp.31-32; Kaag, 2020b, pp.163-168)
[129] (Lamberth, 1997)
[130] (Hollinger, 2004, 2014)
[131] (Croce, 1995, 1997)
[132] (Carrette, 2013)
[133] (Gale, 1999)
[134] (Sutton, 2023, p.79)
[135] (Carrette, 2013, p.156) quotes (Skrupskelis, 2004, p.xliv)

of thought itself."[136] In other words, James brought science and religion together in the space of uncertainty, especially in the context of his own medical issues. James' work in science and religion, to borrow McGrath's words, was "attuned to the problem of uncertainty, both as a cognitive and existential concern."[137]

James spoke little of "theology" but extensively about religion and what today may be termed "spirituality." In medical discourse, "spirituality" is defined as "a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, transcendence and experience relationship to self, family, others, community, society, nature and the significant or sacred," and "religion" is defined as ways in which spirituality is codified in institutions.[138] How to act, cope, and live meaningfully amidst uncertainty is, by this definition, a deeply spiritual/religious question. "Spiritual care" in medicine involves attending to the existential distress that is caused by medical uncertainties. Palliation of uncertainty, in addressing existential concerns of uncertainty, is therefore a nexus of science and religion that involves both biomedical and spiritual care.

Religion and spirituality are deeply woven into James' philosophy and, consequently, play a central role in shaping this dissertation. Chapter 2 considers the way in which James' medical experiences and engagement with religion/spirituality formed his approach to uncertainty. The approach of Palliating Uncertainty is likewise derived from religious/spiritual elements of James' thoughts, which emphasize relationship and mystery. Each Case in Part II presents the spiritual/religious, along with their relationships with uncertainty, in distinct ways. In Chapter 4, the role of religion/spirituality is developed explicitly by tying together the threads of James'

[136] (Carrette, 2013, p.156)
[137] (McGrath, 2025, p.218)
[138] (Balboni et al., 2022, p.186) cites (Büssing, 2021; Hill et al., 2000; Puchalski et al., 2009; Puchalski, Vitillo, Hull, & Reller, 2014)

philosophy through the "anaesthetic revelation." Chapter 5 furthers this discussion, emphasizing religious/spiritual motifs of relationship and mystery in "holding uncertainty together." James critiqued dogmatism in both science and theology that grasped at certainty.[139] His thought propounds a disposition towards uncertainty that parallels a religious/spiritual approach to the mystical, and it is by focusing on the religious/spiritual elements that these aspects of his thought and approach to uncertainty are brought into focus.

Mystery, for James, is not closure or termination, but a "more" (exceeding, dynamic, unfinished) that draws us further into experience and action. Carrette shows how this "more" is a relational concept that was deeply entangled with James' religious/spiritual thought, and grounded his broader philosophy and approach to uncertainty.[140] James develops this notion of "more" in relation to the religion-science debates of his time. He uses this "more" to critique dogmatism in both science and theology and introduce a relational universe (Chapters 3, 4, 5).[141]

James wrote a vast body of work, and selective engagement was necessary for this project. Works that are repeatedly referenced in this dissertation pertain to science and religion and include the books *Pragmatism, The Principles of Psychology (PoP), VRE, PU, Some Problems in Philosophy (SPP)* alongside essays such as "WtB," "Is Life Worth Living (ILWL)," "SoR," " Reflex Action and Theism (RA&T)" and "A Pluralistic Mystic (PM)" I drew insights from diverse secondary sources on James and found especially useful the works of Ruth Putnam[142] and David Lamberth,[143] who endorse relationality as key to understanding James' pragmatism;

[139] (Carrette, 2013, pp.164, 168-174)
[140] (Ibid., pp.156-181) At times, religion serves to represent a sense of mystery and "more." E.g., (Ibid., pp.176-177; James, 2008q, p.48)
[141] (Carrette, 2013, pp.163-164; James, 2008m, p.116; 2008ag, pp.130-131, 145; 2008av, p.402)
[142] (Putnam & Putnam, 2017; R. Putnam, 1997)
[143] (Lamberth, 1997)

those by Bonnie Sheehey,[144] who analyzes meliorism through melancholy affect and crisis temporality; those by William Gavin,[145] who emphasizes James' "reinstatement of the vague;" those by Paul Croce[146] who identifies James' engagement with uncertainty through science and religion dialogue; and those by Sutton,[147] who shows how James' experience of medical uncertainty shaped his thought. A pragmatic guiding principle lay behind my selection of primary and secondary sources—what might be useful to develop the approach of Palliating Uncertainty and to address issues of uncertainty in medicine.

I found James' writings that pertain to religion/spirituality incredibly helpful. Furthermore, his own methodology took seriously the religious/spiritual as an avenue for contribution to scientific and philosophical thought, and his work reflects this.[148] The task of this dissertation is not a determination of James' personal religious/spiritual beliefs. Though occasionally James referred to himself as a Christian, he does not seem to have used the words "God" or "humanist" conventionally, and the precise nature of his beliefs remains vague. He sometimes hesitated to call himself a Christian because he did not share the faith in the way it was traditionally understood.[149] In a letter to Henry Rankin, he writes, "You see that, although religion is the great interest of my life, I am rather hopelessly non-evangelical..."[150] James was deeply influenced by his father's mystical spirituality and liberal Protestant Christianity.[151] He was drawn to the panpsychic, subliminal, and mystical.[152] James' colleague, George Herbert Palmer, described James as "a peculiarly devout man, and though living at a distance, liked to begin his day with the service at Appleton Chapel." Palmer writes, "To the last [James] kept

[144] (Sheehey, 2019)
[145] (Gavin, 1992)
[146] (Croce, 1995, 1997, 2012)
[147] (Sutton, 2011, 2023)
[148] (James, 2008n, pp.247-249; 2008ag, p.149; 2008av)
[149] (Sutton, 2023, p.108)
[150] (James, 2008at, p.228)
[151] (Carrette, 2013; Levinson, 2016; McDermott, 2013, pp.xix-xxi)
[152] (Carrette, 2013; Croce, 1997; Levinson, 2016)

ample room in his empiric universe for spiritual forces."[153] Regardless of uncertainty pertaining to the precise nature of James "over-beliefs," James was an ardent defender of the right to faith ventures, and what can be said with confidence is what James' wife Alice said—that James "was a man of faith."[154] James may have agreed with Protagoras, "man is the measure of all things," but he would never have reduced the world to what man could measure.[155] Oliver Wendell Holmes, a medical friend of James' who coined the term anaesthesia, commented on Pragmatism, "I now see, as I have seen in his other books that I have read, that the aim and end of the whole business is religious."[156]

The James scholar, Richard Gale, in *The Divided Self of William James,* makes the case that James was divided between his pragmatism and mysticism.[157] I consider that "divided" is too strong a metaphor that was perhaps a trend set by Perry's early biography of James, which was based on this trope.[158] Like all human beings, James was complex and dynamic, and he was exceptionally aware of these movements within himself. James acknowledged that there were tensions in his thoughts.[159] However, I view these tensions through the lens of James' pluralism, psychology, radical empiricism, and pragmatism. His pluralism involves things that exist in relations of continuity and discontinuity; his psychology understands "boundaries" (such as boundaries between "pragmatism" and "mysticism") as dynamic and vague. His radical empiricism includes all elements of experience without excluding for the sake of coherence. His pragmatism assesses ideas by their ability to lead fruitfully in a plurality of different purposes, and "coherence" may be only one type of fruitful leading. Gale's division

[153] (Croce, 1995, p.229) quotes (Palmer, 1920, p.34)
[154] (Hollinger, 2014, pp.31-32) references (Gordon, 1925). See (James, 2008ai, p.144; 2008aj, p.7)
[155] (Kaag, 2020b, p.176)
[156] (Holmes, 1941, p.140)
[157] (Gale, 1991, 1999)
[158] (Perry, 1935)
[159] (James, 2008d, p.491; 2008ag, p.116)

of "pragmatism" from "mysticism" may say more about how Gale views boundaries than it does about James. I echo Ellen Suckiel's question, "Does Gale understand James as James understood himself?"[160]

James' take on religion is also often caricatured as individualistic and reductive.[161] In perhaps one of James' most misquoted statements, he defines religion as "…the feelings, acts, and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine."[162] Many scholars (for example, Taylor[163] and Nicholas Lash[164]) quote this line out of context and conclude that James reduces religion to individual experience. What is often overlooked is the first clause of this sentence, "Religion, therefore, as I now ask you arbitrarily to take it, shall mean for us…" James begins the next paragraph by justifying this definition of religion: "We escape much controversial matter by this arbitrary definition of our field."[165] His purpose in VRE is not to define religion exhaustively but operationally, in order to produce a definition good enough for his purposes and inclusive of a vast range of experience. As is discussed further in this dissertation, relationality is at the center of James' work, especially his work on spirituality/religion.[166]

Engagement with James' reflections on religion/spirituality opens up helpful and oft-overlooked aspects of his pragmatism, which is deeply relational and humbly open to mystery (Chapter 4).[167] This relationality is seen clearly in his spirituality but also permeates his vision in the physiological, psychological, and social/relational spheres and the vagueness of the

[160] (Suckiel, 2000, p.161)
[161] (Shook, 2001, p.16)
[162] (James, 2008av, p.34)
[163] (Taylor, 2002)
[164] (Lash, 1988), see Proudfoot's reply to Lash emphasizing James' relationality (Proudfoot, 1989).
[165] (James, 2008av, p.34)
[166] (Carrette, 2013; Lamberth, 1997)
[167] (Carrette, 2013)

boundaries between them. For instance, relationality can be seen psychologically in the stream of consciousness, socially in his melioristic morality, spiritually in his panpsychic mysticism, and metaphysically in radical empiricism. "PM," the last text that James published before his death, closes with suggestive comments about relationships and mystery (Chapter 4). In a notebook containing his outlines for VRE, he writes, "One feels as if no formula could exhaust the life, or be quite adequate to its mystery. And the religious life is far more at home in the mystery than is the intellectual life."[168] Mystery is not the same thing as uncertainty, but James' 'conclusions' about living with mystery can be helpful for living with uncertainty that cannot be resolved.[169]

Secular Context

What is the role of religious metaphysical commitments in the approach of Palliating Uncertainty? As is discussed below in the "scope and limitations" section, this dissertation is primarily written for an audience of medical practitioners and is therefore written for a secular context, which includes those of many faiths and/or no faith. Whether religious or not, James advocates for a disposition towards the world and uncertainty that is open to mystery.[170] Consideration of uncertainty opens an interesting space for theological engagement in a secular context. In fact, James' self-understanding was that his work created an opening for the religious/spiritual in an increasingly secular world.[171] This dissertation, though submitted in the Faculty of Theology and centralized on religious/spiritual themes, is written in such a way as to be relevant to a secular field.

[168] (James, 2008d, p.496)
[169] (James, 2008af, pp.186-190)
[170] (James, 2008aj, p.6)
[171] (Ibid., pp.8-9)

Why a Case-Based Approach?

Part I of this dissertation provides critical background. Part II, Turning Attention to Action, develops the practice of Palliating Uncertainty in the context of seven cases of patient care. These case studies are derived from actual clinical encounters and are representative of common situations that occur in end-of-life care. As is standard practice in medical literature, all cases are anonymized with identifying factors removed, or publicly available, or used with permission.

Three points are worth noting regarding the case-based methodology of this dissertation:

First, a challenge of interdisciplinary work is the variance in methods between fields. Case-based discussion, which may seem unfamiliar to some scholars in disciplines of philosophical theology, is standard in medical practice.[172] Medical journals such as the *Journal of Palliative Medicine* include "Case Discussion" as a category of manuscript submission for authors. For example, Greenhalgh and her coauthors apply the philosophy of Bernard Lonergan to uncertainty in clinical decision-making through case-based discussion. To do this, they begin with a fictionalized and anonymized case based on a real clinical experience in the emergency department and discuss Lonergan's philosophy in the context of the case. Fulford has used this case-based approach not just to illustrate an idea but to establish a philosophy of medicine, VBM. In his work, *Essential Values-Based Practice: Clinical Stories Linking Science with People,* Fulford begins each chapter with a constructed clinical story (based on real experiences) that presents a familiar clinical problem. From the stories emerge discussions of the principles of VBM and examples of their utility in practice.[173] Most importantly, Fulford

[172] E.g., (Chochinov, 2022a; Fulford, Peile, & Carroll, 2012; Mannix, 2018; Rajagopal, 2022)
[173] (Fulford et al., 2012, pp.xiii-xv)

uses case-based discussions to "link" his philosophy to practice so that the philosophy might be taught and brought into practice.[174]

The cases chosen are not merely illustrative but are doing critical work; critical engagement with James' pragmatism happens in the context of the cases. Medical students are often taught to connect theory and practice through Case-Based Learning.[175] In Case-Based Learning, what is taught is not so much an "answer" but a process for clinical practice. The cases are not merely applications or illustrations of James' ideas but constructive contributions that carry his thought forward into medical practice, into particular and subjective contexts. A physician does face uncertainty in the abstract but is entangled within lived situations and experiences.[176]

Second, the justification for the use of case-based methodology emerges from James' philosophy itself. In *Pragmatism,* James writes, "To take in the importance [of pragmatism], one must get accustomed to applying it to concrete cases."[177] James opens his essay *"*The Experience of Activity*"* by describing the pragmatic method as a turning of attention towards the pragmatic consequences that one's view carries and the assignable difference an idea makes in conduct and experience.[178] He explains that, through the use of this method, one tries to "hinge [discussion] as soon as possible upon some practical or particular issue," and he applies the pragmatic method to the "problem of activity."[179] Following James' advice, I too "hinge" the discussion of Palliating Uncertainty upon practical issues of uncertainty in palliative care. This is also why Part II is a series of case studies.

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[174] In philosophy of religion some scholars, such as Eleanore Stump and John Cottingham, advocate for narrative as a valid mode for serious philosophical/theological engagement (Cottingham, 2024; Stump, 2010; 2022, pp.143-168).
[175] (McLean, 2016)
[176] (McCormick, 2002, p.128)
[177] (James, 2008ai, p.29)
[178] (James, 2008ba, p.94)
[179] (James, 2008j, p.81)

Some scholars may dismiss case studies as too "subjective," yet James takes subjective experience quite seriously in his philosophy. For example, in *VRE,* James considers a variety of individuals' religious experiences and discusses the philosophical reflections that emerge from these cases. In James' words, pragmatism "unstiffens our theories" and "widens the field of search…pragmatism is willing to take anything, to follow either logic or the senses, and to count the humblest and most personal experiences. She will take…[even what] lives in the very dirt of private fact."[180] In the last years of his life, James wrote *PU,* which many scholars regard as expressing his mature thought.[181] James ends the book with the following paragraph: "I have now finished these poor lectures, and as you look back on them, they doubtless seem rambling and inconclusive enough. My only hope is that they may possibly have proved suggestive…of one point of method…" Regarding that point of method, James goes on to explain that "thin logical considerations" of philosophy should be "broadened and thickened up" with real experiences and "actual peculiarities of the world." With his last words, he concludes,

> I urge some of the younger members of this learned audience to… gather philosophic conclusions of any kind from the *particulars of life,* I will say, as I now do say, with the cheerfullest of hearts, 'Ring out, ring out my mournful rhymes, but ring the fuller minstrel in.'[182]

In one sense, "ringing the fuller minstrel in" means bringing the particularities of real experience, real cases into philosophy.[183] In another sense, it might also be James' invitation to those who come after him to thicken James' philosophy, to bring pragmatism into various concrete practices of life, and to allow those experiences to speak to pragmatism.

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[180] (James, 2008ai, pp.43-44)
[181] (Lamberth, 1997, p.238; Slater, 2014, p.165)
[182] (James, 2008ag, p.149) James quotes the poem, "Ring Out, Wild Bells," by Alfred, Lord Tennyson (Tennyson, Shatto, & Shaw, 2016)
[183] (Rasmussen, 2014)

Third, like James' pluralistic philosophy, the cases of Part II hang together through common themes of living with unanswered questions, navigating unresolved tensions, and acting meaningfully amid uncertainty. Acknowledging the importance of plurality for James, the cases engage a variety of perspectives from palliative care and various aspects of pragmatism. Medicine, as Plesk and Greenhalgh argue, is an inherently complex system. Yet, even within complex systems, recognizable patterns may emerge.[184] Clinical reasoning often involves pattern-recognition, and these cases illustrate an important pattern in both the practice of medicine and the philosophy of James.[185] Each case shows a pattern of managing expectations about uncertainty, turning attention to action, and living with uncertainty.

Scope & Limitations

Scope

In medicine, it is often important to manage expectations. This is likewise true in philosophical writing, and I wish to make a few preliminary comments to set expectations for this dissertation.

Written for an Audience of Medical Practitioners

James wrote for an audience beyond scholars. This dissertation is written primarily with an audience of medical practitioners in mind. As stated above, my goal is to contribute to a cultural shift in medicine and to reshape how we engage with uncertainty. I, therefore, write for the purpose of integrating the approach of Palliating Uncertainty into practice. "We," in this dissertation, generally refers to medical practitioners, and though I engage with religious/spiritual themes, I have written this dissertation for a secular context.

[184] (Plsek & Greenhalgh, 2001, pp.627-628)
[185] (Norman, Young, & Brooks, 2007)

These practical interests likewise shape the formation, content, and structure of this dissertation. Many of James' major works were formed from life experiences and conversations with others and were developed from talks/materials written for different audiences.[186] *VRE* was initially the 1901-1902 Gifford Lectures in Edinburgh, Scotland; *WtB and Other Essays* is a collection of talks given to various groups and societies and published as a book; *PoP* was a textbook written for students; and *PU* was originally a lecture to Oxford students given at Harris Manchester. Similarly, much of this dissertation has emerged from personal experience and from dialogue with colleagues, patients, and practitioners in palliative care, as well as from materials I prepared for medical audiences—for example, the plenary address of the UK Palliative Care Congress in Edinburgh, an entry in the Oxford Handbook of Palliative Care, teaching at the Oxford Medical School, etc. This dissertation is structured for reception in medicine. For example, case-based discussion is a methodology well-suited to medical journals. This dissertation is primarily a constructive project (as opposed to a literature review or critical analysis). The content has been selected according to what may be of interest and useful to medical practitioners. James' philosophy of pragmatism suggests that the formation, content, and structure of concepts are shaped by practical aims/interests, and the same is true of this dissertation.

Not a Hermeneutic Project

As stated above, my primary question is how James can speak to uncertainty in medicine. In pursuing this question, contributions are made to Jamesian scholarship; however, my intention, on the whole, is to use a generally acceptable and recognizable interpretation of James that is faithful to his body of work and the tradition of scholarship about him. James is notoriously

[186] (Croce, 2018; Kaag, 2020b; Myers, 2001; Perry, 1948; Sutton, 2023)

difficult to interpret, and there seem to be as many interpretations of James as there are of those who read him. This is not just the fault of the interpreters. James was a protean figure who embodied his philosophy of "fallibility" (in which ideas are provisional and open to revision) and "pluralism" (in which there are dynamic relations of continuity and discontinuity between ideas).[187] Critics of James point out a lack of consistency in his thought. He wrote philosophy in literary prose, at times poetic and cast in imagery. James' works were written as talks in which he addressed the particular needs of various groups. His primary interest was not in creating another great system; instead, he valued creating a philosophy that would be useful for life (and its diverse purposes).[188] He championed that which was excluded from concepts by "vicious intellectualism," even that which was excluded by his own concepts.[189] "Ever not quite" seems to be the attempt to capture James.[190] He exceeds formulations about him, and although his words constrain the number of interpretations, a plurality of interpretation options remain.

In *The Meaning of Truth: A Sequel to 'Pragmatism,'* James complains that "the critics [of pragmatism] have boggled at every word they could boggle at, and refused to take the spirit rather than the letter of our discourse."[191] In this dissertation, I aim to take on the "spirit" of James' ideas rather than engage in debates about "letters" of technicalities. To engage with James in a way faithful to his spirit is not just to create a replica, regurgitation, or reconstruction of his thought, but to test it as a hypothesis and to see how well the idea can lead in life.[192] My aim is to use James' pragmatism to help lead exhausted and disheartened palliative care patients and physicians through the uncertainty of end-of-life care in a way that works and fits with the

[187] (Croce, 2010b; James, 2008ag, p.116; pp.46-47; Taylor, 2002)
[188] (James, 2008ag, p.116; 2008ai, p.94)
[189] (James, 2008ag, p.32; 2008az, p.23)
[190] (James, 2008af, p.189)
[191] (James, 2008ab, p.99)
[192] (Ibid., pp.86-89)

demands of experience.[193] In this sense, this is a pragmatic dissertation, and I imagine that James would be pleased with this as his aim was to craft a philosophy useful for life.[194] In some ways, this project is a continuation of his work.

Not an Analytical Defense of James' Pragmatism

In this dissertation, I argue that James' pragmatism is reasonable, not by providing a theoretical defense of his ideas but by showing how pragmatism can be useful in palliative care. In "SoR" and *PoP,* James argues that rationality has intellectual, aesthetic, emotional, moral, and practical dimensions.[195] Through application to concrete cases, I show that pragmatism (insofar as it contributes to the palliation of uncertainty) can have aesthetic, emotional, moral, and practical appeal.

I take James' pragmatism as a working hypothesis to be tested in the lived experience of clinical practice. In pragmatism, an idea is "made true" as it is tested in experience. Perhaps there is a no more fitting argument for pragmatism than to encourage others to act on it and to see if it leads fruitfully. In the same way that "truth happens to an idea," the performance of James' pragmatism might achieve more than an analytical defense—it might, in a pragmatic sense, "make" it true.[196] If one were writing a dissertation as an apologetic for James, perhaps this is the pragmatic form it would take.

Not a Discussion of Pragmatism as a Theory of Truth

[193] "[Pragmatism's] only test of probable truth is what works best in the way of leading us, what fits every part of life best and combines with the collectivity of experience's demands, nothing being omitted" (James, 2008ai, p.44).
[194] (Putnam & Putnam, 2017, pp.108-120, 225-231)
[195] (James, 2008ak, pp.939-940; 2008ao, pp.61, 65-66)
[196] "Make it true" does not mean that anything can be made true simply by believing. James points towards the role of agency in outcomes that are dependent upon personal action (James, 2008ag, p.148; 2008ap, p.113; 2008ax, p.28).

In this dissertation, I bracket pragmatism as a theory of truth and focus on it as an attitude. James introduces *Pragmatism* with the maxim offered by his friend, the philosopher Charles Peirce, in *How to Make Our Ideas Clear*.[197] James expands this maxim, which is primarily a theory of meaning, into a method. The pragmatic method in its narrowest definition is "a method for settling philosophical disputes" that "interprets each notion by tracing its respective practical consequences. What difference would it practically make to anyone if this notion rather than that notion were true?"[198] James expands the maxim further and shows how this method is part of a broader pragmatic attitude in philosophy.[199]

What does the pragmatic method mean; i.e., what are its practical consequences? James answers the question as follows: "No particular results then, so far, but only an attitude of orientation, is what the pragmatic method means. The attitude of looking away from first things, principles, 'categories' supposed necessities; and of looking towards last things, fruits, consequences, facts."[200] The attitude of pragmatism is described as shifting the direction of attention and where one is "looking" (Chapter 3).

James wrote the first great work of psychology, *PoP,* and in this work he highlights the importance of attention. He explains that attention involves "withdrawal from some things in order to deal effectively with others."[201] In *Psychology Briefer Course* (the abridged version of *PoP*), he writes, "What is called our 'experience ' is almost entirely determined by our habits of attention"[202] The attitude of pragmatism takes on new significance when read in terms of James' psychology of attention. The attitude of pragmatism involves a withdrawal of attention

[197] (Peirce, 2011) See (James, 2008ai, pp.28-29).
[198] (James, 2008ai, p.28)
[199] (Ibid., pp.29, 31)
[200] (Ibid., p.32)
[201] (James, 2008ak, pp.381-382)
[202] (James, 2008al, p.156)

from the “first things” (the theoretical “principles, 'categories' supposed necessities” which grasp at certainty but are often uncertain and in dispute) in order to deal with “last things.” Based on an evolutionary[203] and physiological[204] understanding, James sees the terminus, the “last things” of thought, as action.[205] In other words, the attitude of pragmatism turns attention from uncertainty towards action. “Last things” carries a further connotation for James, as truth is considered to be what leads to fruitful relations “in the long run, on the whole.”[206] For James, the outcome in the “long run, on the whole,” is uncertain and may depend upon our actions. This turn in attention from uncertainty to action is a pattern that manifests in many ways in James’ philosophy, and it is discussed further in Chapters 2 & 3.

In a beautiful passage, James likens pragmatism to a corridor in a hotel.

> [Pragmatism] lies in the midst of our theories like a corridor in a hotel. Innumerable chambers open out of it. In one you may find a man writing an atheistic volume; in the next someone on his knees praying for faith and strength; in a third a chemist investigating a body's properties. In a fourth a system of idealistic metaphysics is being excogitated; in a fifth impossibility of metaphysics is being shown.[207]

If pragmatism can be a corridor in a hotel, can it also be a hallway in a hospital? In one room we find a physician examining a patient’s body; in another, a patient praying on their knees; in another, ideals of EBM, next door heroic, unstudied medical treatments are risked; in a fifth, a physician sitting in silence with a patient, a hand on their shoulder, face-to-face with the mystery of suffering itself. Pragmatism is a method for science, a method for religion, and a method for medicine, which is so often entangled with both. Pragmatism is often considered a philosophy for living; can it also be a philosophy for the dying and a way in which we can care

[203] (James, 2008ar, pp.23-24)
[204] (James, 2008an, p.92)
[205] (Ibid.)
[206] (James, 2008ai, p.106)
[207] (Ibid., p.32) references Papini.

for them in the midst of medical uncertainty? One can almost imagine the different cases presented in Part II of this dissertation as different rooms of a hospital hall.

Two Further Notes on the Scope of Pragmatism

This dissertation focuses solely on James' version of pragmatism. Too often, pragmatisms of various pragmatists, such as Quine, Peirce, Dewey, James, Mead, Santayana, Rorty, and Putnam, are conflated into one. Peirce, for instance, changed the name of his philosophy from pragmatism to pragmaticism to differentiate it from the pragmatism of others.[208] Dewey preferred referring to his philosophy as "experientialism" or "instrumentalism" until after James' death.[209] The distinctions between different pragmatists could make a dissertation in and of itself.

Though this dissertation is focused on James' pragmatism, it also engages with elements of James' philosophy, such as his pluralism and radical empiricism. Boundaries between his pragmatism and other aspects of his thought are vague. Ruth Putnam, for instance, makes the case that James' pragmatism is inseparable from his radical empiricism.[210] My aim is not to delineate boundaries but to draw on what may be useful for the task of Palliating Uncertainty.

[208] (Houser, 2011, p.2)
[209] (Shook, 2001, p.16)
[210] (Putnam & Putnam, p.130)

Not on Decision Theory or Other Probabilistic Methods to Reduce Uncertainty

This is not a dissertation on decision theory or other probabilistic tools for reducing uncertainty. As mentioned above, uncertainty can be approached theoretically and probabilistically, for instance, through various decision-theories, Bayesian probabilities, predictive algorithms, and risk calculators.[211] Generally speaking, such tools pay attention to the uncertainty itself and aim to reduce or control it through measures. The approach of Palliating Uncertainty has a different focal point of attention, looking to the effects of uncertainty on a person's life and experience and what can be done to address these. As is explained in Chapters 1 & 3, reducing uncertainty can be one of many ways to palliate the effects of uncertainty, but sometimes a focus on these methods exclusively can distract from more important issues to be addressed. Furthermore, uncertainty can have positive effects on someone's life and be a source of hope.[212]

My interest is in experiences of uncertainty that are often elusive to probabilistic tools. A helpful analogy can be drawn from the philosophy of religion and the problem of evil. The philosopher Alvin Plantinga makes a distinction between evidential and experiential problems of evil.[213] Evidential problems of evil consider whether the existence of evil is evidence against the existence of an all-loving, all-powerful God, and various "theodicies" are offered, which provide theoretical and intellectual answers to reconcile the existence of such a God with the existence of evil and suffering. Experiential problems of evil are more concerned with personal, individual experiences of suffering and the existential questions that such suffering raises: "Why did God allow this horrible thing to happen to me?" Compelling evidential arguments answering this question do not always help alleviate the concerns of the person who is suffering. Sometimes, for some people, the best theodicies make for miserable comforters.

[211] (Albert, 1978; Ashby & Smith, 2000; Cohen et al., 1987; Dziadzko et al., 2016; Manuel et al., 2012; Medow & Lucey, 2011)
[212] (Han, 2021, pp.5-6)
[213] (Plantinga, 1977, pp.63-64)

Just as it is a mistake to assume that good evidential arguments for the existence of evil answer the questions that are raised in the experience of suffering, so it is a mistake to assume that probabilities fully answer the questions that are raised in the experience of uncertainty. Analytical tools that improve the accuracy of medical predictions are important, valuable, vital, and necessary. However, higher probabilities do not necessarily reduce uncertainty or alleviate the existential concerns associated with it.

Croce gives a helpful example by citing the difference between professional and public perceptions of probability.

> Scientists argue plausibly with great confidence that the disease [AIDS] cannot spread through casual contact because the chance of contracting it from touch or saliva is uncountably remote and undocumented in current research. The public listening to these scientific pronouncements ask a simple question: 'Are you sure?' Scientists respond with extreme probabilities rather than with certainty. The gap between those two kinds of answers is often filled with anger and fear—generated by the anxiety, as the telling popular phrase goes, that the person on the receiving end of the improbable contraction of the disease 'might become a statistic.'[214]

It is challenging to understand probability on an emotional level. A one-in-three chance of a side effect of hair loss is experienced differently than a one-in-three chance of living one year. According to theories of pragmatic encroachment, the more important the question of "whether p," the harder it is to know "that p" (or to feel that one has sufficient evidence for p). In other words, the higher the stakes, the harder it is to be satisfied with the evidence.[215] Generally, the more invested an individual is in an outcome, the less satisfied they are with probability. In palliative care, what is at stake is life itself and the quality of that life. Many studies on

[214] (Croce, 1995, p.8) cites (Shilts, 2011)
[215] (Fantl & McGrath, 2007; Stanley, 2005; Weatherson, 2012)

prognostic communication highlight the challenges of conveying statistics and probabilities to patients and their limitations in addressing the existential questions patients raise.[216] Sometimes, for some people, probabilities make for miserable comforters.

Probabilistic tools can help reduce some types of uncertainty; however, at best, probabilities reduce—but do not eliminate—uncertainty, as the very nature of probability implies that some uncertainty remains. My interest is primarily in uncertainty that cannot be removed and must be lived with. Uncertainty cannot be cured with probabilistic tools, but perhaps with these tools and others, it can be palliated.

Not an Empirical Study

In this dissertation, I extensively reference data from empirical medical literature and rely heavily on such studies, but the dissertation is not an empirical study itself. However, it lays the groundwork for further empirical research, and in the future, I would like to pursue such studies.

Limitations

As is true of most dissertations, my scope is limited. The fact that this dissertation is written with an audience of medical practitioners in mind, is not a hermeneutic project, not an analytical defense of James, not a study of other pragmatists, nor a consideration of decision theory or other probabilistic methods for reducing uncertainty, and not an empirical study are all limitations. Although the use of a case-based approach is justified upon Jamesian grounds and medical literature methodology, it introduces subjectivity. Though I focus on the context

[216] (Dhami & Mandel, 2022; Dhawale, Steuten, & Deeg, 2017; Han, 2013; Kalke, Studd, & Scherr, 2021; Kirkebøen, 2019)

of palliative care, uncertainty is encountered in every specialty. For instance, general practitioners face tremendous uncertainty as they are often the first point of care.[217] Interdisciplinary work is challenging, and I anticipate that, as it stands, this dissertation may be appropriately technical for a DPhil but too philosophically technical for medical practitioners. In its current form, this dissertation is not well-suited for sharing Palliating Uncertainty with busy clinicians. This DPhil, however, does provide an essential foundation for further work.

Structure of Dissertation

Earlier, I referenced James' image of pragmatism as a corridor in a hotel. In line with this image, Palliating Uncertainty might be envisioned as a corridor in a hospital or hospice. Part I is a walk down the corridor and an introduction to uncertainty in James, uncertainty in palliative care, and the method of Palliating Uncertainty. Part II is a visit to various patient rooms in which the methods of Palliating Uncertainty are put into practice. The conclusion serves as a call to move beyond this theoretical hospital into a real one, allowing Palliating Uncertainty to be tested in practice.

In many cases, palliative care stands in a space of transition, where it helps patients and families to identify their goals of care and to come to terms with the realization that a condition might not be curable. In a fascinating study by Back et al., terminally-ill cancer patients and bereaved family members offer advice to physicians on how to tell a patient that their cancer cannot be cured, but can be palliated. These patients suggest three communication practices: 1) Disrupt the previous expectations about treatments and honestly acknowledge that trying another

[217] (Greenhalgh, 2013)

chemotherapy will not cure the disease. 2) Offer actionable responses such as "Here's what we can do now." 3) Find a new place that acknowledges death yet still enables a meaningful life.[218]

What these cancer patients and their family members suggest regarding the communication of goals of care can also be taken as recommendations for dealing with uncertainty. 1) Manage expectations: honestly acknowledge that medicine is uncertain. 2) Turn attention to action: offer actionable responses to the uncertainty such as, "Here's what we can do now." 3) Living with uncertainty: find a new place that acknowledges uncertainty yet still enables a meaningful life. Broadly, this dissertation follows this structure.

PART I: MANAGING EXPECTATIONS ABOUT UNCERTAINTY is an attempt to manage expectations about uncertainty inherent to medicine, James' philosophy, and life in general. A synopsis of each chapter follows below.

Chapter 1. Medicine: A Science of Uncertainty contains an honest acknowledgement of the uncertainty of medical practice. I argue that uncertainty is inherent to the practice of medicine and question the assumption that more knowledge "cures" uncertainty. I describe a "culture of certainty" in medicine in which uncertainty is dealt with through overtreatment, over-investigation, and overmedicalization. I introduce taxonomies of uncertainty by Fox (1957), Eric Beresford (1991), Mishel (1998), Jürgen Kasper et al. (2008), Greenhalgh (2013), Ian Scott et al. (2023), and Han (2021), and discuss types of uncertainty that are especially prevalent in palliative care. I also show that uncertainty pervades the evidence base of medicine. Drawing on Schön's *Reflective Practitioner: How Professionals Think in Action* and James' philosophy, I offer an image of a "bog of uncertainty" in which knowledge and concepts

[218] (Back, Trinidad, Hopley, & Edwards, 2014)

are like a wooden path built across the surface of a bog; they help us to navigate it but do not reduce uncertainty any more than adding wood to the path reduces the amount of bog. I point out that despite the uncertainty inherent to medicine, clinicians can—and still do—act. I discuss how turning attention towards action can "palliate" uncertainty in the sense of covering or comforting and can alleviate the suffering of uncertainty. Medicine is uncertain because life is uncertain.

Chapter 2. Uncertainty & William James, MD James' philosophy starts from a place of uncertainty ontologically, epistemologically, morally, spiritually, and personally. His philosophy turns attention from uncertainty towards action and offers ways to live courageously with uncertainty. In this chapter, I look at the life from which this philosophy of pragmatism arose and tell the story of James' medical biography. Drawing on Sutton's *WJ,MD,* I describe the uncertainty that he experienced in the context of his grappling with his serious illness. In short, James' philosophy is a tool that is especially well-suited for the palliation of uncertainty because it emerged *from* dealing with the uncertainty of serious illness, and it was written *for* dealing with the uncertainty of serious illness.[219] James was a doctor who never practiced, who healed neither his patients nor himself, and who lived with a chronic condition of uncertainty — yet perhaps left behind a philosophy that could help those who cannot be cured. Perhaps the hard-won insights of his philosophy are palliative.

Chapter 3. Palliating Uncertainty outlines key aspects of the ethos of palliative care, introduces James' pragmatism, and brings both together to develop the approach of Palliating Uncertainty. I engage with James' pragmatism not as a theory of truth but as an attitude of orientation, and

[219] I do not mean to suggest that James' philosophy was written only for these purposes, but that these are important purposes to acknowledge.

I make a unique contribution to Jamesian scholarship by summarizing this attitude of pragmatism as a turning of attention from uncertainty towards action. I discuss James' theories of attention in terms of evolution, psychology, physiology, and spirituality and show how a change of attention has practical consequences in conduct and experience. The palliation of uncertainty also requires a shift in attention, from uncertainty to the person and to what can be done to address the effects of uncertainty on a person's life. Palliative care provides a helpful model for dealing with uncertainty because it does not discount the value of knowledge and technology. In palliative care, we draw on the best available science and resources to care for patients at the end of life. We limit the uncertainty we can, but the goal is not to remove uncertainty. The goals of Palliating Uncertainty are, in the negative, to alleviate the suffering it causes and, in the positive, to enable people to live (even flourish) in the midst of it. James' pragmatism reinstates the value of relationships that are on the fringe of the focus. It is known in palliative care that relationships themselves are part of healing. Uncertainty can cause tremendous suffering (especially when unrealistic expectations and feigned certainty creates distrust), but in the face of the incurable and unanswerable, as we step into uncertainty with our patients, uncertainty can also become an opportunity for relationship and healing connection. Uncertainty may be part of the suffering but also part of the healing. The palliation of uncertainty is conducted in a community—whose members hold the uncertainty together. I close the chapter by describing how Palliating Uncertainty can be used in practice.

PART II TURNING ATTENTION TO ACTION develops the practice of Palliating Uncertainty through a series of five case studies that are related to prognostic uncertainty.

Case 1. Family of the Dying: Tasks of Dying is the story of a son coping with the uncertainty of his father's diagnosis of pancreatic cancer. In this case, I use James' pragmatism in "SoR" to help the son to shift attention from the uncertainty of prognosis to the "tasks of dying," such as saying, "I love you, thank you, I'm sorry, I forgive you, goodbye."

Case 2 is composed of two stories. *Case 2A. Meliorism: Between Optimism and Pessimism* considers Dennis, the optimist, who believes that God has told him that his terminally ill daughter with leukemia is going to be healed and stops her pain medication in an act of faith; and Martha, the pessimist, who is given a diagnosis of cancer with a prognosis of six-months and, although currently symptom free, spends all her days in bed waiting to die. James' pragmatism critiques the optimism of absolute monism and the pessimism of Schopenhauer by showing how both lead to paralysis. Building on Han's case for "prognostic silence," I introduce the notion of "prognostic meliorism." James describes meliorism as situated mid-way between pessimism and optimism. Like pessimism, meliorism considers the world to contain real suffering and real evil and to be a universe that is truly dangerous and adventurous. In response to this uncertainty, meliorism calls forth all that is heroic within the hearts of men to stand and act their part. Like optimism, meliorism holds space for hope. In response to the uncertain outcome, it calls forth a religious type of faith to act for the best. Neither outcome of optimism nor pessimism is certain—and in response to the uncertainty, meliorism turns to action.

Case 2.B. Meliorism: Day-to-Day Living with Dying continues the story of Dennis and Martha with a melioristic turn. In the first iteration of their stories, supposed "certainty" regarding future outcomes led to paralysis and inaction. For both Dennis and Martha, melioristic uncertainty inspired action in the present. This meliorism also required a willingness to act

without a guarantee of final results. The physician helped Dennis and Martha to make better that which was within their control, even though the final outcome might not be. Engaging with Sheehey's article "Pragmatism without Progress," I show how "James offers a non-progressivist version of hope that is affectively tempered by melancholy and oriented temporally towards the present." I take the present-oriented reading of James' meliorism one step further than Sheehey. Pragmatic meliorism involves a willingness to risk action in the present without the guarantee that what we strive for will be realized in the future. Meliorism is life lived on a maybe. James highlights how the melioristic condition of the terminally ill is really the condition of us all.

Case 3. How Long Do I Have? Prognostic Paralysis & James' Gnostics is a story from Hospice UK, which shares how a middle-aged musician named Barry lives with Chronic Obstructive Pulmonary Disease (COPD) emphysema. In this case, I discuss the difficulties of prognostication and how the uncertainty of chronic conditions, such as this, can lead to "prognostic paralysis." In prognostic paralysis, uncertainty regarding the illness trajectory leads to an avoidance of end-of-life discussions, reduced access to palliative care resources, and a decreased quality of life. Applying James' critiques of the gnostics, I argue that when it comes to prognostic communication, "being right" about prognosis is not always the most important thing. James' pragmatism, which makes "correct knowledge" secondary to action and relationship, can provide a helpful way forward in the paralyzing uncertainty of prognostication. Han notes that strategies for managing uncertainty usually fall into the categories of "ignorance-focused" and "uncertainty-focused." By shifting the focus of uncertainty from a gnostic domain and considering the plurality of other domains of life, the uncertainty that causes a gnostic prognostic paralysis can be transformed into an uncertainty that inspires a plurality of actions. In the pluralistic world of palliative care, prognostic

uncertainty can be an impetus for conversations that explore a diversity of patient values. In Barry's story, prognostic uncertainty is present in the background, but the attention is not on the uncertainty itself. The case of Barry is an example of turning attention from uncertainty to action. The story illustrates opportunities for managing uncertainty with what Han calls "response-focused" and "person-focused" strategies and shows how the hospice enables Barry to live with his condition according to his values. Barry's future is uncertain, but he has a community of people around him who help him to live with that uncertainty.

Case 4. The Woman Who Wouldn't Die: Mysticism & Reinstatement of the Vague tells the story of the "woman who wouldn't die (WWWD)." This story shows how there is so much more to our patients than we can ever capture with our sciences. James relates this elusive "more" to the notions of vagueness and mystery and suggests what he calls "reinstatement of the vague." I relate James' reinstatement of the vague to Saunders' model of total pain. Following James scholar Gavin, I explore James' reinstatement of the vague in terms of "richness" and "intensity." "Richness" involves a rejection of reductionism and what James terms "medical materialism." Religion and spirituality awakened in James a vague sense of a "moreness" that was elusive to the grasp of a single methodology. The sense of "more," both within and beyond a person, led James to approach science with humility. "Intensity" involves a turn to action in the uncertainty of vagueness. In James' discussion of religious experience, he makes it clear that: the turn to action in vagueness is one in which we are involved as participators, not spectators; vagueness can be a stimulus for action without resolving the vagueness; and it is not only possible for the vague to motivate action, but it might be one of the deepest driving forces behind our actions. Through the story of the WWWD, I illustrate these three points. In one sense, this woman is an exception. In another sense, she is 'every patient' because all our

patients are more than can be captured by our sciences. James reminds us to approach such mysteries with an open posture of humility and moral courage to act.

Case 5. Climbing James' Faith Ladder: Is Intensive Caring Worth Doing? is the story of a patient with end-stage brain cancer who feels that he is a burden to others and wants to end his life. In this case, I apply James' "faith ladder" and "will-to-believe doctrine" to palliative psychiatrist Harvey Chochinov's model of "intensive caring." Chochinov's "intensive caring" is an approach to medical care that "reminds patients that they matter." It offers empirically informed guidance for ways to "be with" patients whose problems are beyond fixing and who have lost hope, meaning, and purpose. Intensive caring requires tolerance of uncertainty. Like patients, physicians act without guarantee. Chochinov reminds patients that their presence matters; James' faith ladder reminds physicians that, in the face of problems that are beyond fixing, their presence matters too. James couples faith not with certainty but with uncertainty. The faith ladder turns attention towards action in the domains of personal relations and social meliorism, and calls forth willingness to act in the uncertainty together. I ask, "Is intensive caring worth doing?" The actions that we take as a community may contribute to the creation of the answer.

PART III: LIVING WITH UNCERTAINTY seeks a place that acknowledges uncertainty and enables a meaningful life. Part I of this dissertation focused on uncertainty, Part II turned attention to action, and Part III expands the field of vision to include the relational fringe that surrounds actions of care.

Chapter 4. The Anaesthetic Revelation explores religious/spiritual notions of relationality and mystery in James' thought. I use James' reflections on mysticism and his image of the "anaesthetic revelation" to connect three key themes that run throughout this dissertation: managing expectations about uncertainty (embracing the uncertainty inherent in life's mysteries); turning attention to action (recognizing the ability to act in relation to that which is not fully understood); and 3) living with uncertainty (through relationships with others).

Chapter 5. Holding Uncertainty Together shows a tension in James' philosophy between acting courageously in uncertainty and surrendering the ability to act and relying on relationships with others, and the way in which this tension is useful to navigate a similarly experienced tension in palliative care. Living with uncertainty entails holding uncertainty together in community with our patients, with each other, and with communities that extend beyond hospitals and hospices.

Chapter 6. Conclusion On James' view, response to uncertainty is largely a matter of temperament, and I suggest that each medical specialty with its unique dispositions may have something to contribute to holding uncertainty together. I close by suggesting that uncertainty is solved (or, rather, "salved") in the act of living, and point towards some practical steps that can be taken to integrate the palliation of uncertainty into practice.

Chapter 7. Epilogue James often attests to the limitations of language. Words can be useful, but in palliative care, we encounter the plain inadequacy of words. In this epilogue, I embody the ideas explored in this DPhil through a cyr wheel dance, which I performed during the plenary address at the 2023 UK Palliative Congress as part of the presentation of this dissertation.

PART I

MANAGING EXPECTATIONS ABOUT UNCERTAINTY

1

Medicine: A Science of Uncertainty

"It's my experience that doctors and their patients benefit when both acknowledge the degree of uncertainty in medical practice…medical schools should perhaps teach William Empson's Seven Types of Ambiguity as closely as they teach the seven muscles of the calf."[220]

~Galvin Francis, *Sir Thomas Browne: The Opium of Time*

"I make no pretense of omniscience. Decisions about diagnosis and treatment are complex. There are dark corners to every clinical situation. Knowledge in medicine is imperfect. No diagnostic test is flawless. No drug is without side effects, expected or idiosyncratic. No prognosis is fully predictable. Still, there are important landmarks that help doctors and patients successfully navigate this uncertain terrain."[221]

~Jerome Groopman, *How Doctors Think*

Introduction

In medical care, it is important to manage expectations. In this chapter, I argue that uncertainty is inherent to medical practice and question the assumption that increased knowledge cures uncertainty. Like a terminal condition, uncertainty may not be curable, but it can be palliated.

My pre-medical training was at the University of Michigan (U of M), a globally recognized leader in healthcare.[222] Nearly forty years ago, the U of M hospital had the motto, "Knowledge Heals."[223] This emphasis on knowledge as the source of healing is reflected in U of M's

[220] (Francis, 2023, p.20)
[221] (Groopman, 2008, p.4)
[222] (Powers, 2023)
[223] (UM, 2024a)

advertising today. In 2021, U of M began a campaign called "Michigan Answers," which illustrates well some of the ways in which uncertainty is dealt with in medicine.

[Please watch]

https://www.youtube.com/watch?v=Oze6St47S0w&t=81s&loop=0

Figure 1) Image from Michigan Answers Campaign.[224]

Uplifting piano music plays in the background as the advertisement flashes scenes of scientists in laboratories and advanced medical technologies. Intermittently sprinkled through are shots of patients smiling brightly.]

[224] (UM, 2024b)

People want cures.
An end to every disease.
And so, we explore. We look further. We advance and iterate and wrestle the unknown, until something new emerges

People want hope.
So, we train, and teach, and question.
Empowering generations of the inquisitive, the caring, and the courageous.

People want certainty.
So, we collaborate, and innovate, and boldly fight for them, and with them.
Using every tool and technology within our reach.

People want to come to one place, and know they can find an answer.
That's what they want.
Cures.
Hope.
Certainty.

They want…
Michigan Answers.[225]

This message was broadcast via television commercials, billboards, radio, print advertising, and social media. The message of "Michigan Answers" is that uncertainty is something to fight and that something is wrong if uncertainty surrounds you. Knowledge, technology, and science will save us from uncertainty. We can promise answers and guarantees.

We have a lot of myths in medicine—one is that science gives us certainty. Yet, what is the actual experience? Patients with life-defining illnesses turn to doctors and medicine looking for answers and find instead a messy, tangled world of conflicting voices, unknown causes, and indeterminate futures. A study from University College London showed that uncertainty caused more stress than painful stimuli.[226] Uncertainty also increases distress from both

[225] (Ibid.)
[226] (De Berker et al., 2016)

psychological and physical pain.[227] Cognitive scientist David Rock argues that the human brain responds to uncertainty in ways analogous to pain and can crave information, not necessarily to be more adaptive or effective, but to decrease the feeling of uncertainty.[228]

Babrow describes an "ideology of uncertainty reduction" in healthcare.[229] As will be discussed in the following sections, studies show that uncertainty in medicine is dealt with through overtreatment, over-investigation, and overmedicalization.[230] Attempts to "cure" uncertainty through clinical exams, tests, treatments, and research, this knowledge does not come without its costs for our patients and medical system. Much suffering is caused by medical uncertainty and by the ways we deal with it.

Training for Certainty: Medical Education and Socialization

As described by palliative care physician Rod MacLeod, socialization into medicine entails the "learning of attitudes, norms, self-images, values, beliefs, and behaviour patterns associated with becoming a doctor."[231] Much medical training is focused on the acquisition of knowledge.[232] Addressing medical uncertainty and the reactions it causes is a neglected element of medical training.[233] After years of being tested by exams with correct answers, searching for security through more knowledge can become almost a reflex response to situations of uncertainty. MacLeod points out, "The human being who suffers ill health is not completely 'knowable'…The consequence of this is that the elements of ill health that can, to a degree, be controlled more readily become the focus of constant improvement or

[227] (Loued-Khenissi, Martin-Brevet, Schumacher, & Corradi-Dell'Acqua, 2022)
[228] (Benjamin, 2017; Peters, McEwen, & Friston, 2017; Rock, 2025; Strigo, Kadlec, Mitchell, & Simmons, 2024; Zhuang, Zhao, & Fu, 2024)
[229] (Babrow & Kline, 2000, p.1806)
[230] (Brashers, 2001; Etkind & Koffman, 2016; Fox, 1980; Fox, 2000; Katz, 1984; Kim & Lee, 2018; Montgomery, 2019; Murray et al., 2005; Scott et al., 2023)
[231] (MacLeod, 2024, p.162)
[232] (Ibid., p.162)
[233] (Luther & Crandall, 2011)

learning."[234] Socialization into the medical field can involve the fostering of a disregard for that which is not completely knowable or controllable, and this situation can create an illusion that there is more certainty than there is.[235] As Eddy writes, "There is…a strong tendency to oversimplify. One of the easiest ways to fit a large problem in our minds is to lop off huge parts of it."[236] In other words, training for uncertainty is training to reduce it through knowledge and to disregard the irreducible.[237]

Overmedicalization of Uncertainty

This approach to uncertainty—focused on reducing it through the acquisition of knowledge and dismissing what cannot be controlled—extends beyond medical education and into clinical practice. Iona Heath, former president of the Royal College of General Practitioners, shows that fear of uncertainty plays a significant role in driving overdiagnosis and overtreatment.[238] Studies show that physicians who are less tolerant of uncertainty are more likely to submit their patients to excessive diagnostic testing and treatments.[239] Psychiatrist TF Main observes that "…history has the awkward habit of judging some [treatments] as fashions, more helpful to the…therapist than to the patient."[240] Such overmedicalization of uncertainty impacts patient safety and can lead to adverse events because of false positive tests and iatrogenic injury.[241] When uncertainty drives towards overutilization of health resources, the "price is paid in terms of inconvenience, pain, distress, days in the hospital, unnecessary risks, and money."[242] In 1984, Eddy observed that in many healthcare systems,

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[234] (MacLeod, 2024, p.162)
[235] (Shelley, 2018)
[236] (Eddy, 1984, p.85)
[237] See James' discussion of vicious intellectualism which excludes that which does not fit into pre-decided conceptual categories (James, 2008ag, p.32).
[238] (Heath, 2014) See (Kassirer, 1989; Meador, 1994)
[239] (Christakis & Iwashyna, 1998; McIlvennan & Allen, 2016; Schneider, Wübken, Linde, & Bühner, 2014)
[240] (Main, 1957, p.9)
[241] (Carey et al., 2015; Kassirer, 1989; Yardley, Yardley, Williams, Carson-Stevens, & Donaldson, 2018)
[242] (Eddy, 1984, p.86) See (Bristowe et al., 2015; Etkind et al., 2024, p.2; Shapiro & Bates, 2010; Simpkin & Schwartzstein, 2016; Thorne, Bultz, & Baile, 2005)

> …A large number of incentives encourage simplifications that lead to overutilization. It is time-consuming, mentally taxing, and often threatening to colleagues for a physician to undertake a deep analysis of a confusing clinical problem. A physician is less likely to be sued for doing too much than too little. Most physicians' incomes go up if they do more and go down if they do less. Hospitals get to fill more beds and bill for more procedures, laboratories collect more money for services, and companies sell more drugs, devices, and instruments...[243]

Nearly forty years later, a 2023 narrative review of clinical uncertainty by Scott and colleagues states that, when it comes to uncertainty, "the current design and funding of health care favour investigations and procedures over the potentially lengthy and cognitively demanding discussions between clinicians and patients in shared decision..."[244] It is often overlooked that uncertainty can play a positive role in maintaining hope and, for some patients, is not always a problem to be eradicated.[245]

A Culture of Certainty

Macleod writes,

> The culture of medicine has had little tolerance for ambiguity and uncertainty…We, as a society, expect that after a thorough subjective and objective assessment of the patient, a physician will be able to make an accurate diagnosis. The inability to make an accurate diagnosis after a thorough evaluation will often lead to frustration on both the part of the patient and the physician.[246]

Such unrealistic expectations oversimplify the complex realities of medical practice and can lead to feelings of "significant anxiety, frustration, disillusionment, self-doubt, feelings of

[243] (Eddy, 1984, p.85)
[244] (Scott et al., 2023, p.424)
[245] (Brashers, 2001; Gough, Ross, Riley, Judson, & Koffman, 2019; Han, 2016; McCormack et al., 2011; Mishel, 1990)
[246] (MacLeod, 2024, p.163) See (Luther & Crandall, 2011)

inadequacy (not being 'good enough') and insecurity."[247] Numerous studies show that intolerance of uncertainty is an important contributing factor to depression, moral injury, and burnout among clinicians.[248] Furthermore, legal pressures and fear of malpractice suits can place pressure on physicians to meet unrealistic expectations of certainty. Robinson and colleagues conducted a study on bereaved families' experiences of care at the end of life. Afterwards, they wrote, "This need for certainty has resulted in a level of discomfort in medical culture in acknowledging uncertainty, despite clinicians being aware of its existence in clinical practice."[249]

Suffering

In a national interdisciplinary consensus that identifies research priorities for uncertainty in serious illness, Etkind and colleagues soberingly remark, "Uncertainty matters because when suppressed and ignored, it can profoundly negatively impact patients and their family."[250] In palliative care, avoidance of uncertainty can lead to "avoidance of discussing prognosis, delays in addressing goals of care, suboptimal symptom management…failure to initiate palliative care in a timely manner,"[251] and decision paralysis.[252] Many studies associate poorly addressed uncertainty with worse psychological outcomes for patients.[253] Negative end-of-life experiences that result from uncertainty can impact bereavement recovery.[254] Uncertainty, especially the irreducible uncertainties that are encountered in serious illness, can be an

[247] (MacLeod, 2024, p.162)
[248] (Begin et al., 2022; Čartolovni, Stolt, Scott, & Suhonen, 2021; Di Trani, Mariani, Ferri, De Berardinis, & Frigo, 2021; Logan & Scott, 1996; MacLeod, 2024, p.163; Van Iersel et al., 2019)
[249] (Robinson et al., 2021, p.2) See (Montgomery, 2019; Simpkin & Schwartzstein, 2016)
[250] (Etkind et al., 2024, p.2) cites (Andersen, Hoeck, Nielsen, Ryg, & Delmar, 2020; Nanton et al., 2016)
[251] (Hill et al., 2020, p.2)
[252] (Davies, 2008; Oksavik, Solbjør, Kirchhoff, & Sogstad, 2021; Robinson et al., 2021; Sellars et al., 2019; Smith, White, & Arnold, 2013)
[253] (Mishel, Hostetter, King, & Graham, 1984; Thorne et al., 2005; Wright, Afari, & Zautra, 2009)
[254] (Mancini, Sinan, & Bonanno, 2015)

emotional burden on physicians,[255] patients,[256] and carers[257] alike and threatens extensive existential and psychological distress—even to the extent of threatening a sense of self and relationships.[258] One thing that is evident from palliative care is that relationships are integral to healing.[259] Patients want physicians who are confident, competent, and above all, honest.[260] Uncertainty can contribute to tremendous suffering, as false assurance and feigned certainty can fracture therapeutic relationships and break bonds of trust.[261]

Simpkin and Schwartzstein write, "Our quest for certainty is central to human psychology…and it both guides and misguides us. Although physicians are rationally aware when uncertainty exists, the culture of medicine reveals a deep-rooted unwillingness to acknowledge and embrace it."[262] As much as I disagree with the campaign "Michigan Answers," there is a deep truth to it: "People want certainty."[263] Palliative care is especially well-situated to challenge the myth that knowledge cures uncertainty. Just as technological interventions can contribute to suffering, knowledge does not always resolve uncertainty but can, in fact, reveal even more to be uncertain about. Sometimes, grasping for answers to remove uncertainty may even interfere with those things that are valued most and, hence, become a source of suffering. Certainty, after all, is just one among a plurality of things that can be valued, and it is not always the most important.

[255] (Etkind, 2022; Lipshitz & Strauss, 1997)
[256] (Brashers, 2001; Donovan et al., 2015; Nanton et al., 2016)
[257] (Andersen et al., 2020; Arias-Rojas et al., 2019; Sellars et al., 2019)
[258] (Etkind et al., 2022; Nanton et al., 2016)
[259] (Sulmasy, 2006b, pp.125-130)
[260] (Gross & Koffman, 2024)
[261] (Etkind et al., 2024, p.2)
[262] (Simpkin & Schwartzstein, 2016, p.1713)
[263] (UM, 2021) See (Rock, 2025)

This chapter focuses on the first of the key themes of this dissertation: managing expectations. In what follows, I argue that medicine is uncertain, and I challenge the assumption that more knowledge cures uncertainty.

Managing Expectations—Medicine is Uncertain

Management of expectations is an important aspect of medical care. In an article titled "Tolerating Uncertainty—The Next Medical Revolution," Simpkin and colleagues propose that changing expectations about uncertainty could help facilitate a shift in the culture of medicine.[264] Much research suggests that one way to deal with uncertainty better in medicine is to normalize it.[265] Just naming uncertainty is a therapeutic technique for dealing with it.[266] Some studies show that good communication of uncertainty can be a starting point for open and honest conversation.[267]

Many taxonomies organize types of uncertainty experienced in medicine. The existing research in this area is well-developed, and my aim in this chapter is not to propose a new taxonomy but rather to briefly survey several well-established ones, as introduced by various researchers, to illustrate the scope of uncertainty in medicine. Uncertainty that arises from personal ignorance might be best managed through a simple information search; however, as the diversity of these taxonomies shows, uncertainty in medicine runs deeper than ignorance of knowledge.[268]

[264] (Simpkin & Schwartzstein, 2016, p.1714)
[265] (Patel, Hancock, Rogers, & Pollard, 2022; Pearson et al., 1995; Scott, Sudlow, Shaw, & Fisher, 2020; Scott et al., 2023; Smith et al., 2013; Sommers, Morgan, Johnson, & Yatabe, 2007)
[266] (Helmich et al., 2018; Scott et al., 2023, p.424)
[267] (Hatch, 2017; Medendorp et al., 2021; Scott et al., 2023)
[268] (Babrow, Kasch, & Ford, 1998, p.3) cites (Sheer & Cline, 1995)

Renée Fox (1957)

Fox conducted pioneering sociological studies of uncertainty in medicine.[269] In her study of uncertainty experienced by medical students, she identified three types of uncertainty that arise from limitations in personal medical knowledge, limitations in collective medical knowledge, and the difficulty of distinguishing between the two. In her fieldwork, Fox noted that the medical training process not only introduced students to uncertainty but taught them ways of thinking about it. The first mechanism for coping with uncertainty was to "gain as much cognitive command of the situation as possible through acquisition of greater medical knowledge, and technical skill and increasing mastery of probability reasoning logic…"[270] As the students matured in their careers, they adopted a more "affirmative attitude" towards medical uncertainty, and used it to foster a "philosophy-of-doubting;" they displayed "certitude" to reassure patients and coped with the stress of uncertainty through dark humor, for example making bets on whether a patient would live or die.[271]

Fox began her 1957 study with a quote from James Constant: "There are areas of experience where we know that uncertainty is the certainty."[272] Although Fox's taxonomy frames uncertainty in terms of limitations in knowledge, it is important to note that she studied medical students (who, by and large, are concerned with acquiring knowledge). In her 1980 article, "Evolution of Medical Uncertainty," Fox reflected on her earlier fieldwork. She observed a "paradoxical" trend in the direction in which uncertainty was evolving in American culture and pointed to medicine as an epicenter. On the one hand, she noticed that interest in medical uncertainty had increased "in order to discover new knowledge, achieve new certainty and

[269] (Fox, 1957; Fox, 1980, 2020)
[270] (Fox, 1980, p.7)
[271] (Ibid., pp.7-8)
[272] (Fox, 1957, p.207)

make progress enhancing the quality and prolonging the length of human life."[273] On the other hand, she observed indignation at the incapacity of medical science and technology to deal with problems of health and well-being, "anxiety" about the "hubris" of medicine in its attempts to master such problems through knowledge, science and technology, and the conviction of the need for limits to deter scientific and technological interventions that were hazardous to health.[274] Importantly, Fox argued that uncertainty in medicine did not stand in isolation but existed within broader philosophical trends that shaped approaches to uncertainty. She also pointed out that medicine was not only an emergence from these trends but a place in which "fundamental aspects of our social, cultural, and cosmic way of thinking, feeling and believing about ourselves, our society, this planet and the universe are gradually being altered."[275] In medicine, larger cultural responses to uncertainty are being created.

Eric Beresford (1991)

Beresford interviewed physicians concerning uncertainty that affected the allocation of medical resources. His taxonomy includes technical uncertainty, which arises from inadequate scientific data; personal uncertainty, which arises from not being able to know patients' wishes; and conceptual uncertainty, which arises from the problem of applying abstract criteria to concrete situations.[276]

Beresford began his taxonomy with an explanation that "[uncertainty] is endemic to clinical practice not merely because there is too little information available to the physician or because available information is inadequately understood, but because of the very nature of the

[273] (Fox, 1980, p.44)
[274] (Ibid., p.45)
[275] (Ibid., p.45)
[276] (Beresford, 1991)

decisions that characterize the practice of medicine."[277] He ended it by reiterating, "Doctors will be able to [acknowledge uncertainty] better if they recognize uncertainty to be not a technological failure caused by limitations in their knowledge or skill in applying it but rather a ubiquitous element of the inherently interpersonal, context-specific and judgment-dependent nature of the practice of medicine."[278] In short, the problem of uncertainty in medicine is not simply caused by a lack of knowledge. Therefore, seeking more knowledge cannot solve it.

Merle Mishel (1998)

Mishel's influential work in nursing literature defined uncertainty from a patient's perspective as "the inability to determine the meaning of illness-related events."[279] In her concept analysis of uncertainty, she identified four dimensions of patients' experiences of uncertainty in illness: ambiguity concerning the state of the illness; complexity of treatment and the system of care; lack of information about the diagnosis and seriousness of the illness; and unpredictability of the outcome of the disease and prognosis.[280]

Below are examples of uncertainty experienced by cancer patients. They were reported in her nursing study "Adjusting Fit: Development of Uncertainty Scales for Specific Clinical Populations."[281]

[277] (Ibid., p.6)
[278] (Ibid., p.11)
[279] (Mishel, 1988, p.225)
[280] (Ibid., p.225) See (Mishel, 1981, 1983, 1988; Mishel & Braden, 1987, 1988)
[281] (Mishel, 1990)

TABLE 6 The Four Uncertainty Clusters for the Symptom Population Scale

Ambiguity Concerning the Meaning of Symptoms
The explanations they give about my condition seem hazy to me.
There are so many different types of staff, it's unclear who is responsible for what.
*I can predict how long my illness will last.
*I'm certain they will not find anything else wrong with me.
*My physical distress is predictable. I know when it is going to get better or worse.
The doctors say things to me that could have many meanings.
Complexity Regarding the Effect of Treatment Upon Symptoms
I have a lot of questions without answers.
It is unclear how bad my pain will be.
I do not know when to expect things will be done to me.
I have been given many differing opinions about what is wrong with me.
My treatment is too complex to figure out.
It is difficult to know if the treatments or medications I am getting are helping.
Deficient Information Concerning Diagnosis
I don't know what is wrong with me.
They have not given me a specific diagnosis.
*The seriousness of my illness has been determined.
*My diagnosis is definite and will not change.
Unpredictability Concerning Outcome
The course of my illness keeps changing. I have good and bad days.
Because of the treatment, what I can do and cannot do keeps changing.
It is difficult to determine how long it will be before I can care for myself.

*Items Reverse Scored

Figure 2) Table by Mishel illustrating four dimensions of patients' experiences of uncertainty in illness.[282]

Mishel's study stressed the emotional burden and anxiety suffered as a result of uncertainty. However, in "Uncertainty and Illness," Mishel questioned the assumption that uncertainty was an inherently negative state that required reduction. She writes,

> …Uncertainty is not inherently a dreaded or desired state until the implications of the uncertainty are determined. Under conditions of uncertainty, there is great potential for diverse evaluations and outcomes because the situation lacks form or structure, thus leaving it open to multiple definitions. Because of the amorphous natures of the stimuli, they can be shaped by the person's appraisal and reformed like putty.[283]

In pragmatic terms, uncertainty is understood through its effects—effects that we actively influence and shape.

[282] (Mishel, 1983, p.365)
[283] (Mishel, 1988, p.225)

Jürgen Kasper and Colleagues (2008)

Kasper and colleagues developed a taxonomy of uncertainties that were experienced by cancer patients in the context of shared decision-making. They discussed uncertainty that arose from disease-related issues such as prognosis, diagnosis, and treatment; risk communication such as how to decipher information, the role of the medical dyad, and physician trustability; and aspects of coping with life with the disease.[284] These were broken down further into eight categories of uncertainty, which are illustrated in Figure 3.

Table I. Categories of uncertainty, definitions and exemplary statements from interviews with people suffering from cancer

Uncertainty	Regarding...	This category includes uncertainties concerning...	Typical statement
1	...social integration	... the reliability of social relationships in the face of the disease's dynamics.	'I often think about my wife. I wonder how long she can stand it.'
2	...diagnosis and prognosis	... the current state of the disease and its future course.	'I don't know how to interpret this kind of pain that I never felt before, you know?'
3	... deciphering information	... the interpretation of the behaviour of medical staff and other kinds of information received by the patient.	'My physician told me about this additional diagnostic procedure. I think he already knew about the tumour, but he didn't want to tell me.'
4	... mastering of requirements	... the ability to cope with disease related life changes.	'So, what about my job?'
5	... causal attribution	... cognitive integration of being affected by a chronic disease.	'Maybe I did something wrong in my life. Maybe God...Well, I don't know.'
6	... own preferred degree of involvement	... the extent to which a patient is willing to play an active role in the physician patient interaction.	'I worry if I drive my doctor mad by expressing all my doubts.'
7	... physician's trustability	... both the professional and the personal competencies of the medical staff.	'I think he is up to date...I hope so at least.'
8	... treatment	... the efficacy of a treatment as well as of other supporting activities.	'In the beginning, I read some books about Chinese medicine and acupuncture and so on. But fortunately the chemotherapy was not so hard.'

Figure 3) Table by Kasper et al. illustrating categories of uncertainty and examples.[285]

Kasper et al. disagreed with those who argued that "certainty should be the goal of evidence-based information process." They proposed that though honest negotiation of uncertainty between physicians and patients might not reduce uncertainty, it still could have important benefits for patients in the context of shared decision-making.[286] Other studies suggest, however, that overexpression of uncertainty can result in poorer patient satisfaction with decisions and distrust of the physician.[287] For instance, Politi et al. reported that in shared

[284] (Kasper et al., 2008)
[285] (Ibid., p.46)
[286] (Kasper et al., 2008, p.42) See (Anderson et al., 2013)
[287] (Barclay, Momen, Case-Upton, Kuhn, & Smith, 2011)

decision-making with breast cancer patients, greater expression of uncertainty correlated with worse decision satisfaction for patients.[288] Other studies show that patients want to discuss uncertainty with their physicians but that these needs go unmet.[289] The communication of uncertainty is complex and has been named an important research priority in uncertainty management.[290]

Trisha Greenhalgh (2013)

Greenhalgh offers a four-part taxonomy of uncertainty based on experiences in primary care. Through a series of cases from a Friday evening clinic she describes uncertainty as rooted in: EBM ("the voice of medicine dimension of the visit"); the narrative of the patient's story ("the voice of the lifeworld dimension of the visit"); case-based reasoning ("what best to do for the particular patient"); and multi-professional care (complications of collaboration with people, medical systems and technology).[291] She makes a key distinction between uncertainty driven by patient agendas and that of physicians. Greenhalgh acknowledges the value of EBM and clinical guidelines but questions how they are used in practice. In her critique she lists the "quality marks" that have been misappropriated by vested interests, the sheer volume of evidence and guidelines that have become unmanageable, the differences between statistical and clinical significance, the overemphasis on following inflexible algorithmic rules, and technology-driven prompts that result in care that is management-driven rather than patient-centered, the poor fit of EBM-based guidelines to complex multimorbidity, and the problems of applying generalized population data to individual cases.[292] From such critiques, it is evident

[288] (Politi, Clark, Ombao, Dizon, & Elwyn, 2011)
[289] (Momen, Hadfield, Kuhn, Smith, & Barclay, 2012; Wright et al., 2008)
[290] (Etkind et al., 2024)
[291] (Greenhalgh, 2013)
[292] (Greenhalgh, Howick, & Maskrey, 2014)

that EBM cannot provide certainty through its surrogate of "probability." The fact that medicine deals in probabilities implies that there is uncertainty embedded within.

Ian Scott and Colleagues (2023)

Scott and colleagues state that "despite the ubiquity of uncertainty in medicine, clinical culture too often fails to acknowledge it…"[293] They provide a helpful corrective through a narrative review of clinical uncertainty experienced by physicians. The taxonomy of uncertainty offered by Scott et al. helpfully integrates several uncertainty taxonomies, and examples are listed in Figure 4.

1 Examples of clinical uncertainty

Type of uncertainty	Example
Diagnostic	Child with irritability and fever — is it meningitis?
	Older patient with exertional dyspnoea and who is overweight, smokes and has cardiac risk factors — is it heart failure, chronic obstructive pulmonary disease, or deconditioning?
Therapeutic	Patient with reduced exercise tolerance, fatigue and "brain fog" post- coronavirus disease 2019 (COVID-19) — what treatments may help?
	Older multimorbid patient with heart failure, chronic kidney disease, Parkinson disease, polypharmacy, and declining function — will starting a new drug to treat one of these conditions make another condition worse?, will ceasing a drug potentially improve or worsen their clinical state?
Prognostic	Patient with a new presentation of depression — are they suicidal and is there an increased risk of suicide if they are started on an antidepressant?
	Older frail patient with hearing impairment presenting for driving assessment — are they fit to drive for another year?
Investigational	Patient with unintentional weight loss and fatigue but no other specific symptoms or signs — what tests will be most useful in diagnosing underlying disease?
	Otherwise well person presenting with mild cough and elevated white cell count — is further investigation required?
Interpretive	Patient with slight enlargement of retroperitoneal lymph glands found incidentally on abdominal computed tomography scan performed to investigate flank pain — is this pathological?
Supportive	Older frail patient living alone who is cognitively impaired and presents with recurrent falls — will a home care package be sufficient or do they need residential aged care?
Triaging	Patient with cardiac risk factors who presents following an episode of retrosternal chest pain, but has normal physical examination and electrocardiogram — should they be referred immediately to an emergency department or urgently to a chest pain clinic, or should they be closely monitored by their general practitioner with further investigations?
Procedural	Patient with suspected giant cell arteritis who needs a temporal artery biopsy — how to organise this and who does it? Vascular surgeon, general surgeon, ophthalmic surgeon, rheumatologist?
Ethical	Morbidly obese patient with poorly controlled diabetes and severe interstitial lung disease who develops severe community-acquired pneumonia with septic shock and acute respiratory failure — will mechanical ventilation be of benefit despite their wishes for full cardiopulmonary resuscitation?
	Male patient with newly acquired chlamydia urethritis after an overseas work trip asks you not to inform his wife who is also your patient — what is the appropriate course of action?
Contextual	Patient who is a female refugee, speaks little English and has cultural sensitivities about being physically examined by a male doctor — how should the required clinical information be obtained?
	Patient who is new to the clinic and has several urgent and complex problems — how to prioritise to make best use of limited time?

Figure 4) Table by Scott et al. illustrating types of clinical uncertainty and examples.[294]

[293] (Scott et al., 2023, p.418) cites (Simpkin & Schwartzstein, 2016)
[294] (Ibid., p.419)

Scott and colleagues write,

> …Uncertainty pervades many…areas of practice, such as how to deal with incidental or ambiguous findings from an ever-increasing array of laboratory investigations, what treatments to prescribe for conditions for which there are multiple options, how to predict illness trajectories and navigate the care of patients through a complex health system, and how to ethically decide what care to provide while reconciling patient wishes with likelihood of benefit and limited resource availability. In addition, scientific evidence is non-existent, conflicting, inconclusive, or not applicable for many clinical questions, so deciding what constitutes best care in a particular set of circumstances remains uncertain (epistemic uncertainty). Equally, even with high-quality evidence, it can be difficult to predict the effects of interventions in individual patients (aleatory uncertainty). Contextual factors can also inject more uncertainty into clinical encounters by disrupting reasoning processes, these being clinician-related (e.g., fatigue, hunger), patient-related (e.g., poor English proficiency, presentation complexity), or environment-related (e.g., noise, distractions, time pressures).[295]

Many of the medical uncertainties that are listed in Figure 4 are *increased* as a result of the increase in medical knowledge. For example, the escalating array of laboratory exams and the increasing ability to detect small findings leads to more uncertainty regarding testing options, incidental findings, and false positives. More treatment options and lengthening the lives of seriously ill patients leads to more complexity and multimorbidity and the uncertainty that accompanies the management of such conditions. The increasing development and complexity of healthcare delivery makes navigation of the system more uncertain. An overabundance of data increases conflicts and confusion amidst the difficulty of interpreting incommensurable studies. Contextual factors that have significant effects on a clinical situation might be overlooked when attention is on increasing certainty through the acquisition of knowledge. Research on uncertainty increasingly shows the limits of scientific evidence and the value of a plurality of alternative care options.[296]

[295] (Ibid., 2023, p.418)
[296] (Ibid., p.434)

Paul Han and Colleagues (2021)

Han developed a comprehensive taxonomy of uncertainty that integrated pre-existing taxonomies, a literature review on uncertainty from the fields of communication, decision science, engineering, health service research, and psychology, and his own empirical research on uncertainty in clinical medicine. In a play on James *VRE,* Han titles his taxonomy "Varieties of Uncertainty in Healthcare"[297] and explains it further in his 2021 book, *UM:FT.*[298] In this work, he proposes a taxonomy that visualizes uncertainty across three dimensions: source (informational or conceptual), issue (scientific, practical, or personal), and locus (the person in whose mind the uncertainty resides).[299] Figure 5 depicts Han's conceptualization of the "sources" of uncertainty.

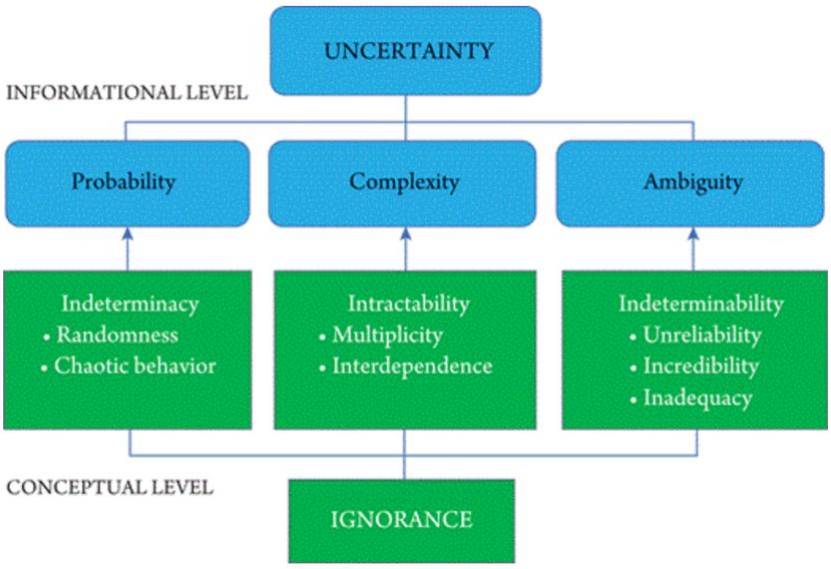

Figure 5) Graphic by Han illustrating sources of uncertainty.[300]

[297] (Han et al., 2011)
[298] (Han, 2021)
[299] (Ibid., pp.31-58)
[300] (Ibid., p.39)

Han argues that uncertainty arises from probability, complexity, and ambiguity, each of which finds its root cause in the fundamental limitations of human knowledge. Probability is rooted in indeterminacy—the ontological lack of a definitive or fixed outcome or result.[301] Ambiguity is rooted in indeterminability—the epistemic inability to establish a definitive or fixed outcome, result, or answer.[302] Complexity is rooted in intractability—the resistance of a problem to human comprehension or control. Therefore, uncertainty cannot be cured through more knowledge because, by the very nature of human knowledge, uncertainty is inevitable.[303]

After explaining sources of uncertainty, Han continues to explore ways in which uncertainty manifests in specific, concrete problems, i.e., issues of uncertainty. He divided issues of uncertainty into three categories: scientific (disease-centered), practical (system-centered), and personal (patient-centered). Then, he broke down these categories further and illustrated them with a specific example of cancer treatment (see Figure 6).

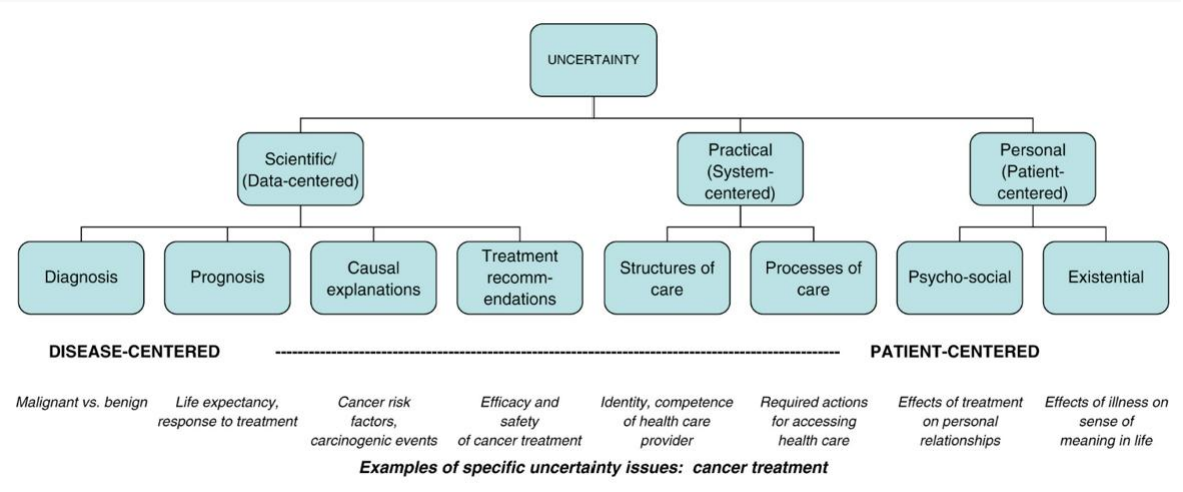

Figure 6) Graphic by Han illustrating issues of uncertainty using an example of cancer treatment.[304]

[301] (Ibid., p.41)
[302] (Ibid., p.43)
[303] (Ibid., pp.39,45)
[304] (Han et al., 2011, p.835)

Han also mentions some of the uncertainties that plague the philosophy of science. Science is a fallible enterprise, provisional, hypothetical, and open to revision. Arthur Koestler, in *The Ghost in the Machine,* writes*,* "The progress of science is strewn like an ancient desert trail, with the bleached skeletons of discarded theories which once seemed to possess eternal life."[305] In other words, the passage of time sweeps away what was once thought to be certain fact.[306] Referencing Karl Popper, philosopher of medicine Benjamin Djulbegovic reminds physicians that "Although it can be argued that in our subjective experiences of convictions, we can be 'absolutely certain,' every scientific statement remains tentative and, therefore, uncertain forever."[307]

I could mention other uncertainties in the philosophy of medicine, such as the uncertain boundary line between "normal" and "abnormal," and the meaning of "health,"[308] controversial disease categories, deeper epistemological debates about the role of evidence, the uncertainty of induction, deduction, abduction and empirical methods, metaphysical questions of realism, antirealism and instrumentalism, problems of subject-object distinction and underdetermination of theories by evidence, etc. The philosophical assumptions behind approaches to uncertainty are rarely addressed.[309]

Also, curiously absent from such discussions of uncertainty are notions of religion/spirituality and mystery and their potential to provide alternative frameworks by which to approach it.[310]

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[305] (Koestler, 1968, p.178)
[306] (McGrath, 2020, pp.43, 138)
[307] (Djulbegovic et al., 2011, p.309) references (Popper, 2005)
[308] (Eddy, 1984, p.75)
[309] See (Djulbegovic et al., 2011) as exception.
[310] If religion/spirituality is mentioned, it is usually in the context of a way in which spiritual/religious beliefs contribute to positive/negative coping among patients. E.g., (Landis, 1996). Rarely is it suggested that religion/spirituality could inform medicine's approach to uncertainty on the whole. See (Sulmasy, 1997) as exception.

The taxonomies of Fox, Beresford, Mishel, Kasper, Greenhalgh, Scott, Han, and other conceptual models of uncertainty, although helpful, cannot capture the depth and significance of the uncertainties that are lived and experienced.

Uncertainty in Palliative Care

To someone outside medicine, palliative care might seem to be the specialty with the least uncertainty. After all, doesn't a patient enter palliative care when it is certain that they are going to die?

Palliative care is not limited to the care of the acutely dying but extends to the management of patients with serious illness. The scope of the specialty encompasses adjustment to a new diagnosis, living with advanced illness, approaching end-of-life, and imminently dying. The provision of palliative care services early (and throughout) this journey has been shown to improve patient outcomes.[311] The specialty cares for patients with a diversity of conditions and complex medical needs, for example, cancer, dementia, HIV, heart, liver, kidney or pulmonary disease, stroke, coma, extreme birth prematurity, the frailty of old age, and more.[312]

It is challenging to predict the prognosis or the course of the illness. The transition from curative to hospice care and decisions to forego curative-aimed treatments (such as chemotherapy) or to suspend supportive care (such as artificial nutrition, dialysis, and ventilator support) is fraught with uncertainty. Even once a patient has entered the stage of actively dying, the uncertainty experienced is as acute as that of labor and delivery because the time of death is unpredictable. After death, uncertainty continues for bereaved family members,

[311] (Greer et al., 2012; Temel et al., 2010; Zimmermann et al., 2014)
[312] (CMS, 2023)

who grieve and cope with their loss. Caregivers and clinicians sometimes look back and wonder, "Did I do the right thing?"[313]

All of the taxonomies introduced above relate to uncertainties that are experienced in end-of-life care. Though diagnostic uncertainty may play a less prominent role than in other specialties, uncertainties that arise from other domains (such as prognosis, causal explanation, structures and processes of care, and psycho-social and existential issues) may be increased.

In palliative care, some types of uncertainty are especially prevalent—for instance, prognostic uncertainty, the predicted course of illness.[314] A commonly encountered question is: "How long have I got, doctor?" In life-limiting illnesses, disease trajectories are often unpredictable, and uncertainty remains even when life expectancy is short. Many studies show the unreliability of prognostic estimates and difficulties in communicating prognosis (Case 3).[315]

Another type of distinctively prevalent uncertainty is interpersonal. Communication is often fraught with uncertainty and is a major source of ethical difficulty and stress.[316] Some examples include navigating complex emotions surrounding death, loss, and grief; facilitating family relationships and dynamics; responding to difficult questions; and understanding a patient's values and wishes even when the patient is not conscious or has lost capacity. The uncertainty of such discussions is a major reason important goals-of-care conversations are delayed or not addressed at all.[317] A study on uncertainty in pediatric palliative care found that prognostic,

[313] (Nelson, Schrader, & Eidsness, 2009; Robinson et al., 2021)
[314] (Gramling et al., 2018)
[315] (Blackmore, Verne, & Pring, 2011; Boyd & Murray, 2010; Christakis & Iwashyna, 1998; Coventry, Grande, Richards, & Todd, 2005; Cowie, 2002; Etkind, Karno, Edmonds, Carey, & Murtagh, 2015)
[316] (Hamui-Sutton, Vives-Varela, Gutiérrez-Barreto, Leenen, & Sánchez-Mendiola, 2015)
[317] (Anselm et al., 2005; Back, 2015; Bekelman et al., 2017; Durall, Zurakowski, & Wolfe, 2012; Granek, Krzyzanowska, Tozer, & Mazzotta, 2013; Hancock et al., 2007; Rasoal, Kihlgren, James, & Svantesson, 2016)

informational, individual, communication, relational, collegial, and inter-institutional uncertainty contributes to delays in even referring patients to palliative care.[318]

The uncertainty of prognosis is compounded by the uncertainty of communication and can cause much suffering. Consider the following quotations from various qualitative studies that report patient and caregiver experiences of end-of-life care:

From a patient with end-stage renal disease:

> *Will I get a warning to go to the hospital? I don't know any of this. They (doctors) don't really give me straight answers, and that's what bothers me. I want answers. I don't want (my children) to get up one morning to find me there.*[319]

A dialysis patient:

> I *need to know what the symptoms are and he wouldn't tell me...because I'm really worried about nausea, vomiting, and not being able to breathe. Someone should be talking to you about what's coming.*[320]

A caregiver reports:

> *We weren't actually told she was dying, she spent one month only on oxygen. Near the end we were offered palliative care people, they spoke with our Dad who wasn't accepting that Mum wouldn't recover. My sister and I were not impressed with them, outward appearance etc. When in hospital I requested timeline but very difficult to get information. Dr said she is in final stages of [heart failure], I asked how much time this meant…months, weeks, days, no one would answer and give me an idea.*[321]

[318] (Hill et al., 2020)
[319] (Davison, 2006)
[320] (Ibid.)
[321] (Robinson et al., 2021, p.4)

A family member of a patient:

> *Based on the care of patients, especially those close to death, I think the staff could have been more open about how much time she had left. I think that there are signs when the body is shutting down and staff, having the experience of caring for the elderly could possibly estimate how long patients have left e.g. discoloration in feet and hands etc…not specific times as no one knows but estimated. I think her children would have had the opportunity to see her before her passing as they were not living in Auckland.*[322]

Another still:

> *"It was a bewildering experience, maybe I could have requested more care but would it have helped him much? I didn't think so at the time."*[323]

Uncertainty in palliative care significantly impacts not only patients' deaths but also patients' lives.[324] A woman diagnosed with stage IV Hodgkin's lymphoma at the age of thirty-three writes:

> *After going through 18 months of hospitalizations, surgeries, chemotherapy, and treatments, I asked my oncologist, 'When will I be out of the woods?' He answered, 'You will never be out of the woods.' Having worked so hard to stay alive, I had not grasped the degree of uncertainty and struggle that would come with being a survivor. Understanding that my life would only ever be lived with the caveat of 'for now' was sobering. I wondered so many things: How do I continue to live this way? What am I able to count on? How do I live while expecting to die*?[325]

In a study of patients with life-limiting conditions, Etkind et al. found that patients suffered distress from uncertainty related to five thematic domains: appraisal and management of multiple illnesses; fragmented care and communication; feeling overwhelmed; the uncertainty of others; and continual change.[326] In a qualitative study that involved interviews with bereaved

[322] (Ibid., p.4)
[323] (Ibid.,, 2021, p.4)
[324] (Bristowe et al., 2015; Cox, Miller, Kuhn, & Fritz, 2021; Donovan et al., 2015; Etkind et al., 2017; Etkind & Koffman, 2016; Fox, 1980 ; I. Higginson et al., 2015; Hoth et al., 2013; Mason et al., 2016; Nanton et al., 2016; Pinnock et al., 2011; Selman et al., 2007)
[325] (Nelson, 2022) quotes (Nelson, 2020, pp.1-3)
[326] (Etkind et al., 2022)

family members regarding personal experiences of end-of-life care, ten significant themes emerged, one of which was explicitly named "uncertainty."[327] To quote palliative care physician Rosalie Shaw, "Caring for the dying is often very demanding. It requires not just clinical competence and the ability to communicate with honesty and compassion. It also demands that we are able to live with uncertainty and the awareness that death comes to us all."[328]

Finally, one must mention the uncertainty that comes with death. This is not just a question of when death will occur. Families and patients are often anxious about not knowing what to expect in the dying process. How will I grieve, how will I cope, what will it be like? Will it be painful? Not to mention the spiritual questions that death raises about meaning, significance, and what comes after. Death has been described as the ultimate uncertainty.

In some ways, death is the one thing that is certain in palliative care. All our patients will die someday. Death is certain, but what is uncertain is what the journey will be like to get there. This is a type of uncertainty in which we can find hope because this uncertainty becomes a space in which we can make a real difference in the journey.[329]

As illustrated by the taxonomies mentioned above, there are a plurality of ways in which uncertainty can be a challenge and an opportunity to make a difference in a patient's journey. Some types of uncertainty can be reduced through the acquisition of more knowledge, but the types of uncertainties are diverse and complex and thus require more than a unilateral knowledge-seeking, uncertainty-reducing strategy, but many ways to respond.

[327] (Nelson et al., 2009)
[328] (Shaw, 2009, p.viii)
[329] (Dempsey & Mulder, 2023a)

Managing Expectations—More Knowledge Cannot Cure Uncertainty

Evidence-Based Medicine

Some have suggested that increasing knowledge through the use of EBM can provide a surrogate for certainty by increasing levels of probability. However, uncertainty in medicine pervades even the evidence-base.[330] The evidence behind EBM is challenged by notions of epistemic injustice—the exclusion of certain patient and professional groups from the opportunity to contribute to the epistemic endeavor of EBM, bias towards certain forms of knowledge, and epistemic privilege for certain groups.[331] Health researcher Jonathan Michaels shows how bias and distortions are present in every stage of the EBM process, from "generation, analysis and reporting of the underlying evidence, through the interpretation of such evidence, to the decision-making that determines access to healthcare resources."[332] Howick shows that third-party economic motivations fund and shape the production of evidence and that political interests determine how such evidence is created and used.[333] Uncertainty can be politicized and manipulated by governments, corporations, and interest groups.[334] Philosophically, Chiffi gives three reasons why medical assertions based on EBM are, by their very nature, always uncertain. First, evidence that justifies medical assertions in one theoretical frame of reference may not justify the same assertion in another frame of reference or for a different clinical purpose; second, as medical assertions are empirical knowledge they can never be conclusively proven and are always subject to the risk of error; third, evidence thresholds for justification are conventional choices based on epistemic and non-epistemic considerations.[335] Greenhalgh and others remind physicians that even with the

[330] (Howick, 2011)
[331] (Greenhalgh, Snow, Ryan, Rees, & Salisbury, 2015)
[332] (Michaels, 2021, p.417)
[333] (Howick, 2019)
[334] (Smithson, 1993)
[335] (Chiffi, 2021)

best evidence and guidelines, the application of abstract generalized knowledge to individual personal circumstances will always be uncertain.[336]

Medical philosopher Kathryn Montgomery, in *How Doctors Think,* puts flesh and bones on the above point by writing about her daughter's breast cancer and the difficulty of sorting through "the evidence."

> Knowing in medicine, a science of individuals, is a two way, bidirectional matter. What can be drawn from the individual experience? Can it be generalized? Abstraction from the particular case is always a problem in medicine. What did [my daughter's] sudden loss of energy 10 days after the first chemotherapy mean? Why did her hands bruise easily for a long time afterward? The usefulness of established abstractions is a puzzle too: how does general, scientific knowledge apply to [my daughter's] particular case? Why did marijuana, which has been declared ineffective, stop her nausea when two well-studied antiemetics with Food and Drug Administration (FDA) approval did not? Regular scans determined that Adriamycin didn't damage her heart. But what about other damage? The radiation that cures cancer causes it too. The statistical chances of developing leukaemia after exposure are known by radiologists. What are [my daughter's] chances? How do they compare to those of an eastern European under Chernobyl rainfall?...[337]
>
> The abstracts printed out were brutally plain: real lives aggregated into bare numbers. But they were no worse than a sentence glimpsed in a woman's magazine doing its Breast Cancer Month duty: only 65 % of young women with breast cancer survive five years. When finally I went to the stacks, I read everything and found no comfort.[338]

Like Montgomery, physicians too can find little comfort in the probabilities with which they work. We seek security in EBM, guidelines, numbers, scientific studies, algorithms, testing, diagnosing, and treating. These tools are valuable, but they cannot provide certainty.

[336] (Chiffi, 2021; Greenhalgh et al., 2014; Heath, 2014; Howick, 2011; Montgomery, 2019)
[337] (Montgomery, 2019, pp.26-27)
[338] (Ibid., p.20)

In a philosophical examination of uncertainty in medicine, Djulbegovic explains that epistemic uncertainty is dependent upon relationships between theory, evidence, and knowledge.[339] Quoting Nidolaidis et al., Djulbegovic states that applied scientists consider uncertainty as "the gap between certainty and the present state of knowledge."[340] Djulbegovic et al. submit that "in this view, the role of information is to reduce epistemic uncertainty" and they illustrates this conceptual relationship between knowledge and uncertainty with the image shown in Figure 7.

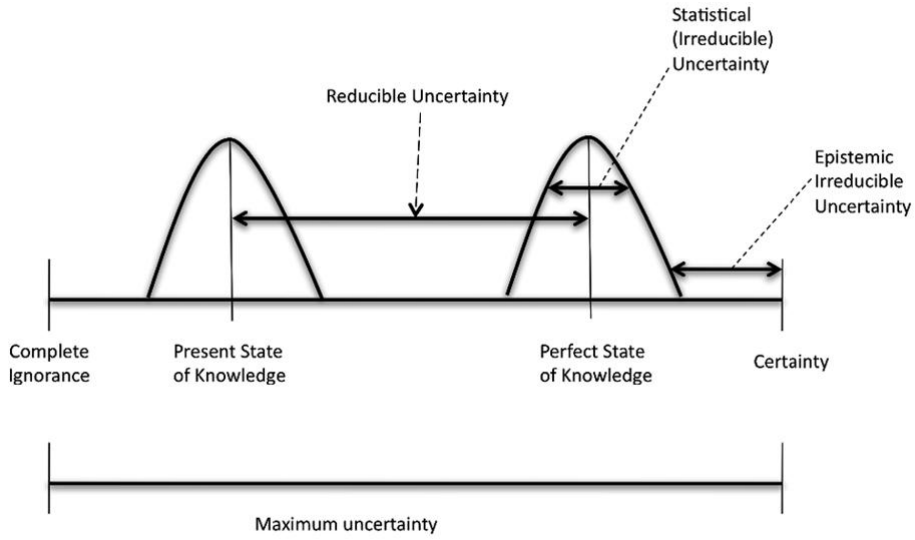

Figure 7) Graph by Djulbegovic illustrating the relationship between knowledge and uncertainty.[341]

In the figure, "complete ignorance" and "certainty" exist on opposite ends of a spectrum. On this spectrum, the "present state of knowledge" (which sits closer to the ignorance end of the spectrum) is compared with the "perfect state of knowledge" (which sits closer to the certainty end of the spectrum). The space between the "present state of knowledge" and "perfect state of

[339] (Djulbegovic et al., 2011, p.301) cites (Djulbegovic, Guyatt, & Ashcroft, 2009)
[340] (Djulbegovic et al., 2011, p.302) quotes (Nikolaidis, Ghiocel, & Singhal, 2005)
[341] (Djulbegovic et al., 2011, p.302)

knowledge" is titled "reducible uncertainty," which can be reduced through increases in knowledge. The small gap between the "perfect state of knowledge" and "certainty" is titled "epistemic irreducible uncertainty," which cannot be reduced due to limitations in the nature of human knowledge. This image illustrates that even in a state of perfect knowledge, irreducible uncertainty would remain.

When clinicians speak of uncertainty, something like Djulbegovic's model (which is organized around knowledge) may rest in the back of their minds. This model of uncertainty comes with its own implications for the solution to uncertainty. Djulbegovic concludes his nearly sixty-page treatise with the following sentence: "Uncertainty can be effectively managed by explicitly recognizing its many sources, improving the quality of medical evidence, using better information technology tools, searching for sources of bias, and applying probability and decision theory to decisions under uncertainty."[342] The model implies a solution that is focused on uncertainty and mostly focused on reducing it through the acquisition of more knowledge.

I find Djulbegovic's model and way of conceptualizing uncertainty to be problematic. In the background of this seemingly simple image are deeply questionable philosophical commitments—epistemic relations of subject-object, a correspondence-copy theory of truth, a fixed nature of the thing that is known, and disregard of the contribution of agency to the creation of that which is known. The image is too static for the dynamic realities of medicine and too impersonal for the personal realities with which medicine deals.

[342] (Ibid., p.347)

Schön's influential work *Reflective Practitioner: How Professionals Think in Action*, a seminal text in the teaching of medical students, offers an image far more suitable to the dynamic complexities of medical practice. He describes the practice of medicine as a swamp.

> In the varied topography of professional practice, there is a high hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution.[343]

Schön's image communicates the dynamic, uncertain, living reality of medical practice (the bog) while also affirming the necessity of simplifications in order to navigate it (high hard ground). He humbly acknowledges a "more" which escapes the grasp of our models. In Djulbegovic's graph, the size of the irreducible uncertainty is small; in Schön's bog, it is the vast majority of the landscape.

Missing from Schön's picture, however, is the active role that we as agents play in the construction of this "high ground." Inspired by James' pragmatism (which emphasizes fruitful leading, fallibility, and agency) and psychology (which considers concepts themselves as part of the stream of experience), I would alter Schön's image slightly and describe medicine as a network of platforms that are built across a bog to allow us to successfully navigate it. Some platforms lead more successfully than others, some break, and sometimes new ones must be built.

[343] (Schön, 1987, p.3)

Figure 8) Image of the "bog of uncertainty" in medicine. The theories and practice of medicine are like a network of platforms that are built across the bog to allow us to move through it, but are themselves part of the bog.[344]

Like Djulbegovic's model of uncertainty, the bog also implies certain ways of dealing with uncertainty. First, in the bog, the attention is not on reducing uncertainty (i.e., reducing the size, depth, or thickness of the bog) but is on acting, moving through the bog, and navigating it successfully to get to where one wants to go. Second, in the bog, one cannot speak of reducing uncertainty with more knowledge in the way that Djulbegovic does with his graph. In the bog model, agents use knowledge (and other things) to construct the trails. At the level of the wooden platform, in ordinary and conceptual language, one can speak of reducing uncertainty through knowledge. But at the level of the bog, uncertainty is not reduced by knowledge any more than adding wood reduces the amount of bog. The very concepts and simplifications we construct to guide us across the surface become part of the bog, added to it. Third, a key to this

[344] AI-generated image https://pixlr.com/image-generator/, Dempsey

image is the active role of the agents in constructing the paths and the practical, personal interests for which the paths are built. Fourth, paths are judged on how successfully they lead across the bog (not by how well they replicate it). Some lead successfully for a while, some rot, break down, or cannot bear the weight, and sometimes new paths might be needed. There is a sense in which our paths are fallible, provisional, and open to revision (or reconstruction).

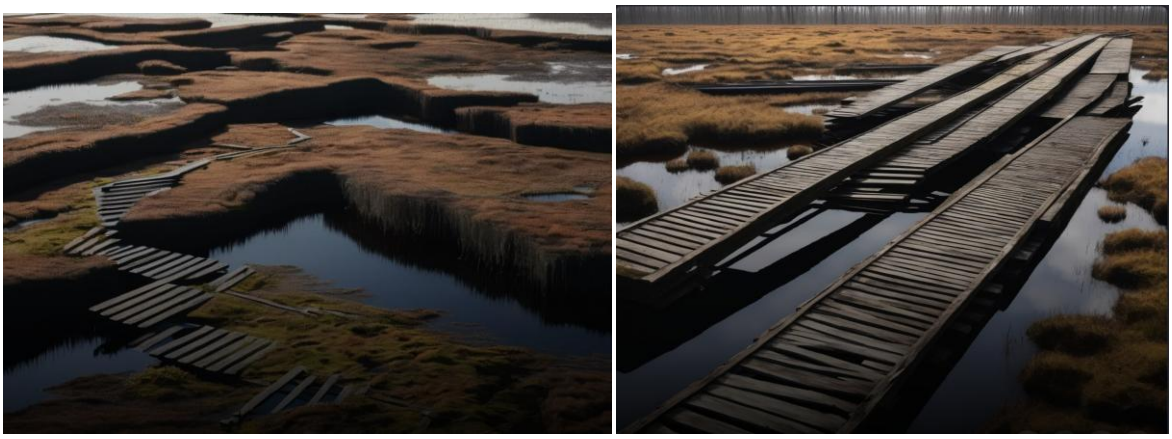

Figure 9) Image illustrating that some pathways in the bog lead more successfully than others and that paths are fallible, provisional, and open to revision/reconstruction.[345]

In the *Danger of Words,* the psychiatrist and student of Wittgenstein[346] O'Connor Drury writes, "However much the realm of what is explained is extended, the realm of the inexplicable is never reduced by one iota."[347] In James' words, "Our science is a drop, our ignorance a sea. Whatever else be certain, this at least is certain—that the world of our present natural knowledge is enveloped in a larger world of some sort of whose residual properties we at present can frame no positive idea."[348]

[345] AI-generated image https://pixlr.com/image-generator/, Dempsey
[346] Wittgenstein was influenced by James (Goodman, 1994).
[347] (Drury, 2018, p.296)
[348] (James, 2008q, p.50)

Conclusion: A Philosophy for Uncertainty

At the keynote address of the 2024 Canadian Palliative Care Congress, I asked an audience of a thousand palliative care providers to participate in an exercise and stand if they had experienced any of the following.

> Please stand up if you've ever been uncertain about how to apply guidelines to a patient in front of you…If you've ever read conflicting studies or gotten conflicting advice from colleagues and didn't know who to believe. If you've ever treated symptoms or pain without really understanding what was causing it. If you've ever been uncertain of your patients' motivation or their family's agenda. If you've ever been unsure if a treatment would make a patient's life better or worse. If witnessing a patient's story has made you ask questions about your own life and meaning. If you've ever seen something happen in your practice that some people might call miraculous.[349]

By the end of the first few statements, nearly all were standing. My point was that we are not alone in uncertainty, which is part of our job as clinicians, and rather than meaning that something is wrong, it might just be normal.

Most of the time, we go through our daily practice without being too fussed about all the uncertainty. When Greenhalgh wrote her taxonomy, she reported that she went to her weekly clinic looking for cases of uncertainty to write up and went home disappointed. She says,

> I had gone to surgery last Friday intending to collect some cases to illustrate uncertainty in clinical practice, having planned to start writing this chapter over the weekend. When I returned, I told my husband I was disappointed: not much uncertainty had been evident today. I would have to try again next week. Yet when I wrote out each of my 15 encounters as a brief case history, uncertainty was a central feature of every single one. I wondered why I had been blind to this at the time, even though I had approached the day's clinic specifically looking for examples of uncertainty.[350]

[349] (Dempsey, 2024a)
[350] (Greenhalgh, 2013, p.2)

As Greenhalgh went about her day, she did not perceive much uncertainty—but upon later reflection, she realized it had been present all along. She further reflects on why.

> It is worth reflecting here on why, as my Friday evening clinic unfolded in real time, I experienced little in the way of conscious feelings of uncertainty…That is not to say I was especially knowledgeable about the clinical topics I was encountering, but that I was processing multiple sources of information rapidly and largely unconsciously–and doing what normally works…[351]

This last line is key. Greenhalgh hardly noticed the uncertainty because she was "doing what normally works." Her attention was on action, doing what she needed to do to care for her patients. In response to uncertainty in medicine, we act; we just get on and do our job. We follow the protocol or the algorithm. We do a trial of treatment and see how the patient responds. We can be uncertain about a diagnosis or prognosis, but we can still be clear about the plan. I think there is something about acting that palliates uncertainty. We focus our attention on what we have to do.

The name "palliative care" is derived from the Latin word *pallium,* which means "to cloak." To cloak can mean to hide and cover, but it can also be to enfold, hold, and wrap around—the way a warm blanket can cloak and comfort. I think this turning of attention towards action can palliate uncertainty in both senses of cloaking.[352]

I began with the video of Michigan Answers. James' philosophy is almost the opposite of Michigan Answers. He argues that certainty cannot be promised as life is a risk of faith, in his words, built on a slope of maybes.[353] Knowledge is not the solution to uncertainty but action

[351] (Ibid., p.12) cites (Benner, 2001; Dreyfus & Dreyfus, 1986)
[352] (Twycross, 2003, p.9)
[353] (James, 2008ap, p.113)

in faith. Uncertainty is not always something to fight but perhaps can even become part of what makes life meaningful as we live into life's mystery.

I previously referenced Back's study in which patients suggested communication practices for when a condition could not be cured and goals of care needed to be transitioned to palliation. What these patients suggested could also be a description of James' philosophy.

1) Managing expectations about uncertainty

James' philosophy starts from a place of uncertainty. He writes,

> The [pluralistic, indeterminate, personal view of the world] which I defend represents that world as vulnerable, and liable to be injured by certain of its parts if they act wrong. And it represents their acting wrong as a matter of possibility or accident, neither inevitable nor yet to be infallibly warded off. In all this, it is a theory devoid either of transparency or of stability. It gives us a pluralistic, restless universe, in which no single point of view can ever take in the whole scene.[354]

Does not this world sound like the world of medicine? Fox, in "The Challenge of Uncertainty in Medicine," describes the pluralistic, indeterminate, personal world of medical practice.

> What a physician can do to help a patient, then, is often limited. What he ought to do is frequently not clear. And the consequences of his clinical actions cannot always be accurately predicted. Yet, in the face of these uncertainties and limitations, the physician is expected to institute measures which will facilitate the diagnosis and treatment of the problems the patient presents…The special difficulty of the physician…is that the material on which he works is the disease-stricken human being. Thus, the decisions the physician makes, the procedures he carries out, the drugs he prescribes have a proximate, visible, flesh-and-blood impact on the patients under his care. To a significant extent, whether patients get better, get worse, or whether their conditions remain stubbornly fixed is contingent upon what the physician is or is not able to do for them. Because the welfare of the patient is thus directly associated with

[354] (James, 2008g, p.136)

> his actions, the human consequences of his uncertainty, limitation, and fallibility are more apparent to the physician than to most other scientists.[355]

Certainly, certainty cannot be the foundation of a philosophy of medicine, but maybe uncertainty might be.

2) Turning attention to action

Voltaire wrote, "Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing."[356] Voltaire's quote seems a bit strong; the uncertain is not the completely unknown.

During our presentation at the UK Palliative Care Congress, my mentor, palliative care physician John Mulder, shared the following:

> I can say to my cancer patient, 'While I may not know precisely how your illness is going to play out, I do know that the disease is progressing, and in my experience, I have a good sense as to the ways in which this might play out, so I have some ideas as to what we might want to try next.'[357]

Mulder's philosophy resonates with James'—that which is beyond our ability to understand and control, we still may be able to act in relation to. In Chapter 3, I discuss James' pragmatism in-depth and summarize it as an attitude of turning attention from uncertainty towards action.

[355] (Fox, 2020) quoted in (Han, 2021, p.1)
[356] (Strauss, 1968, p.394)
[357] (Dempsey & Mulder, 2023a)

3) Living with uncertainty

Living courageously with uncertainty is a theme of James' philosophy and life. To understand how his pragmatism applies to palliative care, we must first look at the life that gave rise to it. Chapter 2 considers pragmatism in the context of James' life and experience with illness. In the words of James scholar John McDermott, "[James] was a man of moral courage, who knew, all too well, the ambiguity and precariousness of the human condition."[358]

[358] (McDermott, 2013, p.xxi)

2

Uncertainty & William James, MD

"*Objective evidence and certitude are doubtless very fine ideals to play with, but where on this moonlit and dream-visited planet are they found?"*[359]

~William James, "WtB"

"*Long after 'pragmatism'…shall have passed into a not unhappy oblivion, the fundamental idea of an open universe in which uncertainty, choice, hypotheses, novelties and possibilities are naturalized will remain associated with the name of James; the more he is studied in his historic setting, the more original and daring will the idea appear."*[360]

~John Dewey, *Characters and Events*

Introduction:

This chapter considers the life context from which James' insights on uncertainty arose. James' pragmatism was written for many purposes, one of which was in reply to the uncertainty of philosophical conversations of his day. After briefly introducing the role of uncertainty in his philosophy, I review James' medical biography and explore how his pragmatism was shaped by the uncertainty of serious illness, and was written for life with that uncertainty.

I develop Han's promising suggestion and show that James' philosophy does provide a foundation for a paradigm shift in medicine, but that the paradigm shift inspired by James does more than "tolerate" uncertainty; it palliates it.

[359] (James, 2008ax, p.22)
[360] (Dewey, 1929, p.440)

Han closes *UM:FT* with a plea for a new paradigm in medicine "that focuses not only on pursuing knowledge but on helping people live with uncertainty." He argues that such a paradigm shift requires "deeper philosophical commitments," and he ends with a suggestion that James' philosophy might provide the foundation.[361]

Uncertainty runs through the ontological, epistemological, and moral aspects of James' thought. Han writes that, for James, "reality is fundamentally indeterminate, human knowledge is inherently limited and right action is contingent on the particulars of the individual and situation."[362] Each of these ontological, epistemological, and moral domains illustrates the themes of managing expectations about uncertainty, turning attention to action, and living with Uncertainty.

Ontologically, James starts with uncertainty by virtue of indeterminism. According to indeterminism, uncertainty runs deeper than subjective perception into the nature of reality itself. The very elements of the universe "have a certain amount of loose play on one another, so that the laying down of one of them does not necessarily determine what the others shall be…and that things not yet revealed to our knowledge may really in themselves be ambiguous."[363] There is a turn action. James writes that in contrast with other views in which "reality is ready-made and complete from all eternity, for pragmatism it is still in the makings and awaits part of its complexion from the future. On the one side the universe is absolutely secure, on the other it is still pursuing its adventures."[364] Han points out that for James this

[361] (Han, 2021, p.133)
[362] (Ibid., p.133)
[363] (James, 2008g, p.118) quoted in (Han, 2021, p.133)
[364] (James, 2008ai, p.123)

indeterminism is not just a source of fear but part of a "gift"[365] that "makes life meaningful."[366] One could take courage from the fact that indeterminism is a gift; one could also say that this gift takes courage. Indeterminism comes with the risk of regret and mistakes.[367] With reference to the cross of Christ, James writes, "The world stands really malleable, waiting to receive its final touches at our hands. Like the kingdom of heaven, it suffers human violence willingly."[368]

Epistemologically, James' philosophy is rooted in fallibility. Human knowledge is at best limited, provisional, constructed, and open to revision. The following quotation from *VRE* describes the honesty of fallibility well.

> He who acknowledges the imperfectness of his instrument, and makes allowance for it in discussing his observations, is in a much better position for gaining truth than if he claimed his instrument to be infallible…The mere outward form of inalterable certainty is so precious to some minds that to renounce it explicitly is for them out of the question. They will claim it even where the facts most patently pronounce its folly. But the safe thing is surely to recognize that all the insights of creatures of a day like ourselves must be provisional. The wisest of critics is an altering being, subject to the better insight of the morrow, and right at any moment, only "up to date" and "on the whole." When larger ranges of truth open, it is surely best to be able to open ourselves to their reception, unfettered by our previous pretensions.[369]

Fallibility begins in uncertainty (as it acknowledges the "imperfectness" of the instrument of human knowledge). Fallibility, however, does not stop in uncertainty but entails a turn to action. First, there is honesty about the state of human knowledge. Second, there is humility.[370] This humility is in regard not only to the openness of revision but also to listening to a plurality of voices and other perspectives. For James, "no single point of view can ever take in the whole

[365] (James, 2008g, p.123)
[366] (Han, 2021, p.133)
[367] (James, 2008g, p.124)
[368] (James, 2008ai, p.123)
[369] (James, 2008av, p.267)
[370] (Croce, 2012; Goodson, 2010; Han, 2021, p.134)

scene."[371] James champions the voices of those who are excluded and the "cries of the wounded."[372] Being fallible does not mean being paralyzed in the face of uncertainty; rather, it means that one should act courageously in the midst of uncertainty. "Meanwhile, we have to live to-day by what truth we can get to-day, and be ready to-morrow to call it falsehood."[373] Fallibility does not preclude commitment and action. It takes courage to acknowledge uncertainty honestly, to listen humbly to the voices of others, to admit mistakes, and to live without guarantee. For these reasons, Han points to humility, flexibility, and courage as capacities to be cultivated to build tolerance of uncertainty.[374]

Morally, one acts in the thick of things and may not know in advance if one has made the right decision.[375] The starting place is that of uncertainty. In reply to those who demand certainty before they act, James replies that a rule that forbids us to act beyond evidence forbids us to live.[376] As he writes in "ILWL," "not a deed of faithfulness or courage is done, except upon a maybe...It is only by risking our persons from one hour to another that we live at all."[377] James preaches courage to act in faith ventures, especially in matters in which the outcomes are dependent upon our personal willingness to act in faith (Case 5).[378] Han cites the example of James' meliorism and summarizes it as a "brave moral optimism—a belief that desirable outcomes in life are neither inevitable nor impossible, but rather possible to attain" (Case 2).[379] In Latin, the word *melior*—from which meliorism is derived—means "better;" meliorism is the conviction that, through faith and effort, the world is not only changeable, but

[371] (James, 2008g, p.136)
[372] (Goodson, 2017; James, 2008ac, p.158; Putnam & Putnam, 2017, pp.360-384)
[373] (James, 2008ai, p.107)
[374] (Han, 2021, p.112)
[375] (James, 2008ac)
[376] (James, 2008am, p.126)
[377] (James, 2008q, p.53)
[378] (James, 2008ay)
[379] (Han, 2021, p.136; James, 2008ai, pp.137-139)

improvable.[380] The faith of meliorism couples uncertainty and action, and it requires courage to risk acting when there is no guarantee that what we strive for will be realized. It is not for naught that Han calls this worldview "brave."[381]

Han concludes his discussion of James as follows:

> An indeterminate conception of reality that construes the universe as unfinished and full of possibility; a fallibilistic conception of knowledge as pluralistic and constructed, and truth as a function of its practical consequences; an individually focused and optimistic conception of right belief and action as requiring a self-fulfilling faith in the possibility of a better world: These are the philosophical commitments inherent to the concept of uncertainty tolerance.[382]

There is an important pattern in the ontology, epistemology, and morality of James. Each starts in a place of uncertainty, turns attention from uncertainty towards action, and calls for living courageously with uncertainty. James' life and thoughts are intertwined. This pattern is evident not only in James' philosophy but also in James' biography, especially in the context of his serious illness.

As evidenced by James' life, his philosophy enabled him to do more than tolerate uncertainty; it palliated it, alleviating his suffering from uncertainty and enabling him to live his life meaningfully even in the midst of it. Pragmatism is for the living; we turn now to the life from which pragmatism emerged.

[380] (Fiala, 2019, p.4)
[381] (Han, 2021, p.136)
[382] (Ibid., p.136)

Managing Expectations: James' Experiences of Uncertainty

James Context: Nineteenth-Century America & "The Eclipse of Certainty"[383]

James (1842-1910) was born in America at a time of considerable social, cultural, technological, and intellectual uncertainty. Robert Richardson's biography of James is aptly titled, *William James: In the Maelstrom of American Modernism.*[384] In the nineteenth-century, industrialization, democratization, capitalism, nationalism, globalization and progressive reforms transformed the landscape.[385] There were rapid advancements in technology, transportation, westward expansion, and the American Civil War.[386] Slavery was abolished, and there was an upheaval of social roles in race, ethnicity, gender, and labor class.[387] There were changes in urbanization, immigration, new social hierarchies, and educational reforms. Also, with the increasing influence of democracy, there was increasing diversity and questioning of authority.[388]

Intellectually, the nineteenth-century witnessed the failure of the Enlightenment to provide philosophical foundations for certainty.[389] The intellectual landscape saw the advent of Darwinism, the blossoming of the Romantic movement and Transcendentalism, and the development of utilitarianism, Marxism, positivism, German idealism, and American pragmatism. There was expanding awareness of world religions, religious pluralism, historical criticism, and secularization.[390] Paradigms in philosophical, religious, and scientific thought were changing, and questions regarding relations between science and religion were of public

[383] (Croce, 1995)
[384] (Richardson, 2007)
[385] (Barney, 2008; Croce, 1995, pp.3-4)
[386] (Angevine, 2004)
[387] (Barney, 2008)
[388] (Croce, 1995, pp.3-4; Rasmussen, Wolfe, & Zachhuber, 2017, p.3)
[389] (Pasnau, 2017)
[390] (Barney, 2008, pp.317-333; Rasmussen et al., 2017)

concern.[391] This "maelstrom" of American modernity was the uncertain cultural context in which James lived.

In *Science and Religion in the Era of William James: Eclipse of Certainty,* Croce traces the cultural and intellectual developments of nineteenth-century America as an "eclipse of certainty" and does so through the life and thought of James. He argues that James' context was one in which foundations of certainty were being eroded by developments in science and religion and an emerging culture of uncertainty in both. New scientific discoveries such as evolution, which reframed science in terms of probabilities, and religious debates around pluralism and secularization raised doubts about dogma.[392] Croce describes a split between popular and professional discourse and promises of certainty from both science and religion.

> Average citizens had been accustomed to turning to religious leaders and scientists for assurance about fundamental truths and ultimate meaning, but as the century wore on, religion and science watchers found less final assurance from intellectual leaders and more frank inquiry among multiple viewpoints. An expanding base of knowledge seemed to the public to offer ever more definitive answers but when experts knew more, they simply multiplied the questions to be asked. Disappointed by the decline of certainty and intimidated by professional methods, many nonexperts exercised their democratic right to reject the best and brightest intellectual insights and cling willfully to conviction and simple common sense facts…professionals, therefore…developed a Janus-face: an edifice of certainty turned toward the public, and a private posture of steady unceasing scrutiny, with constantly multiplying question to their fellows within their disciplinary circle.[393]

In this restless and confused world, there was discord between promises of certainty and lived experience. Croce calls James a "pioneer in the culture of uncertainty" and portrays him as a figure prophesying and embodying the emerging awareness of uncertainty in science and

[391] (Carrette, 2013, p.158; Croce, 1995)
[392] (Croce, 1995, pp.x, 3-22)
[393] (Ibid., p.5)

religion.[394] Croce recounts that as James was raised in a religious home and educated in the sciences, his "early years were dominated by questions about the relations between, and the respective truths of, science and religion."[395] He argues that James "gleaned his messages of uncertainty from the heart of science itself"[396] and, in his maturity, came to embrace the uncertainties of both scientific and religious inquiry "without needing to reject religion or to defy science."[397] In summary, Croce writes, "[James] not only came to understand the intellectual and cultural place of uncertainty in science and religion, but also devised strategies to cope with it and its difficulties."[398]

William James, MD

"Describing William James has never been a straightforward task," begins Sutton in *WJ,MD.*[399] James is a complicated figure. It is for good reason that Gale titled his biography of James,' *The Divided Self of William James,*[400] and in *William James and Transatlantic Conversations*[401] authors Halliwell and Rasmussen trace James' life through the theme of zig-zag. Many discussions of James' life and thought focus on the intellectual and cultural "macro-contexts" and public writings—for instance, Croce's *Science and Religion in the Era of William James: Eclipse of Certainty*.[402] Sutton, however, looks to the "micro-context" of James' personal life and private writings.[403] She investigated 9,400 letters, James' unpublished notebooks, diaries, and reading lists, and concluded that "there is one element of James's life and work that unites [his] disparate identities…James's medical interests, concerns and values

[394] (Ibid., p.17)
[395] (Ibid., p.17)
[396] (Ibid., p.12)
[397] (Ibid., p.230)
[398] (Ibid., p.226)
[399] (Sutton, 2023, p.1)
[400] (Gale, 1999)
[401] (Halliwell & Rasmussen, 2014)
[402] (Sutton, 2023, pp.5-6)
[403] Other have investigated James personal writings, for example, (Perry, 1935). Sutton's work is unique in tracing the themes of James' medical interests.

are the threads that bind his seemingly unconnected pursuits together."[404] Medicine and James' personal experience of living with the uncertainty of serious illness, formed the center of James philosophic vision. James writes,

> Place yourself similarly at the centre of a man's philosophic vision and you understand at once all the different things it makes him write or say. But keep outside, use your post-mortem method, try to build the philosophy up out of the single phrases, taking first one and then another and seeking to make them fit 'logically,' and of course you fail. You crawl over the thing like a myopic ant over a building, tumbling into every microscopic crack or fissure, finding nothing but inconsistencies, and never suspecting that a centre exists.[405]

In this dissertation, I have taken Sutton's suggestion as a working hypothesis, that if James' work is read with medicine as a center of his philosophic vision, the reader is led fruitfully through his philosophy. I do not undertake historical or biographical analysis and am less concerned with defending Sutton's account than with following it and seeing where it leads. Reading James through the lens of medicine may pull disparate elements of his thought into satisfactory relations, carry readers from one part of his philosophy to the next, link things satisfactorily, and be helpful instrumentally in a dissertation that is trying to bring insights from James' philosophy into medical practice.[406]

I take Sutton's suggestion seriously, but with a caveat from James.

> …with every concrete thing…Our intellectual handling of it is a retrospective patchwork, a postmortem dissection, and can follow any order we find most expedient. We can make the thing seem self-contradictory whenever we wish to. But place yourself at the point of view of the thing's interior *doing,* and all these back-looking and conflicting conceptions lie harmoniously in your hand. Get at the expanding centre of a human character, the *élan vital* of a man…by living sympathy, and at a stroke you see

[404] (Sutton, 2023, pp.1-3)
[405] (James, 2008ag, p.117)
[406] (James, 2008ai, p.34)

> how it makes those who see it from without interpret it in such diverse ways. It is something that breaks into both honesty and dishonesty, courage and cowardice, stupidity and insight, at the touch of varying circumstances, and you feel exactly why and how it does this, and never seek to identify it stably with any of these single abstractions.[407]

James' philosophy emerges from the living, and Sutton, looking to the life James lived, offers a center from which to view his philosophy. However, the story of James' life that follows is an "intellectual handling," "retrospective patchwork," and "post-mortem dissection," and the pieces are put together in a way expedient for my purposes. I think Sutton's suggestion is helpful in reaching the "élan vital" of James and making "back-looking and conflicting conceptions lie harmoniously [in] hand." James himself, however, remains elusive. His biographical zig-zag of "honesty and dishonesty, courage and cowardice, stupidity and insight" means that no post-mortem reconstruction of James can be identified with the dynamic reality of James' life itself.

In James' philosophy, concepts cannot replace lived experience but can be pasted back into lived experience to create new experiences and new life.[408] Likewise, this telling of James' biography, and the concepts that I take from it, cannot be substituted for James' experience, but they can be substituted into experience, i.e., into the experience of medical practice in order to help those who live with uncertainty.

In my readings of James' work, I recognize the logic of medicine in which I have lived and trained. Sutton confirmed my intuition through her work, showing that James' pragmatism resonated so deeply with medical intuition because it originated in a medical context. The philosophy of every philosopher is shaped by their experience. For James, this common fact is

[407] (James, 2008ag, p.116)
[408] (Ibid., p.116-118)

of special significance. James' philosophy was written less as a philosophical system and more as a therapeutic tool to address the questions and concerns that were momentous to him.[409] Kaag, in *Sick Souls, Healthy Minds: How William James Can Save your Life,* writes, "James' entire philosophy from beginning to end, was geared to save a life, his life."[410] If James' philosophy was, in part, a form of self-therapy, then understanding his questions and experiences becomes essential to grasping his philosophy—and to exploring how it might help us palliate uncertainty.

William James, the Patient

James' private letters contain references to a vast scope of medical problems including neurasthenia, chronic back pain, poor eyesight, chronic gastric/digestive issues, heart problems, melancholia, and depression so severe that he contemplated suicide. James suffered chronically from medical conditions and the uncertainty associated with such conditions. He experienced the uncertainty of caring for family and loved ones with serious illness (Case 1), the uncertainty of living day-to-day with a fatal condition (Case 2), the uncertainty of prognosis (Case 3), the uncertainty of the "miraculous" and "unexplainable" (Case 4), and the uncertainty of wondering whether life was worth living (Case 5). Throughout his life, James travelled the world and turned to both science and religion/spirituality looking for cures. His ill-health never left him but as James approached death he found a way, when his body was most broken down, to finally become "fit to live."[411]

James earned his MD from Harvard Medical School in 1869, but his ill-health prevented him from practicing. Nevertheless, as Sutton points out, this was not the end of James' relationship

[409] (James, 2008ax, pp.14-15)
[410] (Kaag, 2020, p.3)
[411] (Sutton, 2023, p.167)

with medicine but rather the beginning of a life-long occupation with questions about health, healing, suffering, and a "staunch pursuit of healing wisdom for himself and society at large."[412]

Croce describes the time in which James lived as an "Age of Uncertainty."[413] Sutton states (quoting Peirce) that it was also an "Age of Pain."[414] In James' time, there was an epidemic of invalidism among his social class. His community, friends, and family—and even he himself—were afflicted by a condition of "weak nerves" known as neurasthenia. Neurasthenia was a complicated medical and social phenomenon that occurred among upper-class New Englanders at the end of the nineteenth-century. Medically, it was characterized by psychological and psychosomatic symptoms; according to Beard's diagnostic criteria, one symptom was uncertainty.[415] Socially, neurasthenia was used for personal identity and social manipulation and had great utility in justifying leisure in a work-centered culture—the recommended cure was a trip to Europe.[416] James' era was also an age in which health was elevated to the status of a moral duty to society. Evolutionary notions of health and the public health and hygiene movements placed pressure on the invalid to justify their role in society.[417] In James' world, the uncertainty of physical sickness and mental collapse was in the conversation and in the air.

James was acquainted not only with the uncertainties of being a patient but also those in the medical controversies of his day. Many have reflected upon James' philosophical and literary friendships.[418] Sutton lists James' numerous relationships with those at the cutting-edge of

[412] (Sutton, 2011, p.11; 2023, p.2)
[413] (Croce, 1995, pp.1-22)
[414] (Sutton, 2023, p.13)
[415] (Beard, 1880, pp.11-85)
[416] (Feinstein, 2018b)
[417] (Sutton, 2023, pp.135-157)
[418] (Carpenter, 1939; Kallen, 1914)

medicine. For instance, James knew Henry Ingersoll Bowditch (a forerunner in public health) and Oliver Wendell Holmes (who coined the term "anaesthesia.")[419] Anaesthesia was a mid-century development that raised questions about the alleviation of suffering and pain.[420] James was in correspondence with leading medical practitioners in America, Europe, and England. As Sutton writes, "[His] life was peopled with key protagonists in some of the most significant medical controversies and developments of the day," and thus, he was entangled in their uncertainties.[421]

James was involved in the controversy regarding the state of invalids who could not contribute to society by "doing anything" and were, in the political economy of health, a financial drain on resources. The public concern for personal health and hygiene assumed the pressure of a moral duty to society. The "degenerate" and "invalid" were stigmatized as threats to the future of society both evolutionarily and monetarily, and ideas behind the eugenics movement were beginning to materialize.[422] These medical debates were more than abstract for James, who considered himself to be a lifelong invalid.[423]

James was surrounded by illness among his immediate family and friends. He and his brother Henry shared problems of chronic back pain, constipation, and digestive issues. He and his sister Alice were both diagnosed with neurasthenia—her condition was so extreme that she was bed-bound and dismissed as hysteric. Alice later developed breast cancer and died.[424] James' brother Wilky was wounded while fighting in the Civil War, nearly died, and spent months in

[419] (Sutton, 2023, p.3)
[420] (Ibid., p.4)
[421] (Ibid., p.3)
[422] James was outspoken against the early eugenics movement, (Ibid., pp.4, 48).
[423] (Sutton, 2011, p.389; 2023, p.4)
[424] (Halliwell, 2014, pp.109-114)

bed recuperating.[425] James' brother Robertson suffered from alcoholism and was placed in an asylum in 1888.[426] His beloved cousin Minnie Temple died of tuberculosis at a young age.[427] His father was an eccentric with a prosthetic leg.[428] His Aunt Kate, who lived with the James family, also suffered from chronic pain and neurasthenia. James' letters reveal the extent to which he and his friends and family were preoccupied with projects of health and recovery.

Sutton writes that a defining experience of James' young adulthood was the experience of illness and pain.

> It contorted and tormented his personal writings, his plans and life path and, most notably, his own body. Throughout the late 1860s and early 1870s, James's correspondence, diary, and notes return, again and again, to the subject of pain. This single topic preoccupied James as he strived to cope with the implications of a debilitating back condition and its associated symptoms. Writhing in pain's grip, he repeatedly debated, with himself and others, how he should manage it, how it was managing him, and, ultimately, what it all meant.[429]

Some biographies of James portray him as a psychologically depressed young man who, after a spiritual crisis, emerged as a mature thinker cured of his mental sickness.[430] Sutton, in contrast, makes the case that both physical and mental illness remained a defining feature of James' life from youth until the end of his days.

Furthermore, illness shaped the direction of his life. His ambitions were constantly frustrated by poor mental and physical health. In 1861, he enlisted to fight in the Civil War with his younger brothers Wilky and Robertson but had to retire after a few months due to delicate

[425] (Feinstein, 2018a, p.166)
[426] (Halliwell, 2014, p.p110)
[427] (Richardson, 2007, pp.94-100)
[428] (Kuryla, 2014)
[429] (Sutton, 2023, p.13)
[430] (Myers, 2001)

health. He enrolled in university to study Chemistry but, in the words of his Chemistry teacher, "During the two years in which [James] was registered as a student in Chemistry, his work was much interfered with by ill-health, or rather by something which I imagined to be a delicacy of nervous constitution."[431] In 1865, he paused his studies at medical school to join a scientific expedition to the Amazon with the renowned biologist Louis Agassiz, but poor health and seasickness forced him to quit the expedition and return home early. He re-entered medical school but was debilitated by back pain (which James' mother attributed to long hours spent leaning over the dissection table).[432]

Throughout his mid-twenties James was tormented by depression and thoughts of suicide and in 1867 he took a break from medical school to travel around Europe in search of cures for his mental and physical suffering. Uncertain about the etiology or best treatment for his chronic back pain, he embarked on a "ceaseless merry-go-round of cure-seeking" in Europe—Dresden, Teplitz, Berlin, back to Dresden, Teplitz, etc.—experimenting with diets, spas, baths, mental rest, blisters, electricity, and walking.[433] While in Europe, he intended to study physiology with great contemporary physiologists such as Wilhelm Wundt, but his poor health and bad back interfered with these ambitions too.[434] After months of failed attempts to cure his pain, James wrote in a letter to a friend, "This accursed thing in my back has now lasted for 13 months. It scatters all my plans for the practice of mediecine [*sic]* to the winds."[435]

Between 1860 and 1870 James suffered from severe depression and thought of taking his own life.[436] In 1867, he confessed to his friend Thomas Wren Ward that he had been "on the

[431] (Feinstein, 2018a, p.155) cites (James, 1926b, pp.31-32)
[432] (Sutton, 2023, p.14)
[433] (Ibid., p.15)
[434] (Feinstein, 2018c, p.212)
[435] (Ibid., p.16)
[436] (Ibid., p.219)

continual verge of suicide." [437] In 1869 he graduated from medical school, but rather than practice medicine, he returned to Europe, touring in search of fashionable cures in England, France, Switzerland, and Italy. James scholar Howard Feinstein summarizes,

> …Ill health became central to [James's] life as vague illnesses followed by prolonged periods of convalescence became an established pattern. A simple accounting tells the tale. Of the seven years between his return from Brazil and the start of his career as a teacher at Harvard, two were devoted to medical school and five to the search for health. What in the early 1860s had appeared to be a minor impediment to his career now threatened to become a career in itself. William shuttled nervously between Europe and America, between learning the healing art and becoming his own chronic patient.[438]

Below is a picture that James sketched with a crayon in a notebook in the late 1860's, in what was one of the worst periods of his depression. Kaag and others propose that this is a self-portrait. Written across the top are the words, "HERE I AND SORROW SIT."

Figure 10) Sketch by James with red crayon[439]

[437] (James, 2008x, p.248)
[438] (Feinstein, 2018b, p.1)
[439] (Kaag, 2020, p.3) Image discussed in (Feinstein, 1999, p.250; Kaag, 2016, p.32; 2020, p.3). Kaag argues that this image is a self-portrait as the "N" in "AND" might be an "M," and thus the title may read "HERE I AM."

James diagnosed himself as a "victim of neurasthenia."[440] According to the diagnostics of his day, neurasthenia was a disease of the nervous system characterized by a range of psychosomatic symptoms such as anxiety, depression, phobias, mood swings, fatigue, insomnia neuralgia, headache, pain, indecision, and much more.[441] Over fifty symptoms of neurasthenia were catalogued by the psychiatrist George Beard in his tract *American Nervousness.* These symptoms included "fear of responsibility, of open places or closed places, fear of society, fear of being alone, fear of fears, fear of contamination, fear of everything, deficient mental control, lack of decision in trifling matters, hopelessness."[442] In a letter to philosopher FH Bradley, James described himself as an "abominable neurasthenic, dogged through life by a constant sense of the impossibility of every task, and of my own impotence."[443] During what may have been hospitalization at McLean Hospital for the Mentally Ill, James wrote, "my stomach, bowels, brain, temper & spirits are all at a pretty low ebb."[444]

In *VRE,* James reveals his own case of "an acute neurasthenic attack with phobia" under the pseudonym of a "French correspondent."[445] He experienced a "horrible fear of my own existence," and describes visiting an epileptic patient in medical school and how this experience revealed to him the insecurity and uncertainty that underlies all of life. He saw the epileptic patient and, with "quivering fear," realized "that shape I am." He writes,

[440] (James, 2008y, p.25)
[441] (Sheehey, 2019, p.46)
[442] (Lears, 2010, p.7) references (Beard, 1881). See (Beard, 1869; Beard, 1880)
[443] (Sutton, 2023, p.151)
[444] (Capps, 2008; Halliwell, 2014, p.110; James, 2008s, p.132)
[445] (James, 2008d, p.508)

> After this the universe was changed for me altogether. I awoke morning after morning with a horrible dread at the pit of my stomach, and with a sense of the insecurity of life that I never knew before…I remember wondering how other people could live, how I myself had ever lived, so unconscious of that pit of insecurity beneath the surface of life…[446]

James wondered how he and others could traverse upon the surface of life with any certainty when such depths lay below.

The young James was a man beset by uncertainty. One cannot help but wonder whether his comment in *Psychology: Briefer Course,* "there is no more miserable human being than one in whom nothing is habitual but indecision…," was partly spoken of himself.[447] His letters show endless wrestling with uncertainty about the cause, treatment, management, and meaning of his medical ailments. He was uncertain regarding his vocation—artist, doctor, physiologist, psychologist, philosopher. He was uncertain about the decisions of his personal life and agonized over personal decisions such as courtship and marriage.[448] He was uncertain about his philosophy. As the story of the epileptic shows, the uncertainty that young James experienced went deep, into the very fragility and insecurity of life itself.

The older James had his share of medical burdens and medical uncertainty, too. In the fall of 1899, he began to suffer from severe heart problems with angina, shortness of breath, and fatigue.[449] Once again, he sought cures in Europe that were of no avail, and by December of 1899, he believed that he was fatally ill and nearing the end of his life.[450] Much of *VRE* was written while James lay sick in bed, recovering from this physical and mental breakdown.[451]

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[446] (James, 2008av, pp.160-161)
[447] (James, 2008al, p.134)
[448] (Croce, 1995, pp.47-48; 2018; Kaag, 2020b, p.58)
[449] (Putnam & Putnam, 2017, p.202)
[450] (Sutton, 2023, p.111)
[451] (Putnam & Putnam, 2017, pp.201-224)

At times, his illness meant that he could only work on the lectures for two or three hours a day. He writes, "My discomfort is as great as ever and I can make no exertion of any sort without symptoms of severe distress."[452] His horizons shrank as he could walk less and less and even reading or dictating notes brought pain. The uncertainty of serious illness threatened his ability to do what he enjoyed, to make a meaningful contribution, or to complete his philosophy. He despaired, "I shall very likely die with my great Philosophy of Religion buried inside me and never seeing the light." A notebook entry from this time reads,

> I find myself in a cold, pinched, ~~joyless~~, quaking state…when I think of the probability of dying soon with all my music in me. My eyes are dry and hollow, my facial muscles won't contract, my throat quivers, my ~~throat~~, heart flutters, my breast and body ~~feel as if they were stale and caked~~ as if stale and caked…My mind is ~~pent in and~~ pinned down to the ~~narrow~~ continual contemplation of ~~my own~~ an annihilation which fills me with a kind of physical dread…The increasing pain & misery of more fully developed disease—the disgust, the final strangulation etc., be[g]in to haunt me, I fear them; and ~~they preoccupy my attention~~ the more ~~I think~~ fear them, the more I think about them.[453]

Despite believing himself to be fatally ill in 1899, James lived another ten years with uncertain and unstable health. Yet, arguably, this last decade of his life was his most productive.[454] Many of James' major publications were written at the end of his life, when his health was especially poor and his future was especially uncertain. *Pragmatism, Essays in Radical Empiricism, PU*, *SPP,* and much more were written during, and coloured by, the uncertainty of this time.[455] In the same year he delivered the lectures that would become *Pragmatism,* he resigned from Harvard because his health was so poor that he was worried he might die before completing his philosophical work. James passed away three years later.

[452] (Sutton, 2023, p.109)
[453] (Ibid., p.111) quotes (James, 2008d, pp.498-499)
[454] (Lamberth, 1997, p.237)
[455] (Pomerleau, 2024)

James' relationship with medicine was complicated.[456] While I agree with much in Sutton's account, Feinstein offers an interpretation of James' medical experiences that is more cynical. He emphasizes that James entered medical school reluctantly and for practical reasons—his family wealth was dwindling, and he needed to find a career that could support him financially. He was under pressure from his father to pursue a lucrative career in the sciences, and medicine seemed to be a way to satisfy these demands while remaining intellectually stimulated.[457] He attended lectures for five or six hours a day, gained clinical experience at Massachusetts General Hospital, and was most attracted to psychiatry, but his true desires lay elsewhere. In a letter contemplating his career options, James writes, "Medicine would pay, and I should still be dealing with subjects which interest me—but how much drudgery and of what an unpleasant kind is there!"[458] He felt medicine to be a duty and drudgery, containing "much humbug."[459] In *Becoming William James,* Feinstein suggests that one reason James "fled" to Europe during medical school was not just to seek cures for his invalidism but also to avoid the responsibility and pressure of an inauthentic career in medicine.[460] In Europe, James' poor health supposedly prevented him from studying physiology, yet he also described the time as a "literary debauch" immersing himself in the texts of German philosophy and great literature, all the while promising his family back home that he would get back to his medical studies soon.[461]

James' relationship with illness was likewise complicated. He genuinely suffered from poor health but also was under pressure to maintain the sick role because the sick role came with benefits—for example, it justified his family's financial support for his travels in Europe.[462]

[456] (Feinstein, 2018c, p.207; Richardson, 2007, pp.101-103)
[457] (Feinstein, 2018a, p.162)
[458] (Ibid., p.162)
[459] (Ibid., p.165)
[460] (Feinstein, 2018c, p.208)
[461] (Ibid., p.210) cites (James, 1926a, pp.87, 91)
[462] (Feinstein, 2018b)

Feinstein argues that James used his illness to escape responsibility; upon James' return from the healing baths of Europe, "he still clutched his illness tenaciously, like a talisman, to protect his return to the rigors of medicine and [his family home on] Quincy Street."[463]

Regardless, the important point from this narrative is that medicine and illness played a central role in the formative years of James' twenties and continued to set the tone for the development of his philosophy throughout his life. James was shaped in the pragmatic logic of medicine. Many have commented on how James studies in physiology and psychology affected his philosophy. This therapeutic background left a lasting mark on his philosophy as well. James was preoccupied with the medical and framed his philosophy in therapeutic terms.[464]

Turning to Action: James' Philosophy, Uncertainty & Ill-health

In both James' experience and philosophy there is real pain, real suffering, real uncertainty.[465] In the following section, I discuss how James' philosophy towards uncertainty helped him to cope with it.

For James, "evil [and suffering] are a genuine portion of reality" and cannot be overlooked even when they do not fit nicely into an explanation or system.[466] Sutton makes the case that evil and ill-health are closely intertwined in James' philosophy and, at times, he used these words synonymously.[467] The pessimistic science of medical materialism "blinked evil out of sight;"[468] the optimistic religion of James' father and the Idealists "glossed it over."[469] James

[463] (Feinstein, 2018c, p.219)
[464] (Sutton, 2023, pp.1-3)
[465] (James, 2008q, p.55; 2008ai, pp.139-143; 2008av)
[466] (James, 2008av, p.136)
[467] (Sutton, 2023, p.41)
[468] (Ibid., p.22)
[469] (Ibid., p.43)

writes, “I can’t bring myself to blink the evil out of sight, and gloss it over. It is as real as the good, and if it is denied, good must be denied too. It must be accepted and hated and resisted while there’s breath in our bodies.” Notice that James honestly acknowledges the existence of evil and then exhorts a turn towards action to do something about it. Sutton writes, “Sickness and health were stitched in the fabric of James’s moral universe, a universe in which pain’s existence must be accounted for but eventually, via strenuous personal effort, overcome.”[470] He rejected the certainties of optimism and pessimism as an anaesthetic to the evil that paralyzed action (Case 2).[471] James’ “acceptance” of evil was not complacency or resignation but a determination to do something about it.[472]

Like evil and suffering, uncertainty too can be “blinked out of sight and glossed over.” Insofar as uncertainty can cause suffering, acceptance does not have to entail a paralyzed resignation. For James, uncertainty is to be acknowledged as real, to be met with action, and to be met courageously. James’ experience with illness, however, adds a paradoxical twist to what strenuous effort and courageous action in the face of uncertainty can look like.

In a search for cures for his medical conditions, James turned to both science and religion/spirituality. He experimented with his own cutting-edge research in physiology and psychology as well as with the mind-cure movement and its mystical practices. After James’ death, his colleague and friend, Josiah Royce, commented that James would have been “healthier if he had focused on his health less—not that he wanted to live, but that he thought it somehow was a disgrace to have disease and was always trying to cure himself…If he had only let it alone and thought of something else.”[473]

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[470] (Ibid., p.42)
[471] (Ibid., pp.44, 54)
[472] (Ibid., p.22)
[473] (Ibid., p.168) cites (Bjork, 1988, p.261)

James paid a considerable amount of attention to his ill-health. He conceived of himself as "diseased and unfit." He felt himself to be a burden to society and to his loved ones.[474] He struggled with questions about whether his life was worth living as he suffered from pain, was a burden to others, and was too sick to "do" anything to contribute to society.[475] He wrote in a letter to Thomas Ward, "Sometimes when I despair of ever doing anything, [I] say: 'Why not step out into the green darkness?'[476] He was depressed and, at times, felt a moral pressure[477] to take his own life, wondering whether choosing death stoically was more dignified than living as he was.[478] According to his philosophical studies of utilitarianism and stoicism, suicide was the moral and dignified conclusion. According to his medical studies, suicide was determined by his brain physiology, his genes, and mental pathology. He feared his medical condition was terminal—threatening his life and the meaningfulness of that life.[479]

In James' case, "certainty was the root of despair."[480] The determinism of his philosophy and science condemned him to inevitable suicide. The uncertainty of indeterminism was, for James, a source of hope because it afforded the possibility that "the future may be other and better than the past has been."[481] Uncertainty offered the chance that his situation could improve in ways which he could not expect.

[474] (Ibid., 2023, p.23)
[475] (Ibid., 2023, pp.26-27)
[476] (James, 2008w, p.347)
[477] (Sutton, 2023, pp.135-166)
[478] (Ibid., p.29)
[479] (Kaag, 2020b, pp.1-4, 11-41, 58; Sutton, 2023, pp.24-35)
[480] (James, 2008af, p.189)
[481] (James, 2008g, p.137)

James' belief in indeterminism and free-will was a turn to action in uncertainty in two senses. First, these beliefs became a basis for James' meliorism (Case 2), in which attention shifts from uncertainty of outcome to taking the actions necessary to make an outcome possible. Second, James' acceptance of these beliefs marked a decisive turn to action amid uncertainty. He wanted to believe in free will because such belief gave his life meaning and made action possible. Yet, the evidence was inconclusive; certainty remained out of reach. Could his belief in free will—one that transcended the available evidence and was driven by his passional nature—still be justified?[482] To suspend belief and wait for further proof would, in effect, be to live as though determinism were true—a stance that, for James, was to concede to death. His journals tell of a "spiritual crisis" which James points to as a turning point in his life.[483] On April 30, 1870, James wrote the following in his diary:

> I think that yesterday was a crisis in my life. I finished the first part of Renouvier's second *Essais* and see no reason why his definition of free will…need be the definition of an illusion. At any rate, I will assume for the present– until next year – that it is no illusion. My first act of free will shall be to believe in free will…[484]

His diary then elaborates on the way James applied this insight to his life and health.[485]

> Hitherto…suicide seemed the most manly form to put my daring into; now, I will go a step further with my will…believe in my individual reality and creative power. My belief, to be sure, *can't* be optimistic—but I will posit life (the real, the good)…Life shall [be built in] doing and suffering and creating.[486]

In regard to his incurable back pain, James did exactly what he said he would do in his journal. He used his creative power and built life on "doing, suffering and creating." Part of that turn

[482] (James, 2008ax)
[483] (Neary, 2006; Perry, 1935)
[484] (Sutton, 2023, pp.39-40)
[485] (Ibid., p.39)
[486] (McQuade, 2008, p.xxvi)

towards action was, ironically, a letting go of the doing. At the time of this journal entry, he wrote a letter to his brother updating him on his back. “Strange to say, I feel quite indifferent to the damned thing—and have (any how for a time) cast off that slavish clinging to the hope of doing [some]thing [which] has been the torment of my life hitherto.” About five weeks later, he wrote to his brother again, and explained that his health was less of an all-consuming concern: “for I have loosed the lockjaw grasp with [which] I clung to the hope of accomplishing external work, and transferred my interest…to the subjective attitude, i.e., become moralized...” James expanded his sense of what it was to do something useful and make a meaningful contribution. Acting was no longer limited to the external—to curing his back pain, making a visible difference in society, or accomplishing what he strove for. He believed that the subjective attitude with which he bore his pain courageously could contribute to the moral quality of the world.[487] He found courage in his incurable back pain by creating a way to live courageously with his condition.

Even so, James continued to seek cures and relief from his pain. Disillusioned with institutional medicine, he experimented with the mind-cure movement. Although the mind-cure healers never conclusively cured James’ conditions, these “wonder-mongers, magnetic physicians, seventh sons of seventh daughters” led James to an important conclusion.[488] He writes, “…through all this ‘Psychical Research’ I am coming to believe as I never did before, that the fulness of truth is not given to any one type of mind.”[489] These experiences opened James to a more expansive way of thinking about healing—one in which biomedical interventions were only a small portion among a plurality of methods, and the biomedical itself represented a narrow facet of human experience. “The mind curers have made a great discovery—viz. that

[487] (James, 2008q, pp.52-53; Sutton, 2023, p.40)
[488] (Sutton, 2023, pp.88-89)
[489] (James, 2008au, p.125)

health of soul and health of body hang together…"[490] He began to question his assumption that the world at its base was something impersonal and that the "systematic denial on science's part of personality as a condition of events, this rigorous belief that…[the] nature of our world is a strictly impersonal world, may…prove to be the very defect that our descendants will be most surprised at in our own boasted science."[491] From James' experiments with mind-cure, he recognized the importance of the "vital mysteries"[492] of therapeutic relationship and that "scientific professionals were not the only authority worth consulting."[493] This enlargement of possibilities cast James into a sea of uncertainty. He writes, "…I am all at sea, with my old compass lost, and no new one, and the stars invisible through the fog. But it is exhilarating to have things suddenly enlarge their possibilities—at any rate."[494] The world presented itself as something far more wild, personal, and uncertain than mechanistic laws had led him to believe.[495]

This plurality of values opened a possibility for the invalid to have dignity in weakness. Evolutionarily, James conceived of success as adaptation to environment, but his experiments with mind-cure helped him to realize that there are many environments and "many ways of looking at adaptation."[496] James explains that "success" depends upon the environment considered.[497] Saint Paul "from the biological point of view was a failure, because he was beheaded!...however, his success, measured in terms of his prowess in inspiring subsequent examples of saintliness, virtues such as 'humble-mindedness,' 'patience,' 'charity,' was indisputable."[498] As mentioned above, James saw himself as "diseased and unfit," and

[490] (James, 2008v, p.113)
[491] (James, 2008aw, p.241)
[492] (Sutton, 2023, p.102)
[493] (Ibid., p.100)
[494] (James, 2008v, p.113)
[495] (James, 2008n; 2008af, p.189; Sutton, 2023, pp.101-102)
[496] (James, 2008av, p.299)
[497] (Sutton, 2023, p.149)
[498] (Ibid., p.149)

struggled with questions about whether his life was worth living as he suffered from pain, was a burden to others, and was too sick to "do" anything to contribute to society.[499] This range of values created a pathway forward for both the invalid and James. Courage in suffering became a way of morally contributing to the world. Moreover, James came to believe that this moral courage might even play a role in shaping—even creating—the world.[500] And in James' case, it did.

The context of serious illness was that in which James fashioned the ideas central to pragmatism. He worked out the beginnings of his "faith ladder" and "will-to-believe doctrine" as he experimented with cures for his own health (Case 5). His meliorism, the possibility that "the future may be other and better than the past has been" and willingness to act without guarantee was not just hypothetical, but the way in which he lived day by day with illness (Case 2). His radical empiricism includes the postulate that no element of experience (even experience of suffering, evil, illness, or uncertainty) is to be excluded from experience.[501] He was a caregiver and, in "SoR," portrayed rationality itself in terms of relief from suffering (Case 1). As he asked, 'How long do I have?' he was writing a philosophy that emphasized plurality and action (Case 3). He rejected medical materialism in *VRE* (which could have been subtitled "What Religion Can Do for the Sick and Infirm").[502] James' humility and sense of "vagueness," "moreness," and "mystery" are conclusions both from his philosophy and his experience (Case 4). The trajectory of his thought emphasizes the personal, relational, and mystical—that which is beyond our ability to understand and control, yet that which we still may be able to act in relation to.

[499] (Ibid., pp.26-27)
[500] (Ibid., pp.107-134)
[501] (James, 2008ab, pp.6-7; 2008ai; Sutton, 2011)
[502] (Sutton, 2023, p.112)

Living with Uncertainty: James on Religion/Spirituality, Uncertainty & Ill-health

James' thoughts on religion/spirituality provide insight into his philosophy of uncertainty. There are as many accounts of James' approach to religion as there are scholars of James. I focus on Sutton's account because she uniquely considers James' religion/spirituality in the context of his experience of ill-health, and I use this account as a trope which I will later apply to uncertainty.[503]

James' thoughts on religion/spirituality developed considerably throughout the course of his lifetime. For young James, the "unseen world" of religion provided a deeper dimension of meaning and moral context for events taking place in a world of mechanistic, impersonal laws of nature.[504] Young James (influenced by stoicism) experienced God as an "infinite demander" of moral orders, but believed God to offer no help in completing those tasks.[505] His faith was, in his own words, "a cold activity" that did not provide "sympathy" or any "personal communication" with the "soul of the World."[506] Sutton writes, "His was a removed and authoritarian creator who required much and offered nothing but instruction in return." In this time, James despaired of his invalidism and of being unable to do anything. His self-reliant stoicism offered little comfort.[507]

He described the cold activity of stoicism, not unlike the state of his own health, as "muscular tension" on the verge of breakdown.

[503] (Ibid., pp.79-134) Though selecting Sutton's account, I do not reduce James' complex relations to religion to this account.
[504] (Ibid., p.105)
[505] (Ibid., p.108)
[506] (Ibid., p.108)
[507] (Ibid., pp.107-114)

> Stoicism, with its muscles ~~never relaxed~~ always tense, always ~~tensely sustaining~~ holding its breath is an attitude which is ready to ~~lapse in~~ ~~its opposite, &~~ break down, and at the last extremity always does ~~so lapse~~ break down has in this instability an element of weakness…[508]

His manuscript notes contrast the "muscular tension" of stoicism with the peace and relaxation of religious comfort.

> [In the] radical manifestation of religion…will is ~~swallowed up in~~ drowned in ~~excitement~~ peace attained…The ~~muscular~~ hour of muscular tension is over, that of happy relaxation, of calm deep breathing, of a present with no ~~different~~ possibly different future to be on one's guard against has arrived.[509]

For James, religion functioned to satisfy emotional needs of comfort and security in uncertainty. In the passage of *VRE* in which James recounts his vision of the epileptic patient, he writes, "the fear was so invasive and powerful that if I had not clung to scripture-texts like 'The eternal God is my refuge,' etc., 'Come unto me, all ye that labor and are heavy-laden, 'etc., 'I am the resurrection and the life,' etc., I think I should have grown really insane."[510] In his experience, religion functioned as a peaceful promise amidst the storm, even if that promise came as a result of willful denial of, or turning a blind eye to, evil, suffering, and uncertainty.

As James matured, so did his vision of an intimate and active God. Sutton states that by the time he wrote *VRE,* "James explored and embraced a very different kind of faith and a very different kind of God [than in his younger years]."[511] As written in James' notes, peace in the "pressure of the world's ill and danger" required the "active inflow of super-personal help."[512]

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[508] (James, 2008d, p.501)
[509] (Ibid., p.501)
[510] (James, 2008av, pp.160-161)
[511] (Sutton, 2023, p.108) cites (James, 2008d, p.501)
[512] (James, 2008d, p.502)

"This was a God from whom issued genuine energy and help and not merely commands."[513] These ideas about God were forged in the midst of what James believed to be fatal illness and impending death. In this context, James wrote about a God who could help the invalid endure earthly trials of pain and suffering. Sutton writes, "Fundamentally the difference between moral and religious faiths is their accessibility and value to the sick and dying."[514] In his weakness, invalidism, and inability to act, James recognized a need for help from a power beyond himself. Furthermore, he came to believe by faith that this power may even value help that he could offer from his own weakness.

James closes *VRE* with three points.[515] First, he rejects a "sectarian scientists' attitude" that imagines that the "world of sensations and scientific laws" is all there is. He says, "The total expression of human experience, as I view it objectively, invincibly urges me beyond the narrow 'scientific' bounds. Assuredly, the real world is of a different temperament —more intricately built than physical science allows." James resists reducing the world to what can be captured by the methods of science. There is more.

Second, he confesses uncertainty about the precise nature of what this "wider self" and "moreness" might be. He writes, "The whole drift of my education goes to persuade me that the world of our present consciousness is only one out of many worlds of consciousness that exist, and that those other worlds must contain experiences which have a meaning for our life also." James acknowledged uncertainty, yet he acted on his personal 'over-belief,' one on which he was willing and "ready to make [his] personal [faith] venture."

[513] (Sutton, 2023, p.113)
[514] (Ibid., p.114)
[515] (James, 2008av, p.408)

Third, he speaks of a "pragmatic view of religion" in which faith has concrete effects on this life, in which religion has "body as well as soul," in which God inflows activity to us, and in which our actions may even cooperate with God. He concludes *VRE*, "Who knows whether the faithfulness of individuals here below to their own poor over-beliefs may not actually help God in turn to be more effectively faithful to his own greater tasks?"

In the closing of *VRE,* James explains that his personal over-beliefs were held for pragmatic reasons as they helped him to live. "By being faithful in my poor measure to this over-belief, I seem to myself to keep more sane and true."[516] Sutton makes the important connection between James' conclusion in *VRE* and his own experience of invalidism.

> In summary, the metaphysical realm appeared to represent, for James, a dimension within which he could validate the invalid. Religious faith in an "unseen world" could make sense of their suffering and raise it to the level of a heroic act. On the supernatural battlefield of life, the physically weak became society's most able soldiers; the ultimate annihilation of all that is evil lay in their hands. And, in addition, those who endured ill health, and especially mental disorders such as melancholy, acquired the faculty of a privileged witness. Via their experiences, they alone were permitted to access and give voice to the universe's most profound truths…A vote for the unseen world was a vote for a more meaningful life for those debilitated by ill health. He contended that our epistemological and metaphysical positions inform and define how we value those members of society who are afflicted by sickness and infirmity.[517]

James, like many medics, often employed the battle language of fighting, heroism, and courage.[518] Yet by this point in his life, he battled pain not just to escape it, as he had in his youth, but to live courageously with that which could not be cured.[519] The courage to act did not require the "muscular tension" and manly strength of the stoic. Paradoxically, the very

[516] (Ibid., p.408)
[517] (Sutton, 2023, pp.156-157)
[518] (Ibid., p.152)
[519] (Ibid., pp.40-44)

weakness of illness uniquely suited these individuals to be "spiritual heroes" and to reach ideals higher than biological superiority.[520] The courage to act was available for those who outwardly could do nothing at all.[521]

Sutton continues her narrative by following James' 1907 essay, "Energies of Men." She does not, however, engage significantly with James' later work, the 1908 *PU,* which is a significant text in James' corpus that pertains to religion/spirituality. Lamberth draws on *PU* to trace James' movement in the spiritual/religious further in terms of intimacy and sociality.[522] In his essay, "Interpreting the Universe after a Social Analogy Intimacy: Panpsychism, and a Finite God in a Pluralistic Universe," Lamberth argues that *PU* picks up where *VRE* leaves off.[523]

In *PU,* the "wider self" and "more" of *VRE* becomes the "wider self" and "more" of a pluralistic panpsychic metaphysics. In James' words, "Every bit of us at every moment is part and parcel of a wider self."[524] In *PU,* he says that we may help God because we, in a panpsychic system, are "parts of God."[525] The pluralistic universe then is "self-reparative through us, as getting its disconnections remedied in part by our behaviour."[526] Our efforts do more than aid God in remedying disconnection and creating intimacy. Lamberth explains, "[The ideal of intimacy] is to be achieved in the concrete streams of experience of individuals, which are at the same time, constitutive of the broader stream of the life of us all."[527] In other words, as we remedy

[520] (Ibid., pp.147, 150)
[521] (Ibid., p.136)
[522] Lamberth demonstrates that in *PU*, intimacy is employed in three key ways: 1) Phenomenologically, as "an affect or feeling," such as the sense that a view resonates or fits with lived experience; 2) Metaphysically**,** to refer to the intimacy among "factual relations" that "constitute the world," which James interprets through a personal, pluralistic, and panpsychic lens; and 3) Socially**,** as an ideal of "intimacy-in-the-making," where agents actively co-create meaning and relation through their interactions. (Lamberth, 1997, p.238).
[523] (Ibid., p.254)
[524] (James, 2008ag, pp.130-131, 145)
[525] (Ibid., p.143)
[526] (Ibid., p.148)
[527] (Lamberth, 1997, p.256)

disconnection and create intimacy in our individual streams of experience, we contribute to the intimacy of the larger stream of experience of which we are a part. Lamberth lays out the social implications clearly. "It seems only a short step to comprehending the necessity of reciprocal and thoroughly social relations among human beings, if our intimate philosophical ideal is to be realized." Lamberth (and James) end with the reminder that all this is a hypothesis that may prove to be wrong and that the intimacy for which we act might not be realized. Yet, since the world seems to be in part "remedied" by our actions, it might be worth acting as though our acting together might matter, and the hypothesis might prove to be correct (Case 5).[528]

I have summarized James' pragmatism as a turn towards action in uncertainty. Such a requirement could become like the cold activity of the stoicism of James' youth or unrealistic moral demands to summon manly courage and just face uncertainty. James' invalidism forced him to confront difficult questions: What if the very ability to act is threatened? What if it seems as if there is no way to act to reduce uncertainty? One response is to alleviate the suffering caused by uncertainty—much like the role religion played in James' early life, offering comfort and a sense of security. James' invalidism also led him to lean more towards the personal and relational. This relationality is seen clearly in James' philosophy in that God is a source of comfort, security, courage, and strength, and in turn, our actions and courage may help God and form part of a wider self. The uncertainty of what the world will be is held together by all the agents that constitute it and depends upon each playing their part, and James suggests that sometimes, the seemingly invisible work (such as the invalid living courageously with their condition) might contribute some of the most important work.

[528] (Ibid., p.257)

Conclusion

I began by referencing Han's comment that for James "reality is fundamentally indeterminate, human knowledge is inherently limited and right action is contingent on the particulars of the individual and situation."[529] Ontologically, indeterminism takes on new meaning in the context of James mental illness and questions of suicide. Life (James' life) was fragile and vulnerable to real risk, real loss. However, the uncertainty of indeterminism was not only a source of fear but a source of hope, as life (in the words of James' diary) was built on "doing, suffering and creating." Epistemologically, James' philosophy and approach towards illness was rooted in fallibility. He approached attempts at cures with an attitude of provisionality, judging them by their fruits, and he was open to revising his course of action. He was also open to a plurality of approaches (even the mystical), and through his experiences (and listening to the experiences of others such as the mind-curers), he came to the conviction that moreness, mystery, personalness, and wildness of the world overflowed the best of our concepts. Through sickness he learned lessons of intellectual humility. Morally, meliorism was a faith on which James lived. In terms of his health, he acted in advance of evidence, risking his person, and that he may prove to be wrong. In an uncertain state, when even living long enough to write his philosophy was not guaranteed, he penned the following words: "Not a deed of faithfulness or courage is done, except upon a maybe...It is only by risking our persons from one hour to another that we live at all."

His was also a social vision of health, which extended beyond the public hygiene movement and evolutionary notions into the spiritual. Han speaks of the ontological, epistemological, and moral contributions of James' philosophy. I would add another element of James' philosophy to this list—relational. James offers a vision in which many together hold uncertainty. James'

[529] (Han, 2021, p.133)

personal letters reveal the way in which he held the uncertainty of his medical conditions with a community—of physicians, scientists, philosophers, family, friends, and society at large.

In summary, James' responses to the suffering brought on by the uncertainty of serious illness can be understood in three key ways:

1. Managing expectations: acknowledging suffering and uncertainty as inevitable aspects of experience that cannot be excluded or avoided;
2. Turning attention to action: focusing on actively working to alleviate suffering, even when certainty is unattainable. His experience of invalidism—which threatened his capacity to act—led him to expand the meaning of action in pluralistic and creative ways;
3. Living with uncertainty: accepting that some suffering and uncertainty cannot be resolved and learning to courageously live with them by leaning on relational support.

In the next chapter, I explore James' pragmatism in greater depth and introduce the practice of Palliating Uncertainty, which integrates his philosophical approach with the ethos of palliative care.

3

Palliating Uncertainty

"The core predicament of medicine—the thing that makes being a patient so wrenching, being a doctor so difficult, and being a part of society that pays the bills they run up so vexing—is uncertainty...Medicine's ground state is uncertainty. And wisdom—for both the patients and doctors—is defined by how one copes with it."[530]

~Atul Gawande

"I came upon [James] writings...more than 50 years ago, and he continues to inspire me and teach me...The work of William James provides meaning without false assurance and encourages us to be open to experiences other than our own and to always seek possibility in all beliefs and decisions. In short, I find William James to be a liberating thinker in my life. I want to share that gift with you."[531]

~John J McDermott

Introduction

I closed Chapter 1 with the conclusion that uncertainty could not be cured but could be palliated. In this chapter, I describe key aspects of the ethos of palliative care, introduce James' pragmatism, and bring both together to outline the practice of Palliating Uncertainty.

[530] (Gawande, 2010, p.229)
[531] (Davidson & Kanopy, 2016, p.2 min)

Ethos of Palliative Care

Palliative care is a relatively new specialty in medicine that is focused on improving quality of life and supporting patients and their families as they navigate living with serious (and often life-threatening) illness.[532] The palliative care and hospice movement began in the 1970's with a vision of care for the "whole person" and seeks to relieve suffering—whether that suffering be physical, psychological, social, or spiritual.

A foundational figure in the modern palliative care movement was Dame Cicely Saunders, who founded Saint Christopher's Hospice in London in 1967. It was based on the medieval monastic practice of hospice, which provided refuge and support for sick and weary pilgrims.[533] Saunders' pioneering work in hospice was anchored in her Christian faith.[534]

While the first medical hospices cared primarily for patients with incurable cancer, hospice care has since expanded to include care for all those with serious illness.[535] The National Coalition for Hospice and Palliative Care (NCHPC) takes as its definition of serious illness "a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregiver."[536] The specialty provides care for patients with a wide range of conditions and complex medical needs, including cancer, dementia, heart, liver, kidney, or pulmonary disease, HIV, stroke, coma, extreme prematurity at birth, and the frailty of old age. Its scope includes supporting patients who are adjusting to a new diagnosis, living with advanced illness, approaching the end of life, or actively dying.[537] In the words of the physician JR Curtis, "The goal of palliative care is to prevent and relieve

[532] (ACP, 2023; Tatum, Craig, Washington, & Oliver, 2014; Watson, 2019, pp.xi-xxiv; WHO, 1990, 2020)
[533] (Miličević, 2002; Saunders, Baines, & Dunlop, 1995; Watson, 2019, p.xiv)
[534] (St.CH, 2023)
[535] (Watson, 2019, p.xiv)
[536] (NCHPC, 2018, p.i) See (Kelley & Bollens-Lund, 2018)
[537] (CMS, 2023)

suffering and to support the best possible quality of life for patients and their families, regardless of the stage of disease or the need for other therapies."[538]

Some palliative care teams work within hospital systems, providing consultation services for pain and symptom management, facilitating conversations with patients and families on direction of care, and coordinating advanced care planning and transition to hospice. Some teams are based in hospices, where they address the physical, functional, psychological, practical, and spiritual needs of the imminently dying and seek to improve the quality of patients' and families' lives.[539] Others make home visits to help meet the needs of patients who wish to die at home or in other environments outside the hospital or hospice. The Institute of Medicine (IOM) lists a variety of healthcare settings in which palliative care is provided, including patient homes, nursing homes, hospices, acute-care hospitals, long-term acute-care facilities, and outpatient clinics.[540] In the US, hospices provide care for terminally-ill patients with life expectancies of six-months or less.[541]

Foundational to palliative care is Saunders' concept of total pain, which has expanded the medical understanding of pain to encompass the physical, psychological, social, and spiritual.[542] From conversations with patients with cancer, Saunders recognized that pain management was inadequate in regard not only to the physical relief of pain but in addressing the psychological, social, and spiritual distress that is inextricably linked with the experience of pain. Drawing on her experiences as a nurse, social worker, physician, and person of faith, Saunders developed a multi-faceted approach to pain.[543] In doing so, Saunders set a precedent

[538] (Curtis, 2008, p.796)
[539] (NCHPC, 2018)
[540] (IOM, 2015)
[541] (CMS, 2023)
[542] (Ong & Forbes, 2005)
[543] (Clark, 1999, 2000)

for the multidisciplinary and multifaceted ethos of palliative care.[544] Hospice and palliative care are not just "hand-holding" at the end of life. In the words of the palliative care pioneer, Robert Twycross, "Palliative care is active total care of patients with life limiting disease and their families by a multi-professional team…"[545] Biomedically, palliative care involves complex medical management of physical symptoms of serious illness such as pain, shortness of breath, fatigue, nausea, constipation, delirium, and medication-induced side effects.[546] It also provides psychological support to cope with the depression, anxiety, and mental distress that are associated with pain and serious illness. It is a socially complex specialty in which intricate family dynamics are navigated in contexts such as withdrawal of care, writing advanced directives, and addressing the financial and practical burdens of serious illness and death. It is a specialty of listening,[547] helping to harmonize treatment options with patient values,[548] and attending to the spiritual distress, questions raised by suffering, and hope of finding peace, all of which occur in the midst of loss.[549] Relationships are recognized to be a core element of healing.[550] Palliative care is conducted in partnership with patients and their families, in multidisciplinary teams, and in broader communities that strive to provide holistic care for those at the end of life.[551]

Consider the following definitions of palliative care from three major medical organizations:

[544] (Richmond, 2005)
[545] (Twycross, 2003, p.9)
[546] (Watson, 2019)
[547] (Mannix, 2021)
[548] (Dempsey & Mulder, 2023b)
[549] (Chochinov, 2023b; Steinhauser & Balboni, 2017; Steinhauser et al., 2006)
[550] (Sulmasy, 2006a)
[551] (Twycross et al., 2021, pp.7-8)

The National (US) Coalition of Hospice and Palliative Care states,

> Palliative care focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness…[552]

The Center to Advance Palliative Care and the American Cancer Society define palliative care as,

> …Specialized medical care for people with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of palliative care doctors, nurses, social workers, and others who work together with a patient's other doctors to provide an extra layer of support…[553]

The American College of Physicians says,

> Palliative medicine aims to relieve symptoms and pain a patient suffers due to a serious illness. Goals of palliative care include reducing suffering, improving the quality of life for a patient, and supporting the patient and family throughout the treatment process. Hospice care is provided for patients facing a terminal diagnosis who no longer wish to undergo curative treatment. Goals of hospice care include relieving symptoms and supporting patients in the end-of-life stages.[554]

The core features of these definitions are summarized well by Twycross in his textbook, *Introducing Palliative Care.* He lists the following as defining characteristics of palliative care:[555]

[552] (NCHPC, 2018, p.i)
[553] (Ibid., p.ii) cites (CAPC, 2018)
[554] (ACP, 2023)
[555] (Twycross, 2003, p.10; Twycross et al., 2021, p.1)

Patient-centered rather than disease-focused
Focused on quality of life but can be provided in tandem with life-prolonging treatments
Holistic: addressing physical, psychological, social/family, and spiritual/existential concerns
A partnership between patient and carers; also concerned with patients' families and others close to them
Ideally, provided by a multi-professional healthcare team
Concerned with healing rather than curing
Death-accepting but also life-enhancing

Twycross states that if there is one principle at the core of palliative care, it is that of non-abandonment. He writes. "[In palliative care] there is a commitment to non-abandonment: 'Whatever happens, we will stay beside you every step of the way. Together we will get through this.' Compassionate presence and compassionate listening together demonstrate that the patient still matters and is still a person of worth. This is the essence of palliative care."[556] The patient-centered, holistic, relational values of palliative care give the specialty a distinctive ethos.

[556] (Twycross, 2024, p.6)

In her "Palliative Care: Taking the Long View," Maria García-Baquero Merino explains that "…hospices are far more than mere buildings; they house an ethos of care."[557] The values central to palliative care are not new or expressed in palliative care alone. The specialty, however, is unique in that these values are codified in it as the center of its philosophy and ethos of practice.[558] This patient-centered, holistic, relational ethos of palliative care provides the ethos for Palliating Uncertainty.

The National Health Service (NHS) Physician Higher Special Training Recruitment advises prospective palliative care trainees that palliative care requires comfort with uncertainty. "Palliative Medicine's evidence base is evolving at a great rate, although it will never be a protocol-driven specialty." In response to this uncertainty, "[palliative care] requires you to think on your feet, and to use empathy and pragmatism, as well as science, to make the right clinical decisions."[559]

Chapter 1 outlined some of the uncertainties that are encountered in end-of-life care. One of the great challenges of medicine is that clinicians must act in the midst of uncertainty. As physician Szawarski writes,

> …The *burden* of decision making is exactly that–a burden. End-of-life decision making is difficult and does not come easy to majority of doctors…Given the above viewpoints, one can understand the unease concerning uncertainties inherent in clinical judgements, the potential for differences in value judgements, the need for a pragmatic approach and the need to put the patient at the heart of it all.[560]

[557] (Merino, 2018, p.1)
[558] (Watson, 2019, pp.xxv–xl)
[559] (NHS, 2024)
[560] (Szawarski, 2016, p.246)

The need to act in the midst of uncertainty is one of the challenges of palliative care, but it is also one of its strengths. James' pragmatism suggests that action is a way of moving through uncertainty. When understood through a lens of attention, a pragmatic response to uncertainty can help "put the patient at the heart of it all."

James' Pragmatism as an Attitude of Orientation: Turning Attention from Uncertainty to Action

I engage with James' pragmatism not as a theory of truth but as an attitude of orientation, and offer a new idea to Jamesian scholarship by summarizing this attitude of pragmatism as a turning of attention from uncertainty towards action. This section is broken down into three parts: "Pragmatism as an Attitude of Orientation," "Turning Attention," and "From Uncertainty to Action."

In literature review, the closest reference I found to pragmatism as a turn of attention was in "A Pragmatist Approach to Clinical Ethics Support: Overcoming the Perils of Ethical Pluralism." In this article, Inguaggiato et al. argue that the pragmatism of James, Dewey, and Peirce is valuable for clinical ethics support consultations because it can help achieve practical solutions for moral problems in a pluralistic context. The phrase "attention" is used, but it is not developed as a concept. Furthermore, the authors do not discuss a shift in attention from uncertainty to action but from one type of intellectual investigation to another. Also, the distinctiveness of James' pragmatism is not discussed and multiple pragmatisms are treated as one.[561]

[561] (Inguaggiato et al., 2019)

Before beginning, it is necessary to clarify what pragmatism is not. Pragmatism is not synonymous with "practical," and it is not simply, "truth is what works."

First, in current medical literature, the term "pragmatic" tends to be conflated (and used interchangeably) with the word "practical."[562] Such construals of pragmatism obscure its philosophical nuance and significance.

The Oxford English Dictionary offers the following as a colloquial definition of "pragmatic:"

> Dealing with matters in accordance with practical rather than theoretical considerations or general principles; aiming at what is achievable rather than ideal; matter-of-fact, practical, down-to-earth (sometimes with implications of hard-headedness, lack of principle, or self-seekingness)…[563]

Colloquial references to the "pragmatic" draw a strong dichotomy between theory and practice. In contrast, pragmatism, as a philosophy, challenges the distinction between thought and action, theory, and practice.[564] Theories do not just have implications for action (as if there is a dualism between thoughts and the world). For James, thoughts act on the world and are part of experience. To say that an idea is pragmatic is not simply to say that an idea has practical applications.

Among medical professionals, it is generally regarded as a compliment to be considered pragmatic as it implies that a person is practical and down-to-earth. Long et al. suggest that

[562] (Greenhalgh & Engebretsen, 2022, p.2) E.g., (Dal-Ré et al., 2018; Duenk et al., 2017; Farris et al., 2023; Sage, 2001; Stiefel et al., 2001; Sullivan et al., 2023; Wiles et al., 1999)
[563] (OED, 2024)
[564] (James, 2008ae, pp.75-77)

many healthcare workers identify as pragmatists.[565] However, often in medicine, "pragmatism" is reduced to "practical and efficient."

Some associate the pragmatic with dehumanizing elements of healthcare systems, such as values of "competition, rationalization, productivity, efficiency, and even profit."[566] For example, referencing a decline in the compassion of medical students over the course of medical training, MacLeod writes, "As [medical students] progress, their compassion and understanding of what makes people human and different declines. Students increase their ability to act independently but decrease in benevolence during the beginning years of medical training. Early idealism is replaced by pragmatism and utilitarianism."[567] As another example, Sulmasy, in his book *A Balm for Gilead,* speaks of the "unconscious presumption that medicine is exclusively about outcomes" and the "body count" that cares more about "hard numbers" and treats less measurable outcomes as less valuable. Sulmasy writes, "The idea that only outcomes count has been reinforced and even amplified by the spirit of American pragmatism…"[568] By returning to the philosophical roots of James' pragmatism, I hope to reclaim pragmatism from the idea that it is merely practical, reductive, and efficient and instead recover a vision of pragmatism as relational and open to mystery.[569] I hope that with a renewed understanding of what it means to be pragmatic, physicians might find new reason for being called so.

Second, a common misconception of pragmatism (even in James' time) is that pragmatism is simply a theory of truth, expressed by the maxim, "what is true is what works."[570] James spilled

[565] (Long et al., 2018, p.5)
[566] (Twycross et al., 2021, p.12) cites (Youngson & Blennerhassett, 2016)
[567] (MacLeod, 2024, p.161)
[568] (Sulmasy, 2006a, p.15)
[569] (Greenhalgh & Engebretsen, 2022, p.2)
[570] (James, 2008ab, pp.146-153) See (H. Putnam, 1997)

much ink refuting this construal of his thought—see, for instance, *Meaning of Truth.*[571] Pragmatism can be a theory of truth. However, I think it is unfortunate that so much attention and dispute has focused on the theory of truth and that other valuable aspects of pragmatism have been overlooked. Pragmatism can be a theory of truth, a method for determining meaning, or an attitude of orientation.

Pragmatism As an Attitude of Orientation

I engage with James' pragmatism as an attitude of orientation.[572] In *Pragmatism as a Way of Life,* "Reflections on the Future of Pragmatism," Ruth Putnam reflects on pragmatism as an attitude. She writes, "Pragmatism is not a philosophical 'system,' not a set of propositions, it is a philosophy precisely in the sense of being an attitude, a way of life, in particular, a way of dealing with problems."[573] Chris Hookway likewise considers James' pragmatism as an attitude.[574] Both point towards pragmatism's attitude as a way forward for the future of pragmatism.

James introduces *Pragmatism* with the pragmatic maxim offered by Charles Peirce in "How to Make Our Ideas Clear."[575] This maxim, which is primarily a theory of meaning, James expands into a method. The pragmatic method, in its narrowest definition, is "a method for settling philosophical disputes," which "interprets each notion by tracing its respective practical consequences. In short, "what difference would it practically make to anyone if this notion rather than that notion were true?"[576] James develops the notion further and shows how this

[571] (James, 2008ab)
[572] (James, 2008ai, p.32; 2008ay, p.5)
[573] (Puntam & Putnam, 2017, p.112) See (R. Putnam, 2010, p.114)
[574] (Hookway, 1997)
[575] (Peirce, 2011)
[576] (James, 2008ai, p.28)

method is part of a broader pragmatic attitude in philosophy.[577] He explains what the pragmatic means as follows: "No particular results then, so far, but only an attitude of orientation, is what the pragmatic method means. The attitude of looking away from first things, principles, 'categories' supposed necessities; and of looking towards last things, fruits, consequences, facts."[578] I wish to point out three things from the above quotation.

The first is that pragmatism stands for "no particular results." By this James means that the attitude of pragmatism is dynamic and process-oriented (Case 2b).

The second is that in the quotation, James fittingly turns attention from pragmatism itself towards its fruits and consequences. In the definition of pragmatism that James wrote for Baldwin's Dictionary, James explains that the "meaning of a conception expresses itself in practical consequences, consequences either in the shape of conduct to be recommended, or in that of experiences to be expected."[579] To ask what pragmatism *means* is to ask what difference pragmatism makes in conduct and experience.[580] James' answer is that the "meaning" of the method of pragmatism (i.e., the practical difference it makes in conduct and experience) is in an "attitude of orientation."

The third is that the attitude of pragmatism is described as shifting the focus of attention, where one is "looking," i.e., "looking away from first things" and "towards last things."[581] Elsewhere, James summarizes pragmatism with attention terminology such as the "way we face"[582] and

[577] (Ibid., pp.29, 31)
[578] (Ibid., p.32)
[579] James writes Baldwin's Dictionary definition of pragmatism five years prior to *Pragmatism,* and refers to Pierce's conception of pragmatism as a method for determining meaning (James, 2008ba, p.94).
[580] (Hookway, 1997, p.187; James, 2008j, p.81; Putnam & Putnam, 2017, p.109)
[581] (James, 2008ai, p.32)
[582] (James, 2008ak, p.24)

"turns away…turns towards."[583] He writes, "A pragmatist …turns away from abstraction and insufficiency, from verbal solutions, from bad *a priori* reasons, from fixed principles, closed systems, and pretended absolutes and origins. He turns towards concreteness and adequacy, towards facts, towards action…"[584]

James wrote the first great work of psychology, *PoP,* and an important idea that James highlights in *PoP* is that of attention. In *Psychology Briefer Course* (the abridged version of *PoP*), he argues that "what holds attention determines action"[585] and "what is called our 'experience' is almost entirely determined by our habits of attention."[586] Changing attention, therefore, has practical consequences in conduct and experience.[587] In other words, the pragmatic method makes a practical difference in conduct and experience by means of an attitude that changes the direction of one's attention.

Pragmatism has been interpreted in various ways, and my contribution to Jamesian scholarship lies in offering a unique perspective: reading pragmatism as a shift in attention. This vision of attention shapes James' vision of philosophy. I turn now to "attention" in James' thought, which I have divided, for the sake of discussion, into evolutionary selection, psychological experience, and physiologic conduct.

[583] (James, 2008ai, p.31)
[584] (Ibid., p.31)
[585] (Ibid., p.384)
[586] (James, 2008al, p.156)
[587] (James, 2008ba, p.94)

Turning Attention

Though published over a century ago, *PoP* remains influential and is still a widely read and referenced text today.[588] Some argue that James' philosophy was based on his work in *PoP*.[589] My aim is not to map James' theories onto contemporary studies of psychology with contrasts and comparisons.[590] In the following, I introduce James' theory of attention as it relates to his broader philosophy. His theories of attention have implications for pragmatism and applications for modern medicine.

Although attention is a significant aspect of James' psychology and philosophy, there is comparatively little secondary scholarly work that is focused upon it.[591] The recently released (in 2024) *Oxford Handbook of William James* includes a chapter, "James and Attention: Reactive Spontaneity," which discusses the role of attention in James' theory of mind (including perception, belief, will) and makes suggestive comments about pragmatic ontology in the last few pages but does not develop the relations between pragmatism and attention further.[592]

James explicitly speaks explicitly about attention in *PoP, Psychology Briefer Course*, in manuscript notes for lectures on psychology, and in *Talks to Teachers on Psychology and To Students on Some of Life's Ideals (TTT&S)*, and he characterizes attention in multiple ways. James' interest in attention, however, extends beyond his psychological literature. Attention is

[588] (McDermott, 2013, p.xxvii)
[589] (Edie, 1965, p.113)
[590] (Galin, 1994; Prinz, 2024, p.22) take this approach. Contemporary research on cognitive science of uncertainty suggests that attention is one process the brain uses to "master" uncertainty (Peters et al., 2017, p.173).
[591] (Broniak, 1996; Caliman, 2006; D'Angelo, 2022; Gale, 1991; Galin, 1994; Gavin, 1976; Mangan, 2007; McDermott, 2013; Prinz, 2024; Proust, 2023)
[592] (Prinz, 2024)

a theme manifest throughout his philosophy, shaping his epistemology, metaphysics, and morality.[593]

A famous chapter in *PoP* is "The Stream of Thought;" in this chapter, James introduces his ideas on attention.[594] With the metaphor of a stream, James describes consciousness as a constantly flowing and changing experience. He names five characteristics of consciousness, one of which is selective attention.[595] Attention he defines as:

> The taking possession by the mind, in clear and vivid form, of one out of what seem several simultaneously possible objects or trains of thought…It implies withdrawal from some things in order to deal effectively with others.[596]

Integral to his definition of attention is its selective function—what the mind withdrawals attention *from* is as important as what the mind attends *to*. Also integral to his definition is the purposiveness of this selection. Selection occurs for the sake of action, "in order to deal more effectively" with some things. In his *PoP* chapter, "Attention," he explains the pragmatic consequences of attention in the way it shapes experience and conduct.[597]

James begins his chapter on attention with experiments demonstrating that the mind can only attend to a limited number of things at once.[598] According to James, "millions of items" are present to the senses.[599] Reflecting on the narrowness of consciousness, James writes, "One of the most extraordinary facts of our life is that, although we are besieged at every moment by

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[593] The role of practical and personal interests in shaping thought, action and experience is foundational to James' pragmatism. He writes in *PoP*, "what-we-attend-to and what-interests-us are synonymous terms" (James, 2008ak, p.1164).
[594] (James, 2008ak, pp.219-278)
[595] (James, 2008ak, pp.273-278; 2008al, pp.154-158)
[596] (James, 2008ak, pp.381-382)
[597] (D'Angelo, 2022; Gavin, 1992; James, 2008ak, pp.380-434; 2008al, pp.192-209)
[598] (James, 2008ak, pp.273-278; 2008al, pp.154-158)
[599] (James, 2008e, p.19)

impressions from our whole sensory surface, we notice so very small a part of them. The sum total of our impressions never enters into our experience, consciously so called, which runs through this sum total like a tiny rill through a broad flowery mead."[600] The limited nature of consciousness has consequences. As Mangan writes in an exposition of James' theory of attention, "The key constraint on consciousness is its limited capacity…There is a maximum resolution or articulation capacity that consciousness does not exceed…This mandates various trade-offs: when more articulation capacity is concentrated in one region of the field of consciousness, less is available elsewhere."[601] Due to this limited capacity, the withdrawal of attention is as important as the choice of what to attend to. Withdrawal from one focus can open up resources to invest in another.

For James, the organs of the body (including the brain) are organs of selection. "Out of the infinite chaos of movements, of which physics teaches us that the outer world consists, each sense-organ picks out those which fall within certain limits of velocity. To these it responds, but ignores the rest as completely as if they did not exist."[602] In other words, the brain selects some stimuli and ignores others.[603] James emphasizes that "…selection-implies rejection as well as choice; and that the function of ignoring, of inattention, is as vital a factor in mental progress as the function of attention itself."[604]

If we summarize pragmatism as a turn in attention from uncertainty to action, then the withdrawal of attention away *from* the uncertainty is just as important as the turning of attention *towards* action. Turning attention away from uncertainty does not always entail willfully

[600] (James, 2008al, p.192)
[601] (Mangan, 2007, p.681)
[602] (James, 2008ak, p.46)
[603] (James, 2008ak, pp.380-434; 2008al, pp.192-209; Stevens, 1951, p.239)
[604] (James, 2008ak, p.993)

blinding oneself to it, nor does it necessarily require disregarding or denying its presence. It is simply a turn of attention. And attention (as a dynamic phenomenon) can always be turned back to it—especially when attention on uncertainty is necessary for fruitful action. Withdrawal of attention palliates (in the sense of cloaks) uncertainty, and this is an adaptive move, as the selective nature of attention is fundamental to how human minds function.

Evolution: Selection for the Sake of Action

In the uncertain flux of experience, one way in which the brain deals with this uncertainty is through selection. Furthermore, James makes it clear that selection (the act of attending to some things while withdrawing from others) is for the sake of action.[605] James roots his psychology at a deeply evolutionary level—human minds evolved, first and foremost, to adapt to, survive in, and act on the world.[606] In Gale's words, James' view is a "Darwinian-inspired instrumentalist conception of the function of consciousness,"[607] in which "consciousness is an instrument to help an organism come into the right sort of working relationships with its environment."[608] In James' words, "man, whatever else he may be, is primarily a practical being, whose mind is given him to aid in adapting him to this world's life."[609] "My thinking is first and last and always for the sake of my doing..."[610] In "SoR" James makes this point clearly,

> It is far too little recognized how entirely the intellect is built up of practical interests. The theory of evolution is beginning to do very good service by its reduction of all mentality to the type of reflex action. Cognition, in this view, is but a fleeting moment, a cross-section at a certain point, of what in its totality is a motor phenomenon. In the lower forms of life no one will pretend that cognition is anything more than a guide to appropriate action. The germinal question concerning things brought for the first time before consciousness is not the theoretic 'What is that?' but the practical 'Who goes

[605] (James, 2008ak, p.47)
[606] (Gale, 1991, p.244; James, 2008ak, p.1164)
[607] (Gale, 1991, p.246)
[608] (Ibid., p.244)
[609] (James, 2008ar, p.24)
[610] (James, 2008ak, p.960)

> there?' or rather, as Horwicz has admirably put it, 'What is to be done?'…In all our discussions about the intelligence of lower animals, the only test we use is that of their *acting* as if for a purpose. Cognition, in short, is incomplete until discharged in act…the active nature asserts its rights to the end.[611]

Evolutionarily, the human brain withdrawals attention from the uncertain flux of experience and selectively attends to that which helps it enter into working relationships with the environment and act according to its interests.[612] In the above quotation, cognition is a "first thing" that terminates in the fruits, consequences, and "last things" of action.[613]

Pragmatism is a shift in attention away from the uncertain first things of cognition (theoretical principles, 'categories' supposed necessities, the question "What is that?") and towards last things of practical action (fruits, consequences, the question "What is to be done?"). For James, this reflects a fundamental capacity rooted in the evolved structure of the human mind.

Psychology: Experience

After describing varieties of attention, James describes the effects of attention.[614] The first pragmatic consequence of changing attention is creation of experience. Changing the focus of attention creates novelty, new experience, and new uncertainty, which can open up new possibilities.[615]

In James' words, "what is called our 'experience' is almost entirely determined by our habits of attention."[616] "My experience is what I agree to attend to."[617] In the latter quote, three elements

[611] (James, 2008ao, p.72)
[612] (Gale, 1991, p.244; James, 2008ak, p.1164)
[613] (Caliman, 2006, p.27)
[614] (James, 2008ak, pp.393-411)
[615] (Ibid., p.442)
[616] (Ibid., p.156)
[617] (James, 2008e, p.19)

can be discerned: creation of experience, attention, and an agent. Through acts of attention, an agent organizes and selects from the vast array of stimuli, shaping experience of reality and contributing to reality itself.

James was strongly influenced by Helmholtz's physiological work on the eyes. Helmholtz's work on attention in the visual realm provided helpful frameworks for James' construction of attention in the psychological.[618] In the following, I discuss three visual analogies that James drew.

Visual Analogy 1

Drawing an analogy with Helmholtz's work in the visual field, James argues that "fixing or failing to fix the attention" contributes to the construction of the world which we seem to inhabit. He uses ambiguous shapes to illustrate the role of attention in the creation of experience. "Where the result is ambiguous, we can make the change from one apparent form to the other by imagining strongly in advance the form we wish to see."[619] James uses the images given in Figure 11 to depict this idea. He shows an optical illusion in which the shapes are ambiguous and can be seen as cubes, pyramids, or tunnels depending upon the visual fixing of attention and viewers' expectations.

[618] (Eriksen & Hoffman, 1972, p.204; James, 2008ak, pp.399-400, 411, 417-418, 431)
[619] (James, 2008ak, p.418)

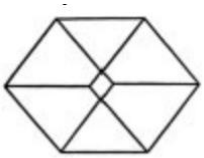

FIG.37

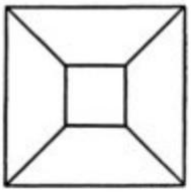

FIG.38

Figure 11) Image from PoP illustrating the role of attention in creating experience.[620]

Quoting Helmholtz's writings on retinal rivalry, James explains that visually, "we must form as clear a notion as possible of what we expect to see. Then it will actually appear."[621] This idea, James extends from the visual field to the psychologically ambiguous stream of consciousness and the metaphysically indeterminate world. James emphasizes that this phenomenon is especially important in the ambiguous relations at the fringes and margins of consciousness.[622] There is creation through the efforts of attention that are exerted by an agent.

In the act of attention, James finds a locus of free-will.[623] These creative acts of attention infuse new experiences into what may seem to be a determined series of events and become a locus of creation for new possibilities.[624] Prinz discusses the constructive role of attention: "For James, attention is not just a tool for sharpening perception. It is a tool for thinking, doing, and worldmaking."[625] Gale likewise notices James' "promethean theme of creation-through-

[620] (Ibid., p.418)
[621] (James, 2008ak, p.206)
[622] (Ibid., p.204)
[623] (Ibid., pp.208-210, 1176-1179) See (James, 2008g)
[624] (James, 2008g, pp.123-124)
[625] (Prinz, 2024, p.39)

efforts-of-attention."[626] He argues that the creative power of attention is central to his pragmatism.

Creation through attention, however, has limits. In *The Meaning of Truth,* James reminds his readers that "if our own particular thought were annihilated the reality would still be there in some shape, tho possibly it might be a shape that would lack something that our thought supplies."[627] For James, attention is powerful, but the world is not infinitely malleable to the human mind. He writes, "That reality is 'independent' means that there is something in every experience that escapes our arbitrary control… an urgency, within our very experience, against which we are on the whole powerless."[628] In *Pragmatism,* James uses the analogy of children making a snowball: "The case is like a snowball's growth due as it is to the distribution of the snow on the one hand, and to the successive pushes of the boys on the other, with these factors co-determining each other incessantly."[629] An individual's creative power of attention functions not in isolation but in relationship with the world and other subjects.

Visual Analogy 2

Another visual analogy for attention that is inspired by James is that of a spotlight with a focus, a fringe, and a margin.[630] The focus is high-resolution and clear, the fringe is low-resolution and contextualizes the focus, and the margin is the boundary of the field of vision.

[626] (Gale, 1991, p.246) See (Ibid., pp.245-250)
[627] (James, 2008ab, p.45)
[628] (Ibid., p.45)
[629] (James, 2008ai, p.108)
[630] (Caliman, 2006, p.24) cites (Mialet, 1999) See (Galin, 1994)

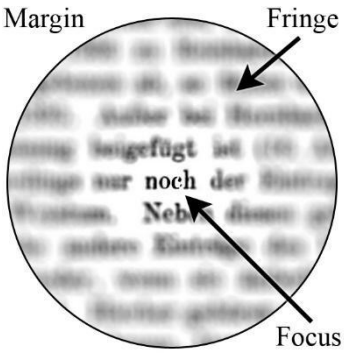

Figure 12) Image illustrating spotlight model of attention with focus, fringe, and margin. "Noch" is German for "still," "not yet," "even," and "more."[631]

The margin introduces uncertainty beyond what is seen, the fringe introduces uncertainty as that of which we are aware but cannot see clearly, and the focus (in this image "noch") introduces uncertainty in the reminder that even what is seen clearly has "more" which cannot be grasped.

The image of a spotlight illustrates some useful points. Attention on one thing implies a withdrawal from others and no matter where attention is focused, there is a "more," an uncertain fringe that escapes grasp. Even that which is focused on is "noch." Like a spotlight, attention can be shifted, is dynamic, and can assume new centers. The visual field can expand and contract or shift focus on certain centers for certain purposes.

In some ways, James' theory of attention is like a spotlight, but in other ways it is not. Galin and Manghan point out important ways in which James' theory of attention is unlike a spotlight.[632] Galin emphasizes that experiences of the fringe are qualitatively different from

[631] (Lovarobot, 2010)
[632] (Galin, 1994; Mangan, 2007)

those of the nucleus. He argues that, unlike most references to a spotlight model of attention, "James did not equate the nucleus with that which is attended and the fringe with that which is not attended,"[633] because "James' fringe presents a separate class of information than the nucleus, not just the same kind of information at a lower resolution."[634] Galin lists as examples of fringe experiences the subjective relations between objects or ideas (and, or, if, but), feelings of familiarity, intention, knowing, tip-of-the-tongue phenomena, expectancy, rightness, harmony, fittingness, and others.[635] Relations on the fringe include (but are not limited to) personal relations. Galin explains that fringe experiences are experiences of a "web of relations that give meaning to the nucleus."[636] In other words, there are things experienced that the spotlight cannot quite shine on.

To develop this point, Galin reminds readers of other metaphors that James uses for consciousness, such as water flowing around a rock in a stream or a bird flying through the air and perching periodically on branches.[637] The idea is that consciousness has substantive and transitive elements. The substantive parts are where the mind rests, and the transitive parts are the moving, flowing relations that lead between substantive thoughts. These transitive elements of relations on the fringe cannot be brought into the focus of the nucleus without changing form. James refers to attempts to observe the transitive as like trying to hold a snowflake in a warm hand, catch the motion of a top by seizing it while it spins, or turn on the light quickly enough to see what darkness looks like.[638]

[633] (Galin, 1994, p.381)
[634] (Ibid., p.382)
[635] (Ibid., p.379)
[636] (Ibid., p.377)
[637] (James, 2008ak, p.236)
[638] (Ibid., pp.236-237)

Can that which is on the fringe be brought into the nucleus of focus? Galin would say no. He concludes that the transitive cannot be brought into the nucleus without changing it.[639] In some ways I agree, but I do not think that Galin distinguishes sufficiently between varying degrees of "fringeness."[640] The focus of attention can shift to a plurality of things, even those that are slightly further on the fringe than the current focus of attention. Furthermore, I suggest that *everything* that enters the nucleus does so only by undergoing a change in form. In the picture above, that which is in the nucleus is called "noch" for a reason.

Visual Analogy 3

James draws another analogy for attention with the visual field which highlights the importance of the marginal and fringe, even if these cannot be "seen" clearly.

> Usually, it is true that no object lying in the marginal portions of the field of vision can catch our attention without at the same time 'catching our eye'—that is, fatally provoking such movements of rotation and accommodation as will focus its image on the fovea, or point of greatest sensibility. Practice, however, enables us, *with effort,* to attend to a marginal object whilst keeping the eyes immovable. The object under these circumstances never becomes perfectly distinct—the place of its image on the retina makes distinctness impossible—but (as anyone can satisfy himself by trying) we become more vividly conscious of it than we were before the effort was made.[641]

For James, there is value in making an effort to attend to the marginal and the fringe (even if it cannot be brought into the nucleus of focus) because awareness of the marginal and fringe shapes perception of experience and creates new experience of that which is attended to.

[639] (Galin, 1994)
[640] Galin accounts for a diversity of types (not degrees) of fringe experiences (Ibid., pp.378-380)
[641] (James, 2008ak, p.203)

Gale, McDermott, Lamberth, and others show that the fringe in James' philosophy is noncognitive, transitive, and relational.[642] Broniak and others make the point that the fringe is temporally modal, bridging what is and the possibility of what could be.[643] Like a flowing stream, the fringe introduces what flows next. The fringe is the origin of transition and leads to transition.[644]

The idea of a relational fringe expands beyond James' psychological theories into his metaphysics.[645] Gavin, for instance, in *William James and the Reinstatement of the Vague* shows correspondence between James' theories of consciousness and his metaphysics of radical empiricism.[646] Radical empiricism's metaphysics is fundamentally relational. Crudely summarized, its postulates include that philosophy should pertain to that which is experienceable, relations are part of experience, and no element of experience is to be excluded.[647] Putnam, McDermott, and others argue that understanding James' psychological/metaphysical view of relations is essential to understanding his pragmatism.[648] Pragmatism occurs in a relational field of experience. Truth is described in terms of "intimacy,"[649] "harmonious working relation,"[650] "leading that is worthwhile,"[651] emerging from experience and dipping back "into the particulars of experience again and [to make] advantageous connexion with them."[652]

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[642] (Broniak, 1996; Gale, 1991; Galin, 1994; Lamberth, 1999; Mangan, 2007, p.674; McDermott, 2013; E. Norman, 2017)
[643] (Broniak, 1996, pp.451-452)
[644] (Broniak, 1996, p.453; James, 2008ai, p.87)
[645] (Brett, 1842; McDermott, 2013, pp.xxvi-xliv)
[646] (Gavin, 1992, pp.17-55)
[647] (Hester, 2009, pp.13-20; James, 2008ab, pp.6-7; Lamberth)
[648] (McDermott, 2013, p.xxxv; Putnam & Putnam, 2017, pp.136-139)
[649] (James, 2008ag, pp.16-19, 145)
[650] (James, 2008av, 401) See (Lamberth, 1997)
[651] (James, 2008ai, p.205)
[652] (Ibid., p.99)

This relational fringe expands beyond James' metaphysics into his spirituality. Mangan explains that the fringe transitions between the conscious and subconscious, "using a few wisps of experience to radically condense or summarize nonconscious information of extreme complexity."[653] Another important transition is at the fringe of the fringe. Attention to the marginal fringe plays a significant role in religious experience, so much so that James describes mystical experience as a widening of attention, broadening beyond usual horizons.[654] Though James does not reduce the spiritual to the subconscious, he suggests that the subconscious may play an important role in religious/spiritual life.[655] James suggests, "just as our primary wide-awake consciousness throws open our senses to the touch of things material, so it is logically conceivable that if there be higher spiritual agencies that can directly touch us, the psychological condition of their doing so might be our possession of a subconscious region which alone should yield access to them."[656] He writes, "Each of us is fringed by a wider 'more.' Every bit of us is at every moment part and parcel of a wider self, it quivers along various radii like the wind-rose on a compass, and the actual in it is continuously one with the possibles not yet in present sight." He continues, "And just as we are co-conscious with our own momentary margin, may not we ourselves form the margin of some more really central self in things which is co-conscious with the whole of us? May not you and I be confluent in a higher consciousness, and confluently active there, tho we now know it not?"[657] In both *VRE* and his essay "A Suggestion about Mysticism," James describes transformative religious experience as a change in attention.[658]

[653] (Mangan, 2007, p.682)
[654] (James, 2008aq)
[655] (Capestany, 1967; Croce, 2012; James, 2008av, p.381; Taves, 2004)
[656] (James, 2008av, p.197)
[657] (James, 2008ag, p.131)
[658] (James, 2008aq; 2008av, pp.79, 126)

In summary, the turning of attention introduces new possibilities and experiences. James sees attention as a locus of free-will, an origin of transition, a pathway that yields access to the influence of broader relationships. One can withdraw attention from uncertainty and turn it towards action. Even when action is focused upon, the relationships on the fringe bridge the possibility of what is and what could be, serve as an origin of transition, and contribute to the creation of experience. In later discussion of Palliating Uncertainty (and in Part III), I will apply this idea of attending to relationships often on the fringe of care.

Physiology: Conduct

On a physiological level, James considers attention both as an action and an origin of action.[659] He develops the importance of attention further in relation to "will." By will, he refers to the mental process by which an individual decides to perform an action and distinguishes it from automatic/reflexive responses. He discusses how "effort," particularly the effort of attention, plays a crucial role in sustaining a particular idea or intention in consciousness until it leads to action. Succinctly, he concludes, "what holds attention determines action."[660]

Physiologically, James considers attention to be a bodily action in which the organs of the body accommodate and adjust—the eyes move, ears listen, lungs breathe, muscles twitch, the heart races, blood flows to the brain, etc.[661] "Ideational attention" (i.e., attention on mental representations of ideas/objects) likewise plays a physiological role in "anticipatory preparation" for acting towards the object of attention. For example, James cites reaction-time experiments, in which keeping the mind's attention upon the motion about to be made shortens the reaction time. He concludes that expectant attention to a reaction thus involves a "sub-

[659] (Prinz, 2024, p.21)
[660] (James, 2008ak, p.384)
[661] (Ibid., p.411)

excitement of the centre concerned."[662] Similarly, he reports experiments in which participants focused on a question, and the time to answer was longer than when participants focused on what might be likely answers.[663] Although it is difficult to control what catches attention, James describes the essential achievement of the will as modulating how much attention is given and to what extent something is held before the mind.[664]

> The essential achievement of the will, in short, when it is most 'voluntary,' is to attend to a difficult object and hold it fast before the mind. The so-doing is the fiat; and it is a mere physiological incident that when the object is thus attended to, immediate motor consequences should ensue…Effort of attention is thus the essential phenomenon of will.[665]

With a physiological metaphor of inhibitory and excitatory signaling, James shows how attention can inhibit or excite discharge in motor action. The attention is "the fiat," the imperative "let it be done," the decree that brings action about, tips the homeostatic balance of inhibition and excitatory signals across the threshold, and terminates in motor consequences (i.e., conduct). "The whole drama of voluntary life hinges on the amount of attention, slightly more or slightly less, which rival motor ideas may receive."[666] After describing various types of decisions and temperaments towards decisions, James concludes that the discharge in action is the result of holding before consciousness that which disposes towards action. Likewise, he shows how holding attention on uncertainty can inhibit action.

> What checks our impulses is the mere thinking of reasons to the contrary—it is their bare presence to the mind which gives the veto, and makes acts, otherwise seductive, impossible to perform. If we could only forget our scruples, our doubts, our fears, what exultant energy we should for a while display![667]

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[662] (Ibid., p.205)
[663] (Ibid., p.410)
[664] (Ibid., p.974)
[665] (James, 2008ak; 2008al, p.386) See (James, 2008ak, pp.1166-1167; 2008al, pp.208-209)
[666] (Ibid., p.429)
[667] (Ibid., p.1164)

In homeostatic balances, inhibition of inhibition is excitatory. If attention on uncertainty is inhibiting action, then turning attention from it inhibits the inhibition and can promote discharge in action.

To illustrate pragmatism as a turn of attention, I use an image that James uses: that of an Alpine climber.[668] Suppose a climber has worked herself into a terrible position where she is stuck on a ledge and the only way out is by a terrible leap. She could focus all her attention on the uncertainty, the fact that she is not guaranteed to make the jump, the doubt in her ability, and in James' words, "hesitate so long that at last, all unstrung and trembling, [she] launches herself in a moment of despair, and rolls in the abyss."[669] Or she could turn her attention to the leap; focus on what she needs to do to make the leap, steadying her feet, acting as though she can do it, and committing to jump. She takes a risk of faith and leaps without the guarantee that she will make it or that it will turn out as she hopes. The turning of attention from uncertainty to action disinhibits the inhibition of uncertainty, excites the exertion of the leap, and plays a part in the creation of the outcome.

James argues that this "leap" applies to a class of facts in which the outcome is yet uncertain and underdetermined, in which "belief creates its own verification."[670] Referring to the mountain climber, he writes,

[668] (James, 2008c, p.332; 2008q, p.53)
[669] (James, 2008q, p.53)
[670] (James, 2008c, p.332)

> Refuse to believe, and you shall indeed be right, for you shall irretrievably perish. But believe, and again you shall be right, for you shall save yourself. You make one or the other of two possible universes true by your trust or mistrust—both universes having been only *maybes,* in this particular, before you contributed your act."[671]

James explains that everyone is constantly making this "jump" without being aware of it, but sometimes, situations in life force us to confront this reality. In an essay on religion titled "Will to Believe," he writes,

> In all important transactions of life we have to take a leap in the dark…We stand on a mountain pass in the midst of whirling snow and blinding mist through which we get glimpses now and then of paths which may be deceptive. If we stand still we shall be frozen to death. If we take the wrong road we shall be dashed to pieces. We do not certainly know whether there is any right one. What must we do? 'Be strong and of a good courage.' Act for the best, hope for the best, and take what comes. If death ends all, we cannot meet death better.[672]

In the passage, the starting place is one of uncertainty—standing on a mountain pass, whirling snow, blinding mist, deceptive paths, unknown which road to take. One can keep attention on the uncertainty, frozen and paralyzed by it. When feeling trapped and paralyzed by uncertainty, sometimes changing attention can open new possibilities. James turns the attention from uncertainty to action. He asks, "What must we do?" This action itself is a leap, a risk of moral courage as one lives with uncertainty.

James also discusses attention in his chapter titled "Will" in *PoP.* He explains how the will is involved in the formation and breaking of habits, and he emphasizes the role of repeated actions in solidifying behaviors. He shows how the effort of attention is central to making moral decisions in which one must choose between competing moral values or duties and uphold

[671] (James, 2008q, p.54)
[672] (James, 2008ax, p.33)

moral principles that may conflict with other personal desires. Finally, he relates the efforts of attention (which manifest will and habits) to the character of who we choose to become.[673] In James' philosophy, redirecting attention from uncertainty to action can be understood as an act of moral will—one that, when enacted repeatedly, may form a habit of moral courage and help cultivate the character of someone who lives courageously with uncertainty.

In summary, turning attention from uncertainty to action has effects on both conduct and experience. Evolutionarily, attention is selective for the purposes of action and the withdrawal of attention from uncertainty can open up other resources that can be invested in action.[674] Psychologically, shifting attention from uncertainty to action creates new experience and can open up new opportunities.[675] Physiologically, "what holds attention determines action."[676] Placing attention on action can help overcome the paralysis of uncertainty and is a locus of agency, will, habit, and character. Experience of uncertainty is part of being human, yet we can and still do act.

From Uncertainty to Action

Ruth Putnam lists two key features of pragmatism. The first is that pragmatists take themselves to be agents who play active roles in the selection and creation of experience, acting on the world and acted upon by it. The second is that pragmatists broaden the notion of experience to include experience of relations. She then describes the attitude of James' pragmatism as public philosophy, addressed to ordinary people dealing with problems of life.[677] In other words, attention in pragmatism is turned towards action.

[673] (James, 2008ak, pp.157-158)
[674] (James, 2008ar, pp.23-24)
[675] (James, 2008ak, pp.380-433)
[676] (James, 2008al, p.384)
[677] (R. Putnam, 2010, p.114)

James' pragmatism is a philosophy for those who find themselves thrust into the thick of things, who have to act and make decisions before all the evidence is in and without the guarantee that they will be right. As physicians we have all been there. Consider how Barrows and Feltovich describe the clinical reasoning process,

> Patient problems are ill-structured problems: all the information needed for the solution is not available at the outset; the nature of the problem changes as investigation proceeds; the approaches that lead to the solution are generally not standardized but are unique to the problem; and the problem-solver may never be certain that a solution has been reached.[678]

So often in medicine we wish we could have clear evidence, answers, and guarantees before we act, but in many cases, we do not have that luxury. Pragmatism offers a framework for moving forward, even in the absence of complete knowledge. I imagine pragmatism as something like the online navigation tool, Google Maps. When using Google Maps, sometimes the navigation arrow will start to spin. You stand at a crossroads; the arrow is spinning. You do not know what direction you should go or even what direction you are facing. If you just stood there waiting to know for certain in which direction to go before you took a step, you would never move. The only way to fix the arrow is to just start walking. You might not walk the right way, but at the very least, the arrow corrects itself and then you know you have gone the wrong way. Similarly, in palliative care, sometimes the only way to determine the right direction is to start walking: taking small, meaningful actions can provide clarity and comfort amidst uncertainty. James challenges the idea that we have to wait for evidence and certainty before acting and suggests that, often, it is the other way around.

[678] (Barrows & Feltovich, 1987, p.90)

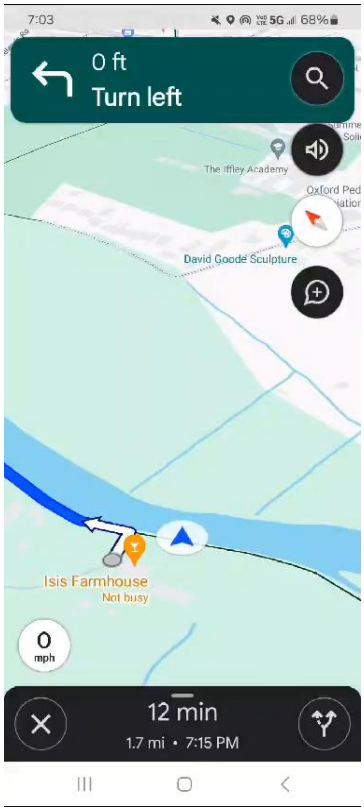

Figure 13) Image from Google Maps when the navigation compass arrow is spinning.[679]

Osler was deeply influenced by James' pragmatism.[680] He referred to James as "the American Socrates"[681] and quoted James' Hibbert Lectures in his invocation speech at Osler Hall in Maryland.[682] He described James as a "master"[683] and compared him to a Biblical wiseman "who taught that 'wisdom' refers to both practical matters and research in the scriptures and sciences."[684] In an address to Yale students entitled "A Way of Life," Osler summarized his philosophy of medicine and philosophy of life and espoused an attitude resonant with pragmatism. As mentioned earlier, Osler wrote what could be a description of the attitude of

[679] Personal records
[680] (Bryan, 1997, pp.23, 210-212; Edelstein, 1946; Inlow, 1964; Knight, p.18; Osler, 1918, p.13)
[681] (Knight, p.18)
[682] (Cushing, 2013, p.863)
[683] (Osler, 2001, p.25)
[684] (Ibid., p.25 fn.65)

James' pragmatism: "Our task is not to see what lies dimly at a distance, but to do what lies clearly at hand."[685]

Osler was a friend of the James' family and James corresponded with him to seek medical advice—both for his own ailments and on behalf of others. James even consulted Osler on his heart condition, visiting him for appointments in Oxford.[686] Tucked into Osler's copy of *Pragmatism* is a letter from James.[687]

> 95 Irving St. | Cambridge. April 3. 08
> My dear Osler,
>
> I thank you for your letter of March 24th., but listen to how it is with me! I find myself in a state of as bad nervous fatigue as I have ever been in my life, and that says a good deal. [Today, e.g., awake since 2.30-, and had to stop work on my 5th lecture (out of 8) after two hours because of flushed head.] Three-hour-long dinner parties tire me badly; and if I succeed in getting thru my lectures themselves, I shall be lucky…All that I am good for under present conditions is a few more intimate talks with old (and new) Oxford friends...
>
> Wm James[688]

At the time that James wrote this letter, he was suffering from a heart condition and was unsure how long he might yet live.[689] The lectures that James was writing in his state of "nervous fatigue" were the Hibbert Lectures he was due to give at Manchester College, Oxford. These were later published as *PU,* and Osler quoted them years later during his invocation speech at Osler Hall in Maryland.[690] The letter serves as one of hundreds of examples of the way in which

[685] (Osler, 1918, p.18) quotes Carlyle.
[686] (Bliss, 1999, pp.370-371; James, 2008aa, pp.491-492)
[687] (Cushing, 2013, pp.805-806)
[688] (James, 2008z, p.2)
[689] Cushing suggests that the nervous fatigue of James could be the "infernal nervous condition which, James confessed, "always accompanied literary production" (Cushing, 2013, pp.805, fn.801).
[690] (Cushing, 2013, p.863)

James' physical condition cast uncertainty into his work. James had to focus on doing the task at hand, while the outcomes of the future lay dimly at a distance.[691]

In Palliating Uncertainty, I apply the attitude of pragmatism as Osler does —turning attention away from uncertainty and towards action, from trying "to see what lies dimly at a distance" to doing "what lies clearly at hand."

Palliating Uncertainty

Palliative Care & Palliating Uncertainty

The approach of Palliating Uncertainty is based on the ethos of palliative care. Like palliative care, Palliating Uncertainty focuses on alleviating suffering, improving quality of life and supporting patients and their families as they navigate living with the uncertainties of their conditions. Twycross' characteristics of palliative care (modified in the table below) express this ethos well.[692]

[691] (Osler, 1918, p.18)
[692] (Twycross, 2003, p.10; Twycross et al., 2021, p.1)

Palliating Uncertainty is:
Patient-centered rather than uncertainty-focused
Holistic: addressing physical, psychological, social/family, and spiritual/existential *effects* of uncertainty
Focused on quality of life but can be provided in tandem with uncertainty-reducing measures sought through acquisition of more knowledge
Holds uncertainty in partnership with patient and carers; is concerned with caring for patients' families and others close to them
Holds uncertainty in a multi-professional healthcare team and broader communities beyond medicine
Concerned with healing rather than curing
Uncertainty-accepting but also life-enhancing

Twycross places non-abandonment at the core of palliative care. If there is one principle at the heart of Palliating Uncertainty, it is likewise that of non-abandonment. In the approach of Palliating Uncertainty, relationships that are often on the fringe of care are recognized to be a core element of healing. Furthermore, these relationships are broader than patient-physician relationships as uncertainty is palliated in partnership with patients and their families and multidisciplinary teams, which work alongside larger non-medical communities to provide

companionship and care for those at the end of life. The patient-centered, holistic, effects-based, relational, and community-oriented values of palliative care give Palliating Uncertainty its distinctive ethos.

Pragmatism & Palliating Uncertainty

Palliating Uncertainty is based on the philosophy of pragmatism. Like pragmatism, this approach is a turn in attention—shifting the focus from uncertainty towards the person of the patient and what can be done to care for them. Like pragmatism, this change in attention has effects on both experience and conduct. The turn in attention palliates uncertainty in the sense that it "cloaks" by withdrawing uncertainty from the center of attention and in the sense that it "comforts" by taking action to address the effects of uncertainty on a patient's life and enabling them to live a life that is meaningful according to their values.

Figures 14 and 15 illustrate this idea with altered images of the spotlight model.

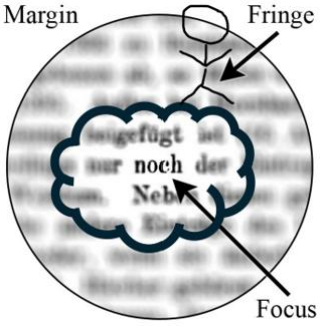

Figure 14) Image of uncertainty as the focus and the patient on the fringe—attention on removing uncertainty.

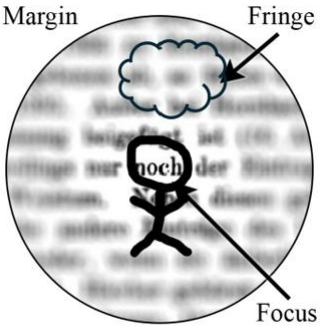

Figure 15) Image of the patient as the focus and the uncertainty on the fringe—attention on what can be done to care for the patient to address the effects of uncertainty on their life and enable them to live meaningfully in accordance with their values.[693]

Figures 14 and 15 illustrate the relationship between Palliating Uncertainty and changes in attention, according to the spotlight model. Figure 16 offers another representation that draws on James' concept of the fringe.

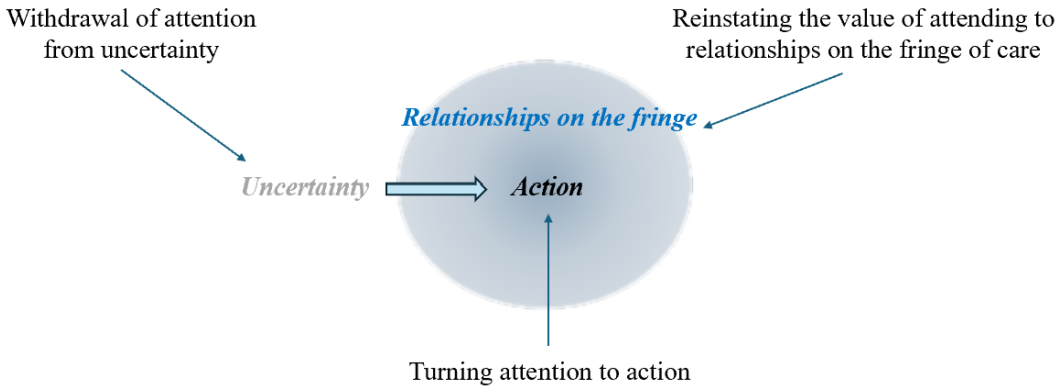

Figure 16) Image illustrating a shift of attention from uncertainty (on the left) to action (on the right) and the value of relationships that surround and sustain care (represented by the blue gradient circle).[694]

[693] (Dempsey, 2024a)
[694] Image by Dempsey, personal records

Figure 16 depicts a shift of attention away from uncertainty and towards purposeful action, while also reaffirming the importance of relationships that surround care. These relationships are often at the fringe of care, yet deeply affect it.

James' philosophy reinstates the value of the relations on the fringe—the web of relationships that give meaning to the nucleus, the place of the transitive, and the origin of transitions. In James' relational metaphysics, pragmatism itself is framed as that which leads harmoniously amidst these dynamic relationships, which are biological, psychological, sociological, and spiritual. It may not be possible to bring the relationships themselves into focus without changing the form; however, the palliation of uncertainty serves to reaffirm the importance of relational dynamics.[695] There is value in trying to attend to the marginal and the fringe because these relationships bridge the possibility of what is and what could be, serve as an origin of transition, shape the perception of experience, and create new experiences.

One way that Palliating Uncertainty reinstates the fringe is by elevating the importance of non-abandonment. When brought into the focal point of attention, non-abandonment is itself a turn towards action. Even when not the focus, non-abandonment can be at the fringe, surrounding and contextualizing whichever actions are taken. A second way in which Palliating Uncertainty reinstates the relational is the emphasis on the broader communities that together hold the uncertainty and hold the individual living with it. As uncertainty shifts from the center of attention, it moves to the fringe—into the network of relationships that contain it and offer support to the person within it.

[695] I take the definitions of these relationships vaguely and broadly, for example, they may be patient values, commitment to non-abandonment, peace, personal relations with family/carers, multidisciplinary teams, broader communities, and even spiritual relations.

The table below shows how Palliating Uncertainty is based on the philosophy of pragmatism and ethos of palliative care.

Palliating Uncertainty	
Pragmatism	Palliative Care
Turns attention from uncertainty to action	Patient-centered rather than uncertainty-focused
Takes action to address *effects* of uncertainty	Holistic: Takes action to address the physical, psychological, social, and spiritual/existential *effects* of uncertainty
Embraces a plurality of values and approaches for alleviating the suffering of uncertainty	Focused on quality of life, but can be provided in tandem with uncertainty-reducing measures sought through the acquisition of more knowledge
Reinstates the relational fringe	Uncertainty is held in partnership with patients and carers; it is also concerned with caring for patients' families and others close to them
Reinstates the relational fringe	Uncertainty is held by a multi-professional healthcare team and broader communities beyond medicine
Living with uncertainty	Concerned with healing rather than curing
Living with uncertainty	Uncertainty-accepting but also life-enhancing

Palliating Uncertainty: In Practice

The goal of Palliating Uncertainty is not always to remove uncertainty. The goals are, in the negative, to alleviate suffering caused by uncertainty and, in the positive, to help people live (even flourish) in the midst of uncertainty.

Goals of Palliating Uncertainty
⊖ Alleviating the suffering of uncertainty ⊕ Living with uncertainty

Managing Expectations

Clinicians can feel uncomfortable sharing uncertainty with patients for fear that it may undermine trust. However, studies show that it is not the communication of uncertainty that undermines trust but *how* that uncertainty is communicated.[696] Physicians' expressions of uncertainty negatively affect patient satisfaction if the physicians do not "perform actions to support patients in managing the uncertainty" or build partnering relationships with their patients.[697] Done well, communication of uncertainty strengthens trust in the patient-provider relationship, leads to greater patient satisfaction, is essential to shared decision-making and person-centered care, and improves healthcare outcomes and therapeutic effectiveness.[698]

The approach of Palliating Uncertainty begins with managing expectations about uncertainty in medicine. Uncertainty is an underlying, chronic condition of medicine and life; incurable but palliatable.

[696] (Scott et al., 2023, p.421) cites (Han et al., 2019)
[697] (Medendorp et al., 2021, p.1026) cites (Ogden et al., 2002) See (Patel et al., 2022, p.834)
[698] (Scott et al., 2023)

Honestly acknowledge uncertainty and manage realistic expectations.

- Acknowledge, normalize, and empathize with experiences of uncertainty.
- Observe verbal and non-verbal cues that may indicate a patient's desire to discuss their uncertainties and develop communication skills such as empathetic listening.
- Remember, it is not the presence of uncertainty that undermines trust but *how* that uncertainty is communicated: 1) Take action to support patients in the uncertainty and 2) Build a partnership and relationship of trust with patients.

Turning Attention to Action

The attitude of pragmatism can be helpful to patients, families, and healthcare because it replaces a paralyzing focus on uncertainty with a focus on concrete actions that make a meaningful difference. The uncertain is not the unknown. Sometimes what is more clear than the dimly distant future is:

- *The Task at Hand:* taking action to support patients in managing uncertainty and focusing on the plan for what needs to be done today, as we take things one day at a time.
- *The Relationship*: building a partnership and healing relationships with patients and reaffirming non-abandonment
- *Holding Uncertainty Together:* with our patients, multidisciplinary teams and communities that extend beyond hospitals and hospices.

Etkind et al. suggest that there are parallels between Saunders' "total pain" and "total uncertainty."[699] As pain has bio-psycho-social-spiritual effects and the management of pain requires total bio-psycho-social-spiritual care, so uncertainty has multiple domains of effects and can likewise be addressed through multiple avenues of care (See Cases 3, 4, & 5).[700]

In medicine there are:

- Biomedical interventions: focused on reducing the uncertainty
- Psycho-social-spiritual interventions: focused on the patient and alleviating the effects of uncertainty
- Non-abandonment, therapeutic presence, "being with": focused on the person

In medicine, the default is to focus on the uncertainty, target biomedical interventions, and treat everything else as a "consolation prize" if there is not anything biomedical to offer. Yet, alleviating suffering and being with our patients are not just "consolation prizes." They are something that should be done all the time. Often the impulse to act is associated with "doing something biomedical," but to act can mean to relieve suffering. To act can mean to "be with."

For example, consider the case of a patient with pancreatic cancer. Biomedically, we can reduce prognostic uncertainty by checking the CA-19 markers and monitoring progression with computed tomography (CT) imaging. But this does not alleviate uncertainty. Even just waiting for test results can be excruciating. There are other psycho-social-spiritual person-focused things we can do. We can get back to the patient quickly with the results of tests, connect them with patient groups, provide counselling to manage anxiety through Cognitive Behavioral

[699] (Etkind et al., 2022, p.8)
[700] (Ong & Forbes, 2005)

Therapy, involve family relationships and community in care, and even allow for uncertainty when it provides hope. Non-abandonment is the relationship of trust that is at the heart of care. Practically, this involves listening to patients, therapeutic presence, continuity, and follow-up. "We've been down this road before with other patients, sometimes this happens, sometimes that. We have plans in place for each and I and my team will be with you through this no matter what happens."

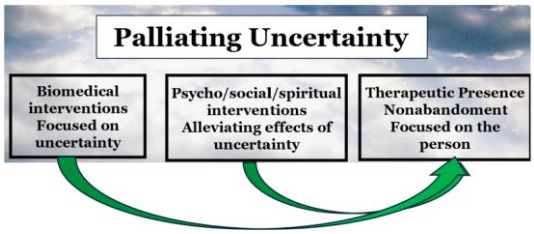

Figure 17) Image illustrating that the reduction of uncertainty through biomedical and/or psycho-social-spiritual interventions can be a way of alleviating the suffering caused by uncertainty, as well as a way of "being with" a patient and affirming non-abandonment.[701]

Osler speaks about approaching medicine in "day-tight compartments."[702] I do not know what will be a month from now, but I might know what I'm supposed to do today. If I do not know even that, I do know what I am supposed to do in this conversation—namely, listen to this person and be with them in the suffering, even in the suffering of the uncertainty. Just naming an emotion and sitting with someone in it without trying to fix it is a "therapeutic gift."[703]

Sometimes in end-of-life care, the task at hand, the thing to do next is, paradoxically, not to focus on the doing at all.[704] I worked with a palliative care physician who used to be in the military. He said that in the military the motto was "Don't just stand there, do something," but that in palliative care it is, "Don't just do something, stand there." Be present with the patient

[701] (Dempsey, 2024b)
[702] (Osler, 1918, p.23)
[703] "Therapeutic gift" from conversation with psychiatrist, Daniel Maughan.
[704] (Oliver, 2001, p.70)

and their family. I love this quote, but in some ways, I disagree with it. I think being present with our patients is doing something—perhaps doing one of the most important things we can do for our patients at the end of life.

The promise of non-abandonment is the ultimate turn to action in uncertainty. We may not know what the prognostic future will hold, but even in the most uncertain of circumstances, we do know what we can do next. We can hold the uncertainty with our patients and walk alongside them.

One thing known in palliative care is that relationships are part of healing. Yes, uncertainty causes tremendous suffering, but in the face of the incurable and unanswerable, as we step into uncertainty with our patients, the uncertainty becomes an opportunity for relationship and healing connection. Holding the uncertainty with our patients can help to transform the uncertainty from being part of the suffering to becoming part of the healing.

Turn attention to what *can* be done: 1) the task at hand 2) the relationship

- Act to support patients in managing the uncertainty, addressing the suffering it causes
- Pull in the horizon: make a plan for what needs to be done today, taking things one day at a time
- Provide a safety net, "hoping for the best and preparing for the worst"
- Palliate the suffering caused by uncertainty using a bio-psycho-social-spiritual approach
- Acknowledge that living with uncertainty is hard and discuss strategies to help patients cope in a way that preserves hope
- Build a partnership
- Transform uncertainty into an opportunity for a healing relationship
- Reaffirm non-abandonment

Living with Uncertainty

In uncertainty, our patients (and we ourselves) need something to hold on to. We are not just individuals bravely acting in uncertainty alone, but are held in community. Many practitioners have walked these uncertain paths before us, passing on their wisdom to others. Even our biomedical and clinical knowledge is not solely our own—it is shared and built collectively over time. Uncertainty is not a weight that we have to carry ourselves, but we hold it in community; with our patients, their families, with multidisciplinary teams and with communities that extend beyond hospitals and hospices into places of work, education, worship, recreation, cities, nations, and society as a whole.

Holding uncertainty together does not necessarily make the uncertainty go away (sometimes communities are the source of uncertainty), but it can help to palliate it in the sense of surround, enfold, *cloak.*

Hold the uncertainty together.

- Uncertainty is something that is held together. In moments of uncertainty, patients want to know that they will not be abandoned.
- Non-abandonment requires more than words. It involves compassionate action, therapeutic presence, and non-verbal cues that affirm a person's worth, value, and dignity.[705]
- Share the holding of uncertainty with communities both in and beyond healthcare.

Guideline

Palliation of uncertainty requires more than words, but words can be a good place to start. In practice, it might look like saying:

[705] (Chochinov et al., 2013)

Guidelines for Practice	
Managing Expectations	"Honestly, here is **what we don't know.**"
Turning Attention to Action	"Here is what we **can do.**"
Living with Uncertainty	"I and my team will be **with you** through this. Whatever happens, we will stay beside you every step of the way."

With permission, I share the following story from rounds with a physician in a hospice in Ireland. A 58-year-old woman with end-stage ovarian cancer presented with ascites that would not drain and blood in the collection fluid. The physician, who had built a relationship of trust with her, explained that he did not know why the ascites was not draining—possibly due to septations—and apologized that this issue had not been identified earlier by the staff. Using ultrasound guidance, he attempted to place the drainage needle, but the fluid still would not drain, and he explained that the reason remained unclear. Tearfully looking at the ultrasound, the patient said, her voice cracking, "The tumor, we don't have the control of it that we used to have." Setting down the ultrasound, the physician took her hand and reassured her, "We are going to work together to do everything we can to keep you comfortable and control symptoms from this tumor." She visibly relaxed, her relief evident.[706]

This case highlights the importance of the physician's relationship of trust, which allowed him to openly to acknowledge uncertainty. He did not leave her feeling helpless but focused on

[706] Personal records. Another example of Palliating Uncertainty can be seen in (Dowd & Salama, 2024).

what could be done: ensuring her comfort and managing symptoms. He also reaffirmed his commitment to non-abandonment with the words, “We are going to work together to do everything we can.” After all, accepting that there are things we cannot fix and staying alongside our patients is at the heart of end-of-life care.

In summary, Palliating Uncertainty is a shift in attention from uncertainty to the person and what can be done to address the effects of uncertainty on that person’s life. While palliative care seeks to limit uncertainty, the goal is not to remove uncertainty. James’ pragmatism reinstates the value of the relationships on the fringe of the focus. One thing known in palliative care is that relationships are part of healing. Uncertainty can cause tremendous suffering (especially when unrealistic expectations and feigned certainty creates distrust), but in the face of the incurable and unanswerable as we step into uncertainty with our patients, uncertainty can become an opportunity for relationship and healing connection. Uncertainty can be part of the suffering but can be part of the healing, too. The palliating of uncertainty is conducted in community because uncertainty is something which is held together.

In Part II, I “turn attention to action” and develop the approach of Palliating Uncertainty through a series of five cases.

PART II

TURNING ATTENTION TO ACTION

Introduction to Part II

Part I focused on uncertainty and laid the general framework for Palliating Uncertainty. The first chapter acknowledged uncertainties experienced in palliative care, discussed various taxonomies, and challenged the assumption that more knowledge "cures" uncertainty. The second chapter reviewed the role of uncertainty in James' life and philosophy. The third chapter developed an approach to uncertainty through pragmatism and the ethos of palliative care. Palliating Uncertainty turns attention away from knowledge as a "cure," away from uncertainty itself, towards alleviating the suffering of uncertainty, acting with uncertainty unresolved, and holding that uncertainty in relationship with others.

Part II shifts attention to action and develops the practice of Palliating Uncertainty within the context of five typical cases of caring for individuals at the end of life. The case studies are pragmatic instantiations of the theoretical points discussed in Part I. The methodology for Part II is outlined in the Introduction. There, I explained that case-based discussion is standard practice in medicine and used for teaching and bridging the gap between theory and practice; that case-based methodology is resonant with James' philosophy and the method that James chose for his book *Pragmatism*; and that these cases are not merely illustrative but involve critical analysis that further develops and unpacks James' thought.

James calls pragmatism "a new name for old ways of thinking," naming tendencies that had long been present in philosophy but had previously lacked a collective name.[707] In some ways, his pragmatism is also a new name for old ways of thinking in palliative care. James' pragmatism names ways of dealing with uncertainty that some physicians do well, and helps serve as a guide for acting intentionally when uncertainty is paralyzing or overwhelming.

[707] (James, 2008ai, pp.5, 29)

Each of the case studies furthers the exploration of key concepts in James' attitude of pragmatism. All the cases are derived from actual clinical encounters and are representative of common situations encountered in end-of-life care. As is standard in medical literature, all cases are anonymized with identifying details removed, drawn from publicly available sources, or included with permission. James, in *TTT&S,* advocates for inspiring change by pointing to the appeal of good examples rather than by instilling fear of the negative.[708] As modelled by Fulford in *Essential Values-Based Practice: Clinical Stories Linking Science with People*, the cases that have been selected are examples of good practice to be emulated and have been chosen based on what may be existentially relevant and useful to practicing clinicians.[709] In adopting a narrative approach, the style of writing shifts slightly and is more reflective in tone and style.

In the Introduction, I referenced James' image of pragmatism as a corridor in a hotel. Following this image, Palliating Uncertainty might be envisioned as a corridor in a hospital or hospice. Part I was a walk down the corridor and an introduction to uncertainty in medicine, the life of James, palliative care, pragmatism, and the method of Palliating Uncertainty. Part II is a visit to various patient rooms in which the methods of Palliating Uncertainty are put into practice.

There are many types of uncertainty in James' work, many ways to act in uncertainty, and many reasons that James gives for doing so. Below, I list several types of "turning attention from uncertainty to action" present in James' thought. The list is introductory rather than

[708] (James, 2008ar, pp.113-114)
[709] (Fulford et al., 2012)

comprehensive; although alternative organizational schemes were possible, it provides a sufficient framework for the cases that follow.

Acting in uncertainty…
1. can create the possibility of something becoming true.[710]
2. may result in evidence that would not be available in advance of action.[711]
3. is attended with the same risks of not acting, i.e., risk is unavoidable.[712]
4. may be a temperamental disposition of passional nature.[713]
5. can create subjective conditions for belief.[714]
6. may have benefits for life, regardless of the "truth" of the matter.[715]
7. is, in some circumstances, a moral duty because not to act may have consequences on others.[716]
8. is necessary for the testing of an idea as a hypothesis and the evolutionary testing of ideas in "faith ventures" and contributes to the creation of what may prevail "in the long run, and on the whole."[717]
9. is a source of novelty, growth, and new possibilities.[718]
10. bypasses problems of the theoretical sphere by moving into the practical.[719]
11. is necessary because decreasing uncertainty might not change the course of action.[720]
12. is necessary because uncertainty is solved in the living.[721]
13. is part of the condition of being human and what we all do all of the time.[722]

[710] (James, 2008q, p.56; 2008ag, p.148; 2008ai, pp.137-138; 2008ap, p.113; 2008ax, pp.28,80)
[711] (James, 2008ao, pp.80, 88)
[712] (James, 2008ax, pp.30, 33)
[713] (James, 2008h; 2008ai, p.11; 2008ax, p.24)
[714] (James, 2008ak, p.1077; 2008ax, p.16)
[715] (James, 2008av, pp.382-383, 399)
[716] (James, 2008q, p.56; 2008ac; 2008ap, p.113)
[717] (James, 2008ai, p.144; 2008ao, pp.81-83, 87)
[718] (James, 2008l, 2008o; 2008ag, p.149; 2008ao, p.82; 2008aw, pp.222-223)
[719] (James, 2008ao, p.65)
[720] (James, 2008q, pp.51-52; 2008ai, pp.27-30; 2008al, p.150)
[721] (James, 2008ag, p.116; 2008ap, pp.45-50)
[722] (James, 2008af, pp.189-190; 2008an)

Case 1. *Family of the Dying: Tasks of Dying* engages primarily with type 10, but also with 1, 4, 6, 7, 11, and 12. Case 1 engages with James' essay "SoR" in which he writes, "Impediments that arise in the theoretic sphere might perhaps be avoided if the stream of mental action should leave that sphere betimes and pass into the practical."[723] This case shows that uncertainty in the theoretical sphere which has caused obstruction and distress (i.e., trying to project conceptual probabilities of prognosis), can be bypassed and relieved through a return to the practical, enabling action in the present (i.e., focusing on the tasks of dying).

Case 2a. *Meliorism: Between Optimism and Pessimism*, engages primarily with type 1 but also with 2, 3, 4, 5, 7, and 9. Case 2a introduces James' meliorism (which is a condition between optimism and pessimism in which the outcome is an unguaranteed possibility and dependent upon agent actions). The certainty of both pessimism and optimism results in paralysis. This is illustrated by the case of Dennis, whose optimism regarding God's intervention leads to the rejection of care that would alleviate the suffering of his daughter, and Martha, whose pessimism has led her to give up on life when she still has significant time left. Meliorism is itself a turn to action in uncertainty; the outcome is uncertain, so the focus is on acting to shape that outcome. I apply James' meliorism to Han's "prognostic silence" and argue instead for "prognostic meliorism."

Case 2b. *Meliorism: Day-to-Day Living with Dying*, explores type 1 further with a special emphasis on 3 and 13. Case 2b acknowledges that meliorism requires the courage to risk acting in a world without the guarantee that what we strive for will be realized. The cases of Dennis and Martha are reinterpreted with a melioristic spin. I engage with Sheehey's article "Pragmatism without Progress" and her reading of James' pragmatism through a lens of crisis,

[723] (James, 2008ao, p.65)

melancholy, and orientation towards the present, but I take the present-oriented reading of James' meliorism one step further than Sheehey. I show melioristic turning of attention towards action, not just related to the outcomes of serious illness but to the day-to-day of living with a terminal illness.

Case 3. *How Long Do I Have? Prognostic Paralysis & James' Gnostics* engages primarily with type 11 but also extensively with 6. Case 3 considers James' critique of gnosticism (which prioritizes correct knowledge as the highest value) and, in the case of prognostic paralysis (the avoidance of end-of-life discussions due to prognostic uncertainty), shows that "being right" about prognosis is not always the most important thing. Drawing on James' pluralism, this section turns attention from uncertainty to action by showing that there are sometimes other values more important than certainty. Drawing on Han's taxonomy of ignorance-focused, uncertainty-focused, response-focused, and person-focused responses, I highlight the plurality of ways in which uncertainty can be addressed.

Case 4. *The Woman Who Wouldn't Die: Mysticism & Reinstatement of the Vague* engages primarily with type 1. Case 4 considers James' "reinstatement of the vague" through the story of the "woman who wouldn't die." This story shows that there is much more to our patients than we can ever capture with our sciences. This case employs Saunders' model of total pain and Gavin's exposition of vagueness in James in terms of richness and intensity to show how vagueness can inspire action without decreasing the vagueness.

Case 5. *Climbing James' Faith Ladder: Is Intensive Caring Worth Doing?* engages with types 1, 5, 7, 8, and 9. Case 5 applies James' "faith ladder" and "will-to-believe doctrine" to Chochinov's model of "intensive caring" through the story of a patient with end-stage brain

cancer who desired to end his life. In light of James' social meliorism, this chapter asks, "Is intensive caring worth doing?" The actions that we take as a community may contribute to the creation of that answer.

The cases illustrate various ways in which turning attention towards action palliates uncertainty. My claim is *not* that acting removes uncertainty; in fact, the decision to act (or determination of how to act) may be part of the uncertainty. I do not suggest that acting cures uncertainty, only that sometimes, acting can palliate it.

Case 1

Family of the Dying: Tasks of Dying

"My father was diagnosed with pancreatic cancer,"[724] *said Mark. "I found out two days ago and wanted to talk with you." "I'm so sorry," I said. "Here, let's sit down." We sat together and for the first part of the conversation, I said very little. I listened and reflected back what I heard as he spoke. His father was back home in another country. He had been unwell, he was in pain, the doctors figured out it was pancreatic cancer, no one knew how long his father had. Maybe he would recover. The grief was like a cloud. How to act normal at work and even answer the question 'How are you?' What caused the cancer? He did not want his father to die suffering. What was going to happen? I held the silence and let him fill it with unanswerable questions about life and suffering, causes, explanations, God, and the future. Finally, out of words, he looked to me. I asked him, "What is the hardest part in all this?" "The uncertainty," he said. "I don't know what is going to happen or what it is going to be like or how we are going to deal with it. I feel useless, like I can't do anything."*

We spoke about being okay with the uncertainty. You're about to go on a journey. You don't have to have all that journey figured out all at once. You found out about the cancer two days ago. You don't have to have it figured out how you will live your life without being consumed by the cloud of grief. It's been two days. You don't have to figure out how much pain your father will have on his deathbed. You are trying to do the whole journey all at once, and it is overwhelming. Let's do the part we are responsible for now. We take it one day at a time. What

[724] Pancreatic cancer is an aggressive cancer with poor prognosis and high mortality rate (Cai et al., 2021).

do we do next? That is more clear. I spoke with him about things that can generally be expected in pancreatic cancer and in coping with grief.

I spoke about how being with his father was doing something, perhaps one of the most important things. You can't do anything about his outcome, but you can make a profound difference in his journey. I held the space for more unanswerable questions. I held them with Mark and let them be. And then, instead of staying and swirling in the questions and emotions, I turned our attention towards action. "What do you do to cope?" I asked. "By working out, by calling family," he said. "What do you want to do about this?" "I want to fly home and see him." "Go," I said, and he nodded and smiled. We started talking about the logistics of the flights and getting time off work.

A week later, I met with Mark again. He was on his way to see his father and was distressed because he didn't know how long his father had left to live—days, weeks, months, a year, more? What we talked about were the tasks of dying. "We don't know how long your father has, but we do know that there are important tasks to be accomplished in this time. Dying is important work, and there are important things to do: saying I love you, I'm sorry, I forgive you, thank you, goodbye.'[725]

In the uncertainties of prognosis, I helped Mark to find his tasks. This pragmatic attitude can be helpful for patients and their families because it substitutes teasing apart the cloud of the unknown with something that we can actually do and make a meaningful difference in.

[725] (Bedard, 2022; Twycross, 2003, p.10)

The WHO definition of palliative care begins by referencing the responsibility of palliative care to improve the quality of life of patients *and their families.*[726] Although Mark was not a patient, his life was deeply affected by the uncertainty surrounding his father's illness. Studies show that families/caregivers of patients in palliative care experience high levels of uncertainty.[727] A 2019 descriptive correlational study of families of palliative care patients, which was conducted by Arias-Rojas et al., showed higher levels of uncertainty in family caregivers of patients in palliative care than in other populations of caregivers, and that uncertainty was likely to increase as the patients approached the end of their lives.[728]

When I asked Mark, "What is the hardest part in all this?" He said it was "the uncertainty…I feel useless, like I can't do anything." In "SoR," James proposes that a philosophy must do two things: "Banish uncertainty from the future."[729] Enable action in the present.[730]

"Banish Uncertainty from the Future"

James states,

> The first practical requisite which a philosophic conception must satisfy: It must, in a general way at least, banish uncertainty from the future…Now there is one particular relation of greater practical importance than all the rest—I mean the relation of a thing to its future consequences…our consciousness at a given moment is never free from the ingredient of expectancy. Everyone knows how when a painful thing has to be undergone in the near future, the vague feeling that it is impending penetrates all our thought with uneasiness and subtly vitiates our mood even when it does not control our attention; it keeps us from being at rest, at home in the given present...[731] philosophies of uncertainty cannot be acceptable; the general mind will fail to come to rest in their presence, and will seek for solutions of a more reassuring kind.[732]

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[726] (WHO, 2020)
[727] (Connolly et al., 2021; Etkind et al., 2022; Robinson et al., 2021)
[728] (Arias-Rojas et al., 2019, p.5)
[729] (James, 2008ao, p.67)
[730] "Awaken the active impulses" (Ibid., pp.65-66) by "defin[ing] the future congruously with our spontaneous powers" (Ibid., p.70).
[731] (Ibid., p.67)
[732] (Ibid., p.70)

Mark experienced the vague, impending uneasiness of his father's unknown prognosis. Uncertainty about the future can be like a cloud over all of life. Part of the feeling of rationality is a feeling of familiarity and knowing what to expect. But then, some unusual object baffles expectations. Your father gets cancer. What does this mean for your life and his? James argues that for a philosophy to be appealing, it must in some sense "banish uncertainty from the future." How can uncertainty be banished? James' answer is not to deny the uncertainty as the "healthy-minded" deny the existence of evil in the world.[733] Nor is his answer to offer false promises of certainty. As discussed in Case 2, James' meliorism does not even guarantee that uncertainty *can* be banished from the future—at best, it leaves open the possibility.

In the above quote, where James says that a philosophy must "banish" uncertainty, substitute the word "palliate."[734] James begins "SoR" by asking why philosophers philosophize at all. How does the philosopher recognize a rational conception? What are the subjective marks that affect him? James answers that one mark is a feeling of ease, peace, and rest. He draws an analogy between breath and thought. When one's breathing is obstructed, one feels distress. Similarly, when thoughts meet with difficulties that obstruct them, one also feels agitation. Rationality, then, is largely a matter of removing impediments so that one can "breathe" or think unimpeded again.[735] James then considers some philosophical problems of a theoretical rationality and shows that conceptions of rationality are complicated by different temperaments of mind. Unable to solve these problems theoretically, he makes a suggestion that is key for the purposes of this dissertation.

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[733] (James, 2008av, pp.78-79)
[734] James' use of "banish" is appropriate for the purposes of the passage and refers to the subjective feeling of uncertainty. However, I think that "palliate" is more appropriate to James' philosophy overall. To palliate (in the sense of cover) can include "banishing" a subjective feeling of uncertainty even though uncertainty remains.
[735] (James, 2008ao, pp.57-58, 65)

> Impediments that arise in the theoretic sphere might perhaps be avoided if the stream of mental action should leave that sphere betimes and pass into the practical. Let us therefore inquire what constitutes the feeling of rationality in its practical aspect. If thought is not to stand forever pointing at the universe in wonder, if its movement is to be diverted from the issueless channel of purely theoretic contemplation, let us ask what conception of the universe will awaken active impulses capable of effecting this diversion. A definition of the world which will give back to the mind the free motion which has been blocked in the purely contemplative path may so far make the world seem rational again.[736]

In other words, when theoretical thoughts meet with obstructions, one way to bypass the obstruction is by "awakening the active impulses," i.e., turning attention to action. For James, thought exists for the purpose of action.[737] James asks, in the multiplicity of theories and ways of thinking that offer themselves to our mind, which enable us to act well? Focusing on action can help clarify which thoughts are worth engaging with. More importantly, regardless of any unresolved theoretical issues, the very ability to act can bring the mind a sense of ease.

The uncertainties of the prognostic future left Mark paralyzed in a stream of unanswerable questions. We could have stood there forever in "issueless channels of theoretical contemplation" trying to guess what would happen in the future. How long will his father live? Will the cancer be treated? Will it recur? Will his father suffer? Will he die in pain? Will he cope? Will his wife cope? Will Mark find a way to live with the grief? What is daily life going to look like now? What is going to happen? The uncertainty was an obstruction. He felt useless and unable to do anything because he did not know the future.

This leads to the second thing that a philosophy must do:

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[736] (Ibid., p.66)
[737] (James, 2008an; 2008ao, p.72)

Enable Action in the Present

James writes,

> For a philosophy to succeed on a universal scale it must define the future congruously with our spontaneous powers…Incompatibility of the future with their desires and active tendencies is, in fact, to most men a source of more fixed disquietude than uncertainty itself.[738]

"Defin[ing] the future congruously with our spontaneous powers" means that our conception cannot be so pessimistic that it dooms all attempts at action to fail or, worse yet, makes all action meaningless and void.[739] For James, a philosophy must enable us to act because humans are creatures who must act. From studies of evolution, physiology, and psychology, James concludes that human cognition, evolved for action upon the world, is incomplete until discharged in action.[740] Whether a lower form of life is presented with stimuli or a human is presented with the cosmos in its totality, react on it they must.[741] Yet there is no guarantee that reality is such that it can be acted upon by creatures like us. James explains that essential to the practice of science and periods of religious revival is the encouragement that "the inmost nature of the reality is congenial to *powers* which you possess."[742] He writes, "In what did the emancipating message of primitive Christianity consist but in the announcement that God recognizes those weak and tender impulses…Take repentance: the man who can do nothing rightly can at least repent of his failures."[743]

[738] (James, 2008ao, p.70)
[739] (Ibid., pp.70-71)
[740] (James, 2008ak, p.941; 2008an; 2008ao, p.72)
[741] (James, 2008ao, p.72)
[742] (Ibid., p.73)
[743] (Ibid., p.73)

In the case, Mark was presented with the cancer of his father and all that comes with it. React on it he must. He could fall into a pessimistic conception, "I can do nothing. I feel useless," or worse, a conception in which all his actions are meaningless, "Nothing matters, he's going to die anyway." I apply "defining the future congruously with our spontaneous powers" to Mark's case in a sense slightly different than the sense used by James. In the discussion of this passage, James applies this idea to metaphysical claims of various philosophical schools, such as Schopenhauer, and considers how philosophical conceptions of the universe help or inhibit action.[744] The sense in which I apply this phrase is less metaphysical and more experiential. In *PoP,* James explains that the horizon of our universes of experience is, in part, drawn by where we place attention.[745] One way of "defining the future congruously with our spontaneous powers" is by pulling in the horizon of our attention—placing attention less on the unknowns of a distant future and more on the immediate future on which we can act. Alluding to the quote by Osler mentioned earlier, Mark's task was not to foresee the prognostic course that "lies dimly at a distance," but to do what was in his power to act upon, "to do what lies clearly at hand."[746] This is what I guided him towards when I asked him, "What do you do to cope?"…"What do you want to do now?"…"What are the tasks of dying that you need to do regardless of how long your father lives?" At first, Mark felt useless and unable to do anything because he did not know what was going to happen. But actually, there were still things he knew he could do now even without knowing what was going to happen in the long run. Maybe these things are small—like the repentant who can do nothing but repent of his failure to do anything. Yet perhaps, in the long run, these small things can make all the difference.[747]

[744] (Ibid., p.70)
[745] (James, 2008ak, pp.380-381, 401)
[746] (Osler, 1918, pp.17-18)
[747] (James, 2008ai, pp.106, 138-139)

Reminding Mark of the actions within his power helped remove the obstruction of the uncertainty and put his mind at ease. There were still choices he could make, actions he could take, and in doing so, he began to reclaim a sense of agency—not through knowledge of outcomes, but through the will to act despite their absence. Turning attention towards action helped him palliate (in the sense of alleviate) the suffering of uncertainty.

As a physiologist and psychologist, James expands "knowing" from a merely cognitive task to one that is embodied. As a philosopher and mystic, he expands "knowing" from merely an objective theoretical task to a personal one that is entangled with action.[748] Drawing on evolutionary biology and Helmholtz's science of the eye and ear, James argues that turning to action can help reduce uncertainty because knowing how to act in relation to something is a type of knowledge of it (acquaintance). Knowing how to behave towards something, or meet the behavior that is expected from it, is a way of becoming acquainted with it. By acting, we become acquainted with something that was once strange.[749] For this reason, too, turning attention to action can help palliate (in the sense of cloak) the uncertainty.

James consummates his argument by invoking imagery from Ezekiel 2:1, "Son of Man, stand upon thy feet and I will speak unto thee!"[750] Act. Stand on thy feet. Action precedes revelation. Somehow reality may be such that this little thing you can do, standing on *thy feet,* the feet *you* have, in the tiny place in which *you* can stand, can be the beginning of revelation.

[748] (James, 2008an)
[749] (James, 2008ao, pp.72-73)
[750] (James, 2008ao, p.74)

James does not go further into Ezekiel chapter 2, yet the verses that follow his cited passage illustrate the attitude of pragmatism well.[751] In the next verses, God commands Ezekiel to go to the Israelites and say what God commands. God reveals to Ezekiel what he is to do—not the outcome or how the Israelites will respond. God does not promise that everything will be alright in the end. In fact, God seems to suggest that it might not be. In verses 2:6-7, "…Do not be afraid, though briers and thorns are all around you and you live among scorpions. Do not be afraid of what they say or be terrified by them, though they are a rebellious people. You must speak my words to them, whether they listen or fail to listen."[752] God calls Ezekiel to act courageously without regard for the fruit of his labor and without the guarantee that all will be well. Ezekiel turns attention from the briars, thorns, scorpions, and an unknown future and towards the action that God is calling him to do.

And so, in a similar way, by turning to action, I called Mark to courage. Son of Man, stand upon thy feet. Go be with your father. Things will be revealed in time, if at all. We may even find that finding answers to our questions was not as important as doing the things we knew we needed to do. It is not the *idea* of turning to action or the contemplation of action that palliates uncertainty; it is the actual acting. After our conversation, Mark flew to his home country and spent two weeks with his father. Three days after he left, his father passed away. Many of the questions he asked in our conversation were never answered and, in the end, did not need to be. The most important work was done.

Many studies show that communication with patients and their families regarding prognosis at the end of life is often ineffective. There are many well-documented barriers to this discussion.

[751] In Ezekiel 2:2, the spirit of God raises the prophet Ezekiel and helps him to stand on his feet. James would agree that religious faith can awaken the active impulse, strengthen capacity for strenuous mood and unleash moral energy for action (Chapter 5) (James, 2008h; 2008ac, pp.159-162).
[752] Ezekiel 2:6-7 (NIV) (Barker, Burdick, & Burdick, 1993)

These include lack of time, insufficient training in communication skills, discomfort with death, and a patient/caregiver's desire not to know the prognosis.[753] One important reason is the inherently uncertain nature of prognosis itself.[754] In a mixed-methods study of communication between physicians and family caregivers at the end of life, 20.8% of family caregivers reported that no physician ever told them that the patient's illness could not be cured. Of those who were told that the illness was incurable, 40% were never told about a life expectancy, 32.2% never discussed the possibility of hospice care, and for a significant number of family caregivers, the first discussion of incurability or hospice occurred only in the last month of the patient's life. This study called for strategies that would improve the effectiveness of communication so that "families and patients can begin the physical, emotional, and spiritual work that can lead to acceptance of the irreversible condition."[755]

When uncertainty regarding prognosis is an underlying reason for ineffective communication, a strategy from James' pragmatism is to turn the family's attention to the physical, emotional, and spiritual work that needs to be done. By doing so, uncertainty is transformed from a barrier to communication to an opportunity to discuss what is most important to patients and families and, in the midst of an uncertain future, empowers patients and their families to act in the present and palliate the uncertainty.[756]

[753] (Anselm et al., 2005; Arias-Rojas et al., 2019; Bernacki & Block, 2014; Leung, Udris, Uman, & Au, 2012; Smith, Brøchner, Nedergaard, & Jensen, 2022; Periyakoil, Neri, & Kraemer, 2015; Robinson et al., 2021)
[754] (Anselm et al., 2005, p.219; Brighton & Bristowe, 2016, p.467; Goold, Williams, & Arnold, 2000, p.912; Han, 2016, p.571)
[755] (Cherlin et al., 2005, pp.1176, 1184)
[756] (Kimbell et al., 2016, p.2)

James speaks of "problems [which] disappear in the vanishing of the question, rather than in the coming of anything like a reply."[757] As in the case of Mark, sometimes, many of the questions asked are never answered and, in the end, do not need to be in order for the most important work to be done.

Mark started in uncertainty; turned attention to action; and lived courageously with uncertainty unresolved. Case 1 shows how the pragmatic and palliative attitude outlined in "*SoR"* can be used to support families and caregivers of the dying as they navigate uncertainty. Case 2 considers how James' meliorism can be helpful for patients living with a terminal diagnosis.

[757] (James, 2008q, p.36)

Case 2a

Meliorism: Between Optimism and Pessimism

Case 2 presents the parallel stories of Dennis and Martha to illustrate the pragmatic attitude of James' meliorism. "Pragmatism," James writes, "is melioristic,"[758] and meliorism is an outlook that is situated between optimism and pessimism.[759]

The Case of Dennis: Optimism

Dennis was a 47-year-old man whose 14-year-old daughter, Amelia, was dying from leukemia. Amelia was originally diagnosed at age nine, but chemotherapy, a bone marrow transplant, and even a second transplant had all failed. There were no other options to treat her disease, and she was not going to survive this illness. Dennis was devastated. He had placed much hope in each treatment along the way, but in each case, his hope was dashed when her numbers skyrocketed and her condition deteriorated.

As Amelia's disease progressed, so did her symptoms, particularly nausea and vomiting. I, (Dr John Mulder) as a palliative care physician, was asked to consult with her to address these issues. Amelia's symptoms were rapidly controlled, and within a couple of days, she was discharged home under hospice care, anticipating death within a few weeks.

[758] (James, 2008ai, p.8)
[759] (Ibid., p.137)

Through the course of Amelia's illness, Dennis' faith was challenged. He vacillated between pleading with God to save his precious daughter and cursing him for the pain she was enduring and the profound grief he was experiencing.

When I visited Amelia at home a week later, I discovered the direction in which Dennis' faith had progressed. Initially, I was alarmed to find that Amelia was again suffering: her pain and nausea were back in full force. I asked Dennis about her medication regimen; I was surprised when he told me that he had stopped all her medications. He went on to explain that God had spoken to him in a dream: He had promised Dennis that Amelia would be healed and would bear his grandchildren. In what Dennis interpreted as a sign of obedience, he had stopped all her medication, stepped aside, and was waiting for God to work His miracle.

I am accustomed to helping patients and families to integrate their faith into their end-of-life journeys, respecting religious traditions, and encouraging them to rest on the strength and assurance that they find through their spiritual faith. I have helped many to reframe the things in which they hope, hang on to the promise of eternal life, and anchor the validity of their faith expressions. I have had many discussions about how God works miracles (and how often His answers might be disappointing) and the nature of true healing. But how was I to reply to Dennis?[760]

[760] Personal records, adapted from (Mulder, 2023b)

The Case of Martha: Pessimism

I knocked on Martha's front door. After a moment, her husband Thomas answered. He was a physician, retired for two decades, and he had called me and asked if I would stop by to talk with Martha. Two weeks earlier, Martha had gone to the emergency department at a local hospital to evaluate abdominal pain. The pain was felt to be related to acid reflux, and by the time the doctor saw her, the pain had gone. But they decided to run some diagnostics "just to be sure," and imaging revealed pancreatic cancer. The cancer was an incidental finding and was not contributing to any of her symptoms. She was back to her baseline, both in terms of how she felt and how she functioned. Given the extent of cancer and her age (well into her 80s), Martha and Thomas had determined that they would not pursue any tumor-directed therapy. Thomas asked me to help develop an end-of-life plan for Martha.

As I entered the house, there was a somber sense in the air. It was very quiet, and Thomas spoke in hushed tones, "The oncologist told her that she had less than six months left to live." When I asked where Martha was, he directed me to their bedroom. She was lying in bed, her head propped up on a pillow, the flowered duvet pulled up to her chin and without a wrinkle. Around the room, on the wall and on stands, was an amazing display of various styles of complex needlework. She was awake and greeted me, evidently depressed.

I presumed that because she appeared to be in a bed-bound state, she must be experiencing some element of pain, nausea, debility, or other such negative impact of her progressive cancer. However, as our conversation progressed, it became clear that Martha was symptom-free, comfortable, and had not experienced the fatigue and weakness that is typically associated with advanced pancreatic cancer. I asked her why she was in bed. She replied, "I'm dying."[761]

[761] Personal records, adapted from (Mulder, 2023a)

The case of Dennis is an example of optimism, and the case of Martha is an example of pessimism. In optimism, "the world's salvation is inevitable" (as Dennis believed that his daughter's recovery from illness was guaranteed by God). In pessimism, "the salvation of the world is impossible" (as Martha believed there was nothing meaningful left to do because of her six-month prognosis). In meliorism, "salvation is neither inevitable nor impossible…[but is treated as] a possibility..."[762] Meliorism leaves open the possibility that God might heal Dennis' daughter…but perhaps not. Meliorism leaves open the possibility that there might be nothing left for Martha to do but to lie depressed and wait to die…but perhaps not.

For James, uncertainty is part of the definition of meliorism. The outcome is underdetermined epistemologically and perhaps even ontologically. James' response to the uncertainty of meliorism is a pragmatic attitude of turning to action. I mentioned that meliorism treats the salvation of the world as a "possibility." The quote continues, "[the possibility of the salvation of the world] becomes more and more of a probability the more numerous the actual conditions of salvation become."[763] In response to the uncertainty of the future, meliorism turns to creating conditions of salvation in the present.

In the case of Dennis, optimism that God would heal his daughter led him to stop all medications, step aside, and wait for God to work a miracle—and his daughter suffered because of it. In the case of Martha, her pessimism about the inevitability of dying led her to stop all the things that made her life meaningful and wait to die—and she suffered, mentally and emotionally, because of it. Although these two cases of optimism and pessimism may seem to

[762] (James, 2008ai, p.137)
[763] (Ibid., p.137)

be opposite responses to a terminal diagnosis, they are very similar. Both protagonists were certain of the outcome, and this certainty led to a paralysis of action and an increase in suffering. According to the pragmatic method, notions are interpreted by tracing the respective practical consequences, and if no practical difference can be traced, then the alternatives are considered to mean practically the same thing.[764] On this method, both the hypotheses of Dennis' optimism and Martha's pessimism were the same, in that they both inhibited action and increased suffering.

Meliorism, on the other hand, poses a different hypothesis. According to meliorism, the final outcome is an unguaranteed possibility, and furthermore, it is a possibility that may depend upon our actions.[765] In Latin, the word *melior* (from which meliorism is derived) means "better," and that is what meliorism is: a pursuit of better.[766] Whereas the despair of pessimism and complacency of optimism can paralyze action, meliorism inspires action. However, meliorism also requires courage to act in a world where there is no guarantee that one's efforts will succeed or that one's aims will be realized.

Optimism, pessimism, and meliorism are, according to James, "definitions of the world"[767] and temperaments towards the world.[768] Both optimism and pessimism, in James' view, have a religious and medical character. Optimism he calls a "spiritual opium,"[769] pessimism a "religious disease,"[770] of those with a lower pain threshold for misery.[771] Medical literature often points to prognostic uncertainty as paralyzing.[772] As seen in the cases of Dennis and

[764] (Ibid., p.28)
[765] (Ibid., pp.137-139)
[766] (Fiala, 2019, p.4)
[767] (James, 2008q, p.54)
[768] (James, 2008ai, p.144)
[769] (Ibid., p.133)
[770] (James, 2008q, p.40)
[771] (James, 2008av, p.115)
[772] (Boyd & Murray, 2010; Epiphaniou et al., 2014a; Epiphaniou et al., 2014b, p.46; Murray et al., 2005)

Martha, prognostic certainty can be equally paralyzing. In the following, I show how prognostic uncertainty (as framed melioristically) can inspire action.

Optimism & Paralysis

James discusses optimism in the context of absolute monism—the metaphysical hypothesis that all is one, and all is the absolute (i.e., God). The optimism of absolute monism promises that "however disturbed the surface may be, at bottom all is well with the cosmos"[773] because all is well in the Absolute. The finite evils are illusions or necessary for a greater good.[774] This promise has opium-like peace-conferring effects. When our lives and bodies break down, when we are sick and scared, the monist guarantee has an appeal, and James considers the comfort and peace that this belief confers to be a valid pragmatic argument for absolute monism.[775] He explains that absolute monism is "true" in so far as it yields religious comfort to certain temperaments of mind and, pragmatically, "what is better for us to believe is true unless the belief incidentally clashes with some other vital benefit."[776] James then points out "the vital benefit" with which belief in absolute monism clashes. James fiercely resisted absolute monists such as Josiah Royce because the optimism of absolute monism could lead to complacency towards the problem of evil.[777] He explains that the consequence of the belief that "evil is overruled already" is that we can "dismiss our fear and drop the worry of our finite responsibility. In short, [it means] that we have a right ever and anon to take a moral holiday, to let the world wag in its own way, feeling that its issues are in better hands than ours and are none of our business."[778] One can take a "holiday" from the responsibility of working to get

[773] (James, 2008ag, p.55)
[774] (James, 2008ai, p.140)
[775] (Ibid., p.41)
[776] (Ibid., pp.41-42)
[777] (Sutton, 2011, p.391) James critiques Royce's absolute monism on the grounds of creating a speculative problem of evil (as opposed to the practical problem of lessening evil) (James, 2008ag, pp.55-56)
[778] (James, 2008ai, p.41) James argues for the importance of "moral holidays;" however, he does not justify them through absolute monism, nor endorse them "ever and anon" (Ibid., pp.41-43).

rid of evil and to alleviate suffering because the absolute has already guaranteed that all is already well. The certainty and optimism of absolute monism paralyzes action. In some ways, this is like the religious optimism of Dennis who, casting his daughter into the "better hands of God," interpreted this to mean that human hands must be idle.

Pessimism & Paralysis

Pessimism (even naturalistic atheistic pessimism such as Schopenhauer's) James considers a "religious" disease because it is "…a religious demand to which there comes no normal religious reply."[779] In pessimism, a person's "tough-minded" temperament and loyalty to "hard facts" clashes with their religious desire for "atonement and reconciliation, and [craving for] acquiescence and communion with the total soul of things."[780] Drawing on the analogy of a neural pain threshold, James proposes that a person of pessimistic temperament is especially sensitive to misery, both their misery and that of the world as a whole. What is evil negates what is good: "All natural goods perish. Riches take wings; fame is a breath; love is a cheat; youth and health and pleasure vanish…[At the] back of everything is the great spectre of universal death, the all-encompassing blackn[ess]."[781]

James holds that future possibilities are what give the present moment its "lustre."[782] Therefore, for some temperaments, when the future is certain and bleak, the present is drained of its meaning.[783] James draws the analogy of a group of people living on a frozen lake.

[779] (James, 2008q, p.40)
[780] (Ibid., p.40)
[781] (James, 2008av, p.118)
[782] (Ibid., p.119)
[783] (Wynn, 2021, p.309)

> [They are] surrounded by cliffs over which there is no escape, yet knowing that little by little the ice is melting, and the inevitable day drawing near when the last film of it will disappear, and to be drowned ignominiously will be the human creature's portion. The merrier the skating, the warmer and more sparkling the sun by day, and the ruddier the bonfires at night, the more poignant the sadness with which one must take in the meaning of the total situation.[784]

Is this "living on a frozen lake" not the experience of so many at the end of life? Martha might resonate with such a frigid analogy. For her, the certainty of the future drained life of its present meaning. James parallels the situation of the people on the frozen lake with that of an old man who has just been given a terminal diagnosis.[785] He writes, "...life and its negation are beaten up inextricably together…and all natural happiness thus seems infected with a contradiction. The breath of the sepulchre surrounds it…the skull will grin at the banquet."[786] This "skull grinning at the banquet" is the experience of all humankind, but it is an experience felt acutely by those at the end of life. For those of a pessimistic temperament, such as Martha, such an experience may freeze action. Nothing is left to do but to wait, frozen, for death, and this bleak response adds to the bleak pessimism of the world that engendered it.[787]

Meliorism & Turn to Action

Optimism and pessimism are temperaments, and temperaments, even within individuals, fluctuate. James states, "…As human beings we can be healthy minds on one day and sick souls on the next…"[788] Moreover, most individuals are neither purely optimistic nor purely pessimistic but are some sort of mixture. James offers meliorism to meet the needs of the dynamic and mixed temperaments that make up most of us.[789] Like pessimism, meliorism sees

[784] (James, 2008av, p.120)
[785] (Ibid., p.119)
[786] (Ibid., pp.118-119)
[787] (James, 2008q, p.54)
[788] (James, 2008ai, p.141)
[789] (Ibid., p.144)

the world as consisting of real suffering and real evil, a universe charged with danger.[790] In response to this uncertainty, meliorism calls forth all that is heroic within the hearts of men to stand and act their part. Like optimism, meliorism holds space for hope. In response to the uncertain outcome, it calls forth a religious type of faith to act for the best.[791] As described earlier, James illustrates meliorism with the image of a mountain climber stranded on a ledge from which the only escape is a dangerous leap. There is no guarantee that they can make the jump, but to be paralyzed by "maybe" is to guarantee a fall.[792] Neither outcome of optimism nor pessimism is certain—and in response to the uncertainty, meliorism turns to action.

Summarizing meliorism as a live hypothesis, James writes,

> Suppose that the world's author put the case to you before creation, saying: "I am going to make a world not certain to be saved, a world the perfection of which shall be conditional merely, the condition being that each several agent does its own 'level best.' I offer you the chance of taking part in such a world. Its safety, you see, is unwarranted. It is a real adventure, with real danger, yet it may win through. It is a social scheme of co-operative work genuinely to be done. Will you join the procession? Will you trust yourself and trust the other agents enough to face the risk?[793]

What James describes as a hypothetical universe to be accepted or rejected is the scenario in which patients living with serious illness find themselves cast with no choice over the matter. Whereas James discusses meliorism in terms of metaphysical hypothesis and ultimate outcomes, I once again want to pull in the horizon to individual experience. Regardless of what one thinks of meliorism metaphysically, it describes well the experience of living with the uncertainty of a serious, life-threatening illness. In what follows, I return to the stories of

[790] (James, 2008q, p.55; 2008ai, pp.139-143; 2008av)
[791] (James, 2008ax, p.33)
[792] (James, 2008q, pp.53-54; 2008ax, p.33)
[793] (James, 2008ai, p.139)

Dennis and Martha with a melioristic spin, but first, I draw a connection between meliorism and prognostic uncertainty.

Prognostic Meliorism

Much of the medical literature on communication practices at end of life recommends disclosure of prognosis insofar as this is in accordance with patient wishes.[794] In his article "The Need for Uncertainty: A Case for Prognostic Silence," Han points to the value of prognostic uncertainty.[795] He argues that prognostic certainty is unattainable and questions the assumption that prognostic certainty is what dying persons existentially need from their physicians. He claims that for some patients, prognostic uncertainty is more important than prognostic certainty because it leaves room for hope.

To illustrate this point, Han shares the story of his father, whose unfailing optimism had brought him through many uncertainties in his life (including decades of living with hepatitis B, liver cirrhosis, a liver transplant, dangerously low levels of platelets, and liver cancer). Prognostic predictions were, for him, existentially irrelevant. Despite living with life-threatening conditions, he never once asked how long he had to live or what his chances of survival were. Even in his final days, he was speaking about attending events in the upcoming year. His optimism helped him cope, but at the end of his life, it came with consequences. The lack of prognostic information resulted in unnecessary and ineffective oncological treatments, made it difficult for Han's family to prepare for his father's death, and interfered with the family's opportunity to say goodbye—by the time Han arrived at his father's bedside, his father was unresponsive.

[794] (Fallowfield, Jenkins, & Beveridge, 2002; Han, 2016, p.567)
[795] (Han, 2016)

On the one hand, to guarantee optimistically that a seriously ill patient will recover can lead to false promises of events that are beyond control, unnecessary medical interventions, inadequate preparation for dying, and much left unresolved and unreconciled at death. On the other hand, to give certainty pessimistically that a patient will die can dispel hope and bring about the prematurity of that death.[796] Han testifies to a phenomenon that I, too, have witnessed: patients "…placing complete faith in a prognostic estimate, embracing the necessity of death, fatefully closing off all possibility by foregoing life-sustaining treatment, even hastening the dying process based on prognostic information."[797] Han's conclusion is a case for prognostic uncertainty—that for some dying persons, uncertainty is a greater existential need than certainty and that this can justify prognostic silence (non-disclosure). He urges those who care for the dying to have more uncertainty—recognizing the limits of our capacity to know what is best for someone else and remaining flexible, open, and humble.[798] For Han, "prognostic silence" entails: an acknowledgement that prognostic certainty may be existentially irrelevant to some patients and, in such circumstances, non-disclosure be justified; and a silence (humility) on the part of medical practitioners in claiming to know what constitutes a 'good death,' and in assuming that a good death must necessarily be an informed one.[799]

I agree with much of what Han says and likewise challenge the assumption that prognostic certainty is always what patients (and their physicians) existentially need. Drawing on James' meliorism, I seek to soften Han's idea and extend it across palliative care more generally. For Han's term "prognostic silence," I substitute "prognostic meliorism," as this not only gives space for the value of uncertainty but turns the attention to action amid uncertainty.

[796] (Sullivan, 2003, pp.6-7; Twycross, 2003, p.25)
[797] (Han, 2016, p.572)
[798] (Ibid., p.568)
[799] (Ibid., p.571)

Han makes the case that prognostic certainty is "existentially irrelevant" for some patients and that, in such instances, prognostic silence is justified.[800] In meliorism, the claim is not that the final outcome or certainty regarding that outcome is "irrelevant;" rather, it is that certainty regarding that outcome is not always necessary. Meliorism holds space for possibility and uncertainty but is softer than "silence" regarding something "irrelevant." Sometimes, one shifts attention away from something because it is irrelevant; other times, one does so because they value something else more.[801] Instead of blanket optimism, pessimism, or silence/non-disclosure, I argue for a melioristic disclosure that is honest about the uncertainty of prognosis, values that uncertainty, adapts to meet the mixed temperamental needs of patients, and orients towards action by helping a patient live with the uncertainty of their prognosis.

Han also discusses prognostic silence in relation to the needs of individuals. I think, however, that his claims (softened slightly) can be taken more broadly. Prognostic certainty is not always necessary to meet the existential needs of the dying persons, nor for their physicians or medicine on the whole. For example, studies of what patients want from doctors at the end of life list trust, honesty, non-futile treatments, symptom relief, opportunities to complete things, and preparation for life's end.[802] Prognostic certainty is not on the list. Moreover, much of what patients require at the end of life can be accomplished without prognostic certainty. Han makes the important point that prognostic certainty is unattainable.[803] I argue that prognostic certainty is not always necessary for end-of-life care, as evidenced by the fact that, in practice, we already provide quality end-of-life care without it.

[800] (Ibid., p.567)
[801] (James, 2008ak, pp.380-434)
[802] (Heyland et al., 2006; Singer, Martin, & Kelner, 1999; Virdun, Luckett, Lorenz, Davidson, & Phillips, 2020)
[803] (Han, 2016, p.571)

Han concludes by encouraging physicians to acknowledge the limits of their knowledge and to be flexible, open, and humble.[804] What Han observes in an individual case holds true for palliative care more broadly. I think that there is a "need for uncertainty" in palliative care and a good "case for prognostic silence." However, prognostic silence remains too focused on uncertainty. Melioristically extending Han's argument to palliative care more broadly involves shifting attention from the uncertainty and focusing on what we as physicians can do to "make better," palliate, and live with that uncertainty. Like James, Han calls for action grounded in flexibility, openness, and humility, and from James' meliorism, I would add courage.[805] Like our patients, physicians must have the courage to act without a guarantee.

Case 2b continues the stories of Dennis and Martha but with a melioristic spin. In what follows, I apply meliorism not just to the final outcomes but to the day-to-day experience of living with a terminal illness.

[804] (Ibid., p.568)
[805] Han adds mention of courage in (Han, 2021, p.112)

Case 2b

Meliorism: Day-to-Day Living with Dying

The Case of Dennis continued: Optimism→Meliorism

I gently broached the topic of bringing Amelia's symptoms under control, without diminishing Dennis' perception of his message from God or compromising the faith to which he was now clinging dearly. I clarified that God didn't actually tell him to stop or change anything–only that He was going to heal Amelia and that she would bear Dennis' grandchildren. My initial attempts to try to help Dennis understand different dimensions of healing were not accepted by him. So, I pivoted a bit and explained that the God that I knew, the same God that Dennis worshipped, would certainly not want Amelia to suffer. Indeed, a meaningful expression of Jesus' ministry was His calling of children to Himself and the comfort He offered them. I explained to Dennis that I hoped he would receive the miracle he was expecting, but that recognizing the laws of nature (which are of God's making) would suggest that disease progression was inevitable. If God is to intervene, He can do so irrespective of anything we may or may not do. So, our job at this point is to care for Amelia and ensure that she is as comfortable as possible, to understand reasonable medical certainty, but to allow God to do what only He can do. This resonated with him, and he started her meds again.

Amelia quickly achieved relief from her pain and nausea. She continued to decline, as we anticipated, and died within a week of my visit. She was comfortable and peaceful as she drew her last breath. Dennis said that "Jesus called her to Him."[806]

[806] Personal records, adapted from (Mulder, 2023b)

The Case of Martha continued: Pessimism→Meliorism

I asked Martha how she typically spent her days and what was sacred and important to her. She listed her family, her engagement with friends, her needlepoint work, and benevolent service projects that had occupied much of her pre-cancer time. She seemed surprised when I asked her why she wasn't doing those activities now and why she was in bed. "Well, I have cancer!" she replied. "I'm dying." "Not today, you're not," I responded. I suggested that she get out of bed and back to living the life she loved.

I asked her more about what was important and meaningful to her. Knowing that life was short, I asked what she would like to accomplish while she still had some energy and cognitive vitality. Martha lamented that for their family, Thanksgiving celebrations were some of the most special and meaningful times that they shared, but it was quite possible that she would not survive the six months to November. Tears came to her eyes.

"Well," I said, "You can purchase a turkey all year round," I suggested that they gather the family together for Thanksgiving in May–the Memorial Day weekend would provide a wonderful backdrop for a joyful family celebration, and all the accoutrements that they might enjoy in their traditional feast would certainly be available. Martha smiled. Immediately, she began planning who would bring which dish, where it would take place, etc.

Suddenly, her face changed. Something distressing had come to mind, and her countenance reflected it. "What is it?" I asked. She paused, "Well, what do we do if I live to November?!" I smiled and simply replied, "Then you have two Thanksgivings, and even more to be thankful for!"[807]

[807] Personal records, adapted from (Mulder, 2023a)

In the first iteration of the stories of Dennis and Martha, certainty regarding future outcomes led to paralysis and inaction. Here, for both Dennis and Martha, melioristic uncertainty inspired action in the present and required a willingness to act without a guarantee of final results. The physician helped Dennis and Martha to make better that which was within their control, even though the final outcome might not be.

In the case of Dennis, the physician neither affirmed nor denied that God would heal Amelia. Instead, he shifted attention from the outcome of what God might or might not do and turned attention to what they could do in the present: "Our job at this point is to care for Amelia and ensure that she is as comfortable as possible." This was a melioristic move, first in the sense of "making better" (palliating), and second in the willingness to act while letting go of control of the final result.

In the case of Martha, the physician did not deny that Martha was dying. Instead, he shifted attention from what would happen at a yet-to-be-determined date to what was happening now. When Martha said, *"I'm dying,"* the physician's response was, *"Not today."* The physician and Martha began to talk about the things that made Martha's life meaningful before the diagnosis and the value of continuing those things even though she might not complete them. The physician pulled the horizon of time closer, moving Thanksgiving (a holiday traditionally celebrated in November) to May. As Martha began to plan, she suddenly realized that it was not certain that she would die in six months. Martha had to act without the guarantee that she would die when she thought she would. At first, she was distressed that she would move Thanksgiving to May only to live until November and have to have Thanksgiving again—to which the physician replied, "Then you have…even more to be thankful for!" Martha acted in

the present in a way that would leave her thankful, whatever the end results might be. To act without regard for the fruits of labor was pragmatic for Dennis and Martha insofar as it helped to lead them fruitfully. With meliorism, the physician did more than help Dennis' daughter and Martha to *die* comfortably and meaningfully. The physician helped them to *live* comfortably and meaningfully until they died.

The cases of Dennis and Martha show a transformation from optimism/pessimism to meliorism through a turn towards action in the present and a willingness to risk action when the future is uncertain. The following section further develops this key aspect of James' pragmatic attitude: that meliorism entails a willingness to risk action without guarantee of the fruits of our labor.

Such a statement might seem to be deeply unpragmatic. After all, pragmatism looks towards the last things, consequences, fruits, and outcomes.[808] Is not pragmatism future-oriented and ends-focused? Pragmatism is sometimes characterized as a philosophy in which "ends justify the means."[809] How can a pragmatist act with disregard for future ends? If anything, a pragmatist, it would seem, must sacrifice the present for the sake of future results. This, however, is a mischaracterization. Ruth Putnam, Croce, Hester, and others have challenged the duality between ends and means in pragmatism and argue that pragmatism is process-oriented.[810]

In "Pragmatism without Progress," Sheehey questions the assumption that James' pragmatism is a "forward-looking philosophy that places hope in the future as a site of possibility and improvement."[811] Instead of reading pragmatism through a lens of progress, she reads it

[808] (James, 2008ai, p.32)
[809] E.g., (Eveline, 1997)
[810] (Croce, 2010a; Hester, 2001, pp.32-35; 2003, p.550; Putnam & Putnam, 2017, pp.427-429, 443)
[811] (Sheehey, 2019, p.40)

through a lens of crisis. She argues that "James offers a non-progressivist version of hope that is affectively tempered by melancholy and oriented temporally towards the present."[812]

A reading of pragmatism through a lens of crisis, melancholy, and temporal present is especially well-suited to palliative care. Many patients who are living with serious illness exist in a melioristic state of prognostic uncertainty, in which they pursue treatments because the salvation of their world, their recovery, is neither impossible nor inevitable. They must also risk acting on the possibility of recovery even to make recovery possible. An optimistic, progressive, future-oriented reading of pragmatism might find in James' meliorism justification for risking futile treatments and aggressive medical interventions in the hope of a cure. What can meliorism offer patients who have been deemed "incurable?" Meliorism especially, when tempered with a lens of crisis, melancholy, and orientation towards the present, has relevance for their situation too.

Sheehey examines the concept of a "lens of crisis," drawing on Wendy Brown's medical definition of crisis as a "threshold moment whose urgency demands a call for action to stave off catastrophe," and applies it to James' "spiritual crisis." In palliative care, we care for patients in such moments of crisis, at the thresholds of curable to incurable and life to death.

Sheehey also tempers James' pragmatism with a melancholic mood that acknowledges losses. She contrasts a progressive hopeful mood, which sees the future as an "open horizon" of contingently realizable progress, with a lens of crisis melancholic mood that is "attentive to the

[812] (Ibid., p.40)

limits of the moment and the risk of loss."[813] The latter phrase is a far better description of the experiences of patients such as Dennis and Martha than "open horizon."

The third aspect of meliorism that Sheehey highlights, and the one I wish to bring to attention, is pragmatism's temporal orientation towards the present. Referencing *PoP,* Sheehey points out that "for James, the future is not what lies in the distance, temporally cut off from the present, but rather is what remains near to us insofar as time bears a continuous stream-like flow…"[814] In his essay "The Dilemma of Determinism," James writes,

> The great point is that the possibilities are really *here.* Whether it be we who solve them, or [God] working through us, at those soul-trying moments when fate's scales seem to quiver, and good snatches the victory from evil or shrinks nerveless from the fight…the issue is decided nowhere else than here and now.[815]

In short, the acts which create the world's salvation happen "here and now." James speaks of the gap between the ideals of individuals (live possibilities) and actual things. He says that it is by "our act," meaning our acts in the present, that we spring into that gap and "create the world's salvation."[816]

Many people at the end of life find that there is a gap between their ideals and the actual. Palliative care can help create plans of care that enable patients to act, spring into the gap, and create an end of life that can be meaningful to them. An important part of palliative care is a discussion of goals of care. Such discussions help harmonize treatment plans with patient values and goals.[817] Although such conversations are future-oriented, they are tied to the

[813] (Ibid., p.56)
[814] (James, 2008ak, pp.606-607; Sheehey, 2019, pp.54-55)
[815] (James, 2008g, p.140)
[816] (James, 2008ai, pp.137-138)
[817] (Bernacki & Block, 2014; Jain & Bernacki, 2020)

present. In the article "Quality versus Quantity of Life: Beyond the Dichotomy," Mulder and I propose four practical questions to guide goals-of-care conversations based on a model of values-treatment harmony.[818] The last question is: "Are the plans currently in place helping you to achieve what is important to you, or standing in the way of your goals? In the article, we explained that "This question connects the plan of care to the patient's values and clarifies direction of care. It emphasizes the present—taking one day, one step of treatment, at a time."[819]

Here, I take the present-oriented reading of James' meliorism one step further than does Sheehey. Meliorism involves a willingness to risk action in the present without the guarantee that what we strive for will be realized in the future. Meliorism is life lived on a maybe. The following quote from James' essay "ILWL" illustrates this well.

> But "*may* be! *may* be!" one now hears the positivist contemptuously exclaim; "what use can a scientific life have for maybes?" Well, I reply, the 'scientific' life itself has much to do with maybes, and human life at large has everything to do with them. So far as man stands for anything, and is productive or originative at all, his entire vital function may be said to have to deal with maybes. Not a victory is gained, not a deed of faithfulness or courage is done, except upon a maybe; not a service, not a sally of generosity, not a scientific exploration or experiment or text-book, that may not be a mistake. It is only by risking our persons from one hour to another that we live at all.[820]

This melioristic willingness to act in the present without guarantee of the future has existential relevance for patients living with life-defining illnesses. Mishel defines uncertainty as the "inability to determine the meaning of illness-related events…and [being] unable to predict outcomes accurately."[821] A challenge of living with a serious illness is the difficulty in knowing

[818] (Dempsey & Mulder, 2023b)
[819] (Ibid., 2023b, p.20)
[820] (James, 2008q, p.53)
[821] (Mishel, 1988, p.225)

what an illness-related event means for health, for the future, and more immediately, for plans, projects, and goals of tomorrow. McCormick, in her taxonomy of uncertainty, points out that in uncertain illness situations, the ability to plan ahead is taken away by an unclear and unpredictable future. She quotes a patient who took part in a study of women undergoing cardiac surgery. The patient says, "It's hard to live when you can't plan. I mean nobody really thinks about it until you can't. But we all plan. You write on your calendar what you're going to do next week or two weeks from now...I just hated it."[822] Why start building that home, recording that album, planning that trip, reconciling that relationship, or writing that book if I could die before I finish it? Why even bother if I might be too sick tomorrow to do it? Martha might think, why continue the needlework and projects and relationships I enjoyed? Why plan Thanksgiving early if I might die before I see it or am too sick to enjoy it? What if I live until next Thanksgiving anyways? Why bother? Pragmatism involves a willingness to act without regard for whether we will see the final fruit of our labor. It can be summarized in a quote attributed to Martin Luther: "If I knew the world was to end tomorrow, I would still plant an apple tree today."[823]

James highlights how the melioristic condition of the terminally ill is really the condition of us all. All of life is acting on maybes. Those with serious illness are just more acutely aware of it. The implication is that when a patient realizes that every action they take has the same foundation before and after illness, they just need to keep doing what they were doing before, rather than having to change the way they act by doing so on the basis of maybes.

[822] (McCormick, 2002, p.130) quotes (King, 1993, p.101)
[823] (Silcock, 2017, p.11)

When Croce experienced what threatened to be a serious illness, this willingness to act without guarantee helped him to cope and to continue to do what was important to him. He shares his story in an article entitled "Letting Go of Results: The Education of William James and My Own Medical Crisis." In 2003, while writing *Young William James Thinking,*[824] Croce started to suffer blurry vision, and the diagnostic workup revealed a craniopharyngioma tumor that was compressing his optic nerve. A few hours after the diagnosis, he was back at his desk, working on his book. Croce found inspiration in James' life. He was inspired by the way that young James, in response to the uncertainty of his future career, relationships, and medical problems, stopped focusing on long-term unknowns and instead focused on the worthy tasks at hand without worrying so much about where these tasks would lead. He realized that James had never resolved many of the uncertainties of his youth, but that he had transformed uncertainties into assets and developed a mental posture that was comfortable with living a "life without guarantee." Croce quotes James in what could seem like a very unpragmatic quote: "Results [should] not be too voluntarily aimed at or too busily thought of."[825] Croce explains that this means "do the job that feels right at this moment, and let the future emerge, with all its uncertainties, from this good work." Inspired by James, Croce applied this perspective to his life with illness. He continued to write his book, even though he did not know whether he would complete it or live to see its publication.[826]

In James, Croce found the courage to act in the present, let go of results, and live with uncertainty. What Croce learned from James, we can also learn from our patients. How much do we learn from our patients? How much are we humbled and inspired by them? Their

[824] (Croce, 2018)
[825] (James, 2008x, p.250)
[826] (Croce, 2017)

willingness to act without guarantee can give those who care for them the courage to act and live with uncertainty, too.

Case 2 has shown how meliorism starts from a place of uncertainty regarding future outcomes, turns to a willingness to act in the present without guarantee, and moves to living courageously with uncertainty unresolved. Case 3 follows similar themes in the story of a man with chronic obstructive pulmonary disease (COPD) who, through the support of a community, continues to live according to his values despite prognostic uncertainty.

Case 3

How Long Do I Have?

Prognostic Paralysis & James' Gnostics

The following is a "Hospice Care Story" from Hospice, UK.

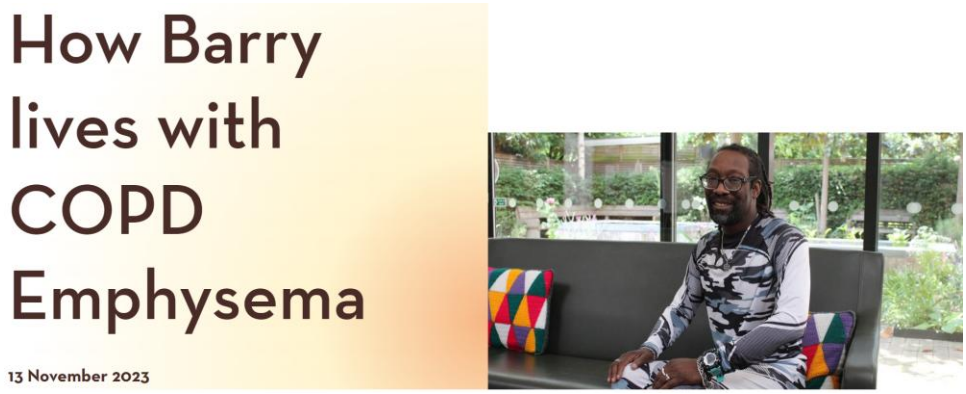

Figure 18) Image of Barry.[827]

"Hospice care comes in many forms. Barry, who lives with COPD Emphysema, is a patient at North London Hospice, and takes part in their music therapy and breathlessness and fatigue groups.

Barry: a musician with a passion

Barry has been the frontman and drummer in a reggae band for many years. So, it's unsurprising that he brings an infectious and encouraging passion to the weekly music therapy

[827] (Hospice UK, 2023)

group at North London Hospice Enfield. He's well known for getting even the most reserved attendee tapping their feet or picking up a tambourine and joining in. "I love that class," says 55-year-old Barry. "It gives people a real sense of confidence, inclusion and encourages expression. It gets you out of the house and gives us all something to do that doesn't revolve around medical appointments." He says he loves that the class allows him to be in the moment: "everyone that attends leaves feeling better than when they arrived."

COPD Emphysema

Diagnosed four years ago, Barry is living with COPD Emphysema, a lung condition that causes breathing difficulties. It's a common condition, mostly for middle-aged and older adults, which happens when the lungs become inflamed, damaged, or narrowed. The condition cannot be cured or reversed, but for many people, treatment can help keep it under control so it does not severely limit their daily activities. In some people, COPD may continue to get worse despite treatment, eventually having a significant impact on their quality of life and leading to life-threatening problems like Barry's. "They make me feel things are ok. The hospice has been able to really support my mental wellbeing."

'It was scary'

In recent years, Barry's COPD Emphysema has caused his breathing to substantially deteriorate. Then, in December 2022, he was admitted to intensive care with breathing difficulties for the third time. It was suggested that he would benefit from hospice support. Barry says that he was 'very frightened' at the prospect: "it was scary for my family too, but my body just wasn't working, and I knew North London Hospice would look after me. They'd

have the care facilities and the expertise to help." But he soon realised that the hospice's support gave him so much more: "sometimes you need to talk to someone, other than your family, and they are always there if I need to talk."

Tailored care planning

Hospices' specialist teams, like those at North London Hospice, provide care planning which is tailored to each person. It always aims to help patients achieve 'the best of life, at the end of life.' In Barry's case this involved regular home visits by specialist nurses, who monitor his medication and have helped him manage his anxiety. Their physiotherapist, Rob, also visits Barry to take him for walks to build and maintain strength. Barry says that thanks to Rob he's made real progress: "He always encourages me to go just that little bit further!"

'I feel like I'm not alone'

Barry attends North London Hospice's Breathlessness and Fatigue sessions, where he's learned the coping strategies to help him continue to sing. "My condition means I often struggle for breath," says Barry, "but there are six or seven people at each session who are going through the same or similar things as me, and that makes me feel like I'm not alone. "The sessions have provided me with techniques on how to cope in situations if I panic or get out of breath."

Hospice support: 'a life saver'

Barry, who has six sons and a daughter, is once again able to make music with one of his sons, thanks to the support he's received from the hospice: "I've played the drums since the Boys' Brigade, and it makes me happy to still be able to play and make music with my son. I do it in stages and he puts it all together." "The support of the hospice has been a life saver to me. My world was crumbling around me, and I was at risk of becoming a hermit. The care they are giving me has given me the confidence to be my extrovert self again! They've made me realise I can still live my life; I just can't run around the block anymore!"[828]

Prognostic Paralysis

According to the WHO, COPD is the third leading cause of death worldwide.[829] Barry describes his experience of COPD in various terms: "life-threatening problems," "frightened," "admitted to intensive care," "breathing difficulties," "scary," "scary for my family too," "my body just wasn't working," and "anxiety." One can hear in Barry's story the uncertainties of life with COPD: from symptoms to relationships to the future. COPD is characterized by uncertainty, especially prognostic uncertainty.[830]

"How long do I have?" is a question many physicians feel uncomfortable addressing.[831] Studies demonstrate that physicians are often mistaken regarding prognostic accuracy.[832] Many prognostic estimates are overly optimistic and overestimate patient survival by a factor of two to five.[833] For example, in a study conducted by Christakis et al., 342 physicians provided survival estimates for 468 terminally ill patients at the time of hospice referral. Among these

[828] (Ibid.)
[829] (WHO, 2024)
[830] (Almagro et al., 2017; Ngwenya et al., 2021; Pinnock et al., 2011; Smith et al., 2017)
[831] (Etkind, 2024; Lamont & Christakis, 2003, p.101)
[832] (Chow et al., 2001; Glare et al., 2003; Higginson & Costantini, 2002; White, Reid, Harris, Harries, & Stone, 2016; Zibelman, Xiang, Muchka, Nickoloff, & Marks, 2014)
[833] (Christakis & Lamont, 2000; White et al., 2016, p.15)

physicians, 63% were over-optimistic by a factor of 5.3, 17% were over-pessimistic, and only 20% were "accurate" (i.e., within 33% of the patient's actual survival time).[834] Further studies show that patients want their physicians to be optimistic and that there can be a discrepancy between what a physician says and what a patient hears.[835] Lamont and Christakis show an additional discrepancy between what physicians predict and what they communicate. In a study on prognostic disclosure, 63% of physicians consciously overestimated, underestimated, or avoided giving an estimate when patients requested to know their likelihood of survival.[836]

A majority of literature on communication of prognostic uncertainty in palliative care pertains to disclosure (how much information to tell a patient regarding the expected course of their illness) and patients with cancer.[837] Non-cancer conditions can be even more difficult to prognosticate.[838] For instance, in a study of palliative care for heart failure, among patients for whom six-month survival was predicted, >50% died within three days.[839] Similarly, in a study among COPD patients for whom six-month survival was predicted 50%, died within five days.[840] Prognostication in patients with advanced chronic illness is especially challenging due to the non-linear variability of illness trajectory.[841] In many cases, questions such as "How long do I have, doctor?" are difficult (if not impossible) to answer, and studies suggest that physicians often feel ill-equipped to deal with prognostic uncertainty.[842]

[834] (Christakis & Lamont, 2000)
[835] (Lamont & Christakis, 2003, p.101)
[836] (Lamont & Christakis, 2001)
[837] E.g., (Van der Velden et al., 2020)
[838] (Curtis, 2008)
[839] (Levenson, McCarthy, Lynn, Davis, & Phillips, 2000)
[840] (Connors et al., 1995)
[841] (Pinnock et al., 2011)
[842] (Christakis, 2001; Christakis & Iwashyna, 1998; Janett-Pellegri & Eychmüller, 2021; Schuster, Hong, Arnold, & White, 2012)

Uncertainty of prognosis in chronic illness leads to what is termed "prognostic paralysis."[843] In prognostic paralysis, an uncertain illness trajectory leads to an avoidance of end-of-life discussions.[844] A report on palliative care for heart failure describes prognostic paralysis well: "[The uncertainty of illness trajectory] can virtually paralyse doctors, potentially preventing them from telling patients when they have reached the terminal phase of their illness and from planning appropriate care."[845] For patients with conditions such as Barry's, uncertainty can become a paralyzing barrier to end-of-life care.[846]

A study by Epiphaniou et al. compared end-of-life care for patients with lung cancer to that of patients with COPD and showed that the uncertain trajectory of COPD resulted in later palliative care referral and less access to resources of palliative care for COPD patients than for lung cancer patients.[847] Even though studies show that earlier palliative care consultation results in better clinical outcomes and quality of life, because of prognostic uncertainty, physicians postpone palliative care conversations, waiting for more test results, further patient decline, and more certainty that a condition is terminal.[848] A systematic literature review and narrative synthesis on end-of-life care conversations in COPD reports,

> The best current prognostic model is the BODE Index, which is better at predicting death than forced expiratory volume in 1 s (FEV1) alone. As with all such models, this is of some use with groups of patients but of little help with individuals. The consequence is often a 'prognostic paralysis'; and because prognosis is so uncertain, [end-of-life care] issues are not addressed.[849]

[843] (Murray et al., 2005; Murray, Kirsty Boyd, & Aziz Sheikh, 2005; Smith & Quint, 2015)
[844] (Murray et al., 2005)
[845] (Stewart & McMurray, 2002, p.915)
[846] (Boyd & Murray, 2010; Curtis, 2008, p.796; Iwashyna & Christakis, 2001; Momen et al., 2012, p.779; Murray, Pinnock, & Sheikh, 2006)
[847] (Epiphaniou et al., 2014b, p.46; Murray et al., 2006)
[848] (Curtis, 2008; Momen et al., 2012; Murray et al., 2005; Temel et al., 2010)
[849] (Momen et al., 2012, p.1) cites (Murray et al., 2005)

As a result of prognostic uncertainty, most COPD patients do not have end-of-life conversations with health professionals, and those that do occur are usually late in the disease course "when there is greater 'certainty,' though patients are less able to participate."[850] For most patients, death occurs "before the patient is perceived as being terminal so missing the opportunity to address important issues."[851] The consequence of prognostic paralysis is that patients do not have access to palliative care resources and symptom management that could improve their quality of life.[852]

In "WtB," James speaks of what he terms a "forced decision."[853] There are some decisions that are underdetermined by evidence, i.e., an appeal to evidence cannot unequivocally determine the best decision either way. In forced decisions, to withhold making a choice is, in effect, an active choice of one option over another. An example James uses is in the context of religion. He describes an agnostic man who, conceptually suspending his judgment about the existence of God because of uncertainty, acts as though he positively disbelieves that God exists. James writes, "Religion is a *forced* option, so far as that good goes. We cannot escape the issue by remaining sceptical and waiting for more light, because, although we do avoid error in that way if religion be untrue, we lose the good, if it be true, just as certainly as if we positively chose to disbelieve."[854] Regardless of what one believes about the validity of applying forced decisions to religion, there are forced decisions in palliative care. In prognostic paralysis, we respond to uncertainty of prognosis by effectively acting as if the patient would not benefit from palliative care, yet doing so cuts a patient off from the benefits they could have received, just as surely as if we had decided that palliative care had nothing to contribute. In prognostic

[850] (Momen et al., 2012, p.779)
[851] (Murray et al., 2006, p.363)
[852] (Curtis, 2008; Habraken, Pols, Bindels, & Willems, 2008; Momen et al., 2012, pp.778-779; Scheerens et al., 2018)
[853] (James, 2008ax, pp.14-15)
[854] (Ibid., p.30)

paralysis, the decision is forced because not to make a decision due to uncertainty is, effectively, to make a decision.

Paul Rousseau, a pioneer of palliative care writes, "The question 'Doctor, how long do I have?' demands an answer—an honest answer, and one without ambiguity or mistruths."[855] But how can we answer a question that we do not know the answer to? What if waiting indefinitely for a certain answer has consequences for our patients? When it comes to prognostic communication, what I want to communicate is that "being right" about a prognosis may not always be the most important thing. James' pragmatism, which makes "correct knowledge" secondary to action and relationship, can provide a helpful way forward in the paralyzing uncertainty of prognostication.

James' Gnostics

In "The Dilemma of Determinism*"* and "RA&T," James critiques what he calls "the gnostical point of view."[856] For the gnostics, knowledge is the "ultimate goal" of humanity and the universe.[857] All experience, sense, emotion, and activity exist "for no other purpose than to illumine our cognitive consciousness by the experience of its results."[858] Alluding to Biblical imagery, "life is one long eating of the fruit of the tree of knowledge."[859] James criticizes the gnostic response to the "question of evil," which justifies the existence of suffering and evil as a necessity for furthering moral knowledge in the universe. According to the gnostic view, "the world [is]…a contrivance for deepening the theoretic consciousness of what goodness and evil in their intrinsic natures are. Not the doing either of good or of evil is what nature cares for, but

[855] (Rousseau, 2013, p.2029)
[856] (James, 2008g, p.128)
[857] (James, 2008an, p.109)
[858] (Ibid., p.109)
[859] (James, 2008g, p.128) See (James, 2008an, p.109)

the knowing of them."[860] The gnostic response to evil and suffering is ignorance-focused, and the solution offered is one of more knowledge. In James' view, the response to evil and suffering is action-focused and a practical call to work together to relieve suffering.

James' description of *gnostics* may be a critique of prog*nostics* too. Han shows that physicians tend to regulate uncertainty by using knowledge-seeking strategies. Like James' philosophy, Han's philosophy is based on human psychology. Han drew on research studies in psychology on "uncertainty tolerance," as well as on his empirical research in medicine and personal clinical experience, to outline a taxonomy of strategies used to regulate reactions to uncertainty.[861] He divides the strategies into ignorance-focused, uncertainty-focused, response-focused, and person-focused and places them along a spectrum from "curative" ("aimed at eliminating or reducing uncertainty") to "palliative" ("aimed at ameliorating the negative psychological effects of uncertainty").[862] The taxonomy is pictured in Figure 19.

[860] (James, 2008g, p.128)
[861] (Han, 2021, pp.65-68)
[862] (Ibid., p.68)

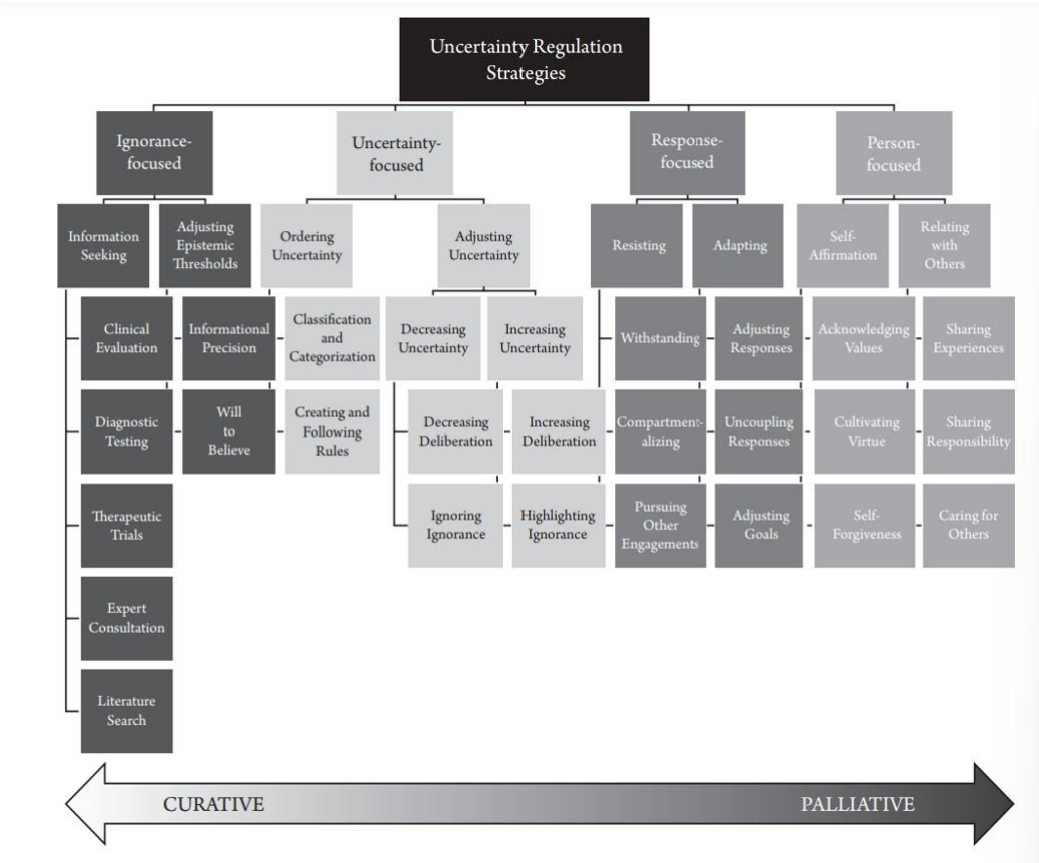

Figure 19) Han's taxonomy of uncertainty regulation strategies.

Han's table can be summarized as follows,[863]

- Curative strategies: aim to eliminate or reduce uncertainty
    - Ignorance-focused (seeking information, adjusting epistemic thresholds)
    - Uncertainty-focused (ordering uncertainty, disengaging from uncertainty)
- Palliative strategies: aim to ameliorate the negative psychological effects of uncertainty
    - Response-focused (resisting uncertainty, adapting to uncertainty)
    - Person-focused (self-affirmation, relating with others)

[863] (Han, 2021, pp.87-88)

The details of each of the subcategory boxes are interesting and discussed further by Han, but for my purposes, the important thing to note is the general, broad structure.[864] Notice that ignorance/uncertainty-focused strategies fall on the "curative" side of the spectrum and response/person-focused strategies on the "palliative" side.[865] Ignorance/uncertainty-focused strategies, like James' gnostics, generally involve turning to more knowledge to "cure" uncertainty. Response/person-focused strategies leave uncertainty unresolved, and, like James' pragmatism, turns to action and relationship to palliate and live with uncertainty.[866]

Han and others note that, by and large, responses to uncertainty and strategies taught to manage uncertainty fall into the category of ignorance-focused.[867] Like James' gnostics, the "cure" that is offered for suffering is one of knowledge—which results in overtesting, overdiagnosing, overtreating and overmedicalizing uncertainty. This knowledge also comes with costs for patients and the medical system—negative side effects of tests and treatments, expenditure of healthcare resources, and many others.[868]

At the Centre for Sustainable Healthcare Education's webinar on overdiagnosis, Han gave a lecture titled "Uncertainty in Clinical Decision Making," in which he named the role of uncertainty in overdiagnosis. In this lecture, Han advocated for greater "uncertainty tolerance" in medicine. He highlighted the importance of recognizing uncertainty as a problem to be managed and encouraged the broadening of the goals of uncertainty management. A slide from this lecture and his accompanying words are pictured in Figure 20.

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[864] (Ibid., pp.59-85)
[865] (Ibid., p.68)
[866] Goals of curing and palliating are "not mutually exclusive," and it is possible "to aim at both reducing uncertainty and ameliorating negative responses to it" (Ibid., p.88).
[867] (Ibid., pp.68-70; Kimbell et al., 2016)
[868] (Heath, 2014)

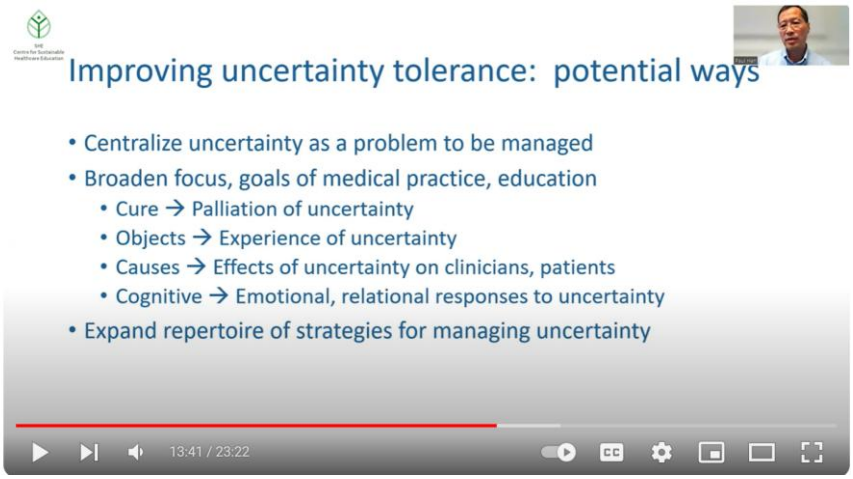

Figure 20) Han's strategies for improving uncertainty tolerance.[869]

Han states,

> Instead of focusing on curing uncertainty, we could focus on palliating it, that is, ameliorating its negative effects. Instead of focusing on what we are uncertain about, the objects, we could focus on the experience of it. So, what is it like to experience uncertainty, and how can we use that to sort of focus on different things to help people live with uncertainty? And then, instead of focusing on causes, we could focus on the effects on clinicians and patients, whether it has psychological or social effects, and this could be really more of a focus. And then we could also get away from the strictly cognitive responses and think about emotional and relational responses…Finally, we could expand the repertoire of strategies that clinicians use to manage uncertainty so instead of reaching for that test and trying to reduce ignorance, there are other things we can do that are more palliative in nature.[870]

An attitude of pragmatism is evident in the quote above. Attention is turned from first things (cures, uncertainty, causes, cognitive,) to last (palliation, experience of uncertainty, effects, relational).

[869] Screenshot taken from (Han, 2023a, 13.5min)
[870] (Ibid., 12:30min)

- cure→palliation: palliate uncertainty that cannot be cured.
- objects of uncertainty→experience: transform the experience of uncertainty into something positive even when uncertainty remains.
- causes→effects: ameliorate negative effects of uncertainty though the causes of uncertainty may be unresolved.
- cognitive→emotional & relational responses: address uncertainty emotionally and relationally even when answers to cognitive questions are unknown or unknowable.

Unlike the gnostics, Han broadens the goals of uncertainty management beyond knowledge and shows a plurality of ways to respond to uncertainty.

PU contains some of James' fiercest criticism of the over-gnostification of uncertainty in monism.[871] In monism, "the knower" is the very center of reality.[872] James offers as a hypothesis a pluralistic universe of many types of relations, of which "knowing" is only one among a plurality.[873]

In *Pragmatism,* James writes, "All our theories are instrumental, are mental modes of adaptation to reality, rather than revelations or gnostic answers to some divinely instituted world-enigma."[874] For James, theories are more than "answers;" they are instruments for leading. In the *Meaning of Truth,* James uses the analogy of "Memorial Hall." He sits in his library in Cambridge, ten minutes' walk from Memorial Hall, and imagines the building. "My mind," he writes, "may have before it only the name, or it may have a clear image, or it may

[871] (Lamberth, 2014)
[872] (Slater, 2011, p.76; Slater, 2014)
[873] (Slater, 2011, pp.75-79)
[874] (James, 2008ai, p.94)

have a very dim image of the hall, but such an intrinsic difference in the image makes no difference in its cognitive function [so long as, no matter how imperfect the image may have been, it can lead you to the Hall]."[875] For some, truth is constructing a mental picture (a "duplication by the mind of a ready-made and given reality") an "answer" identical with the "facts."[876] Herein there is hope—our theories can be instruments for leading even when they do not provide accurate pictures or clear answers. What this means for medicine is that even when we are not able to "answer" a patient's question, "how long do I have" with a date and time, we *can* answer the question in ways that lead fruitfully in a plurality of domains of life.

I began by saying that when it comes to prognostic communication, being right about the prognosis is not always the most important thing. One response to the question, "How long do I have, doctor?" is to turn to ignorance-focused strategies: clinical evaluation, diagnostic testing, therapeutic trials, expert consultation, literature searches, etc. These strategies can alleviate some of the suffering of uncertainty for patients. However, when these strategies fail to offer certainty and at best conjure a dim range of prognostic possibilities, we need not despair or be paralyzed because there are a plurality of other ways to turn to action and adapt.

Earlier, I cited a study by Epiphaniou et al. in which researchers compared end-of-life care that was provided to patients with lung cancer and patients with COPD. The study concluded that prognostic uncertainty resulted in prognostic paralysis and poor last-year-of-life care for patients with COPD.[877] A letter in response to this study by Crawford et al.[878] called for "more

[875] (James, 2008ab, pp.28-29)
[876] (James, 2008ai, pp.92-93)
[877] (Epiphaniou et al., 2014a)
[878] (Crawford, Moudgil, Srinivasan, Naicker, & Ahmad, 2014)

tools for more accurate prognostication as a way forward."[879] Crawford et al. turned to ignorance-focused strategies to overcome prognostic paralysis.

A letter by Kendall et al. challenged Crawford's response.[880] Their qualitative research on the experiences of COPD patients[881] had found that "identifying a time point for transition to palliative care had little resonance for people with COPD or their clinicians."[882] This was confirmed by systematic studies[883] that showed the trajectory of COPD to be "as a roller coaster [with] no one specific event demarcating the 'end-of-life' stage, except perhaps the final acute exacerbation, which is difficult to predict and may be relatively brief."[884] They suggested that there should be less focus on trying to identify a point in time for COPD patients to transition to palliative care, and instead recommended that clinicians "concentrate on developing services that integrate supportive care into the routine care of people living (perhaps for many years) with severe COPD."

Epiphaniou et al. replied to both letters in a pragmatic correspondence entitled "Avoid 'prognostic paralysis'—just get ahead and plan and co-ordinate care."[885] In response to Crawford et al., they acknowledged that more accurate prognostication would be ideal, in theory, but argued that it was near impossible in practice and that "use of a greater number of tools may not be appropriate in fatigued and breathless patients." They agreed with Kendall et al. that "rather than wait to identify a transition point to trigger palliative care, we should avoid 'prognostic paralysis' and plan holistic care according to needs. This will encourage integrated,

[879] (Epiphaniou et al., 2014a, p.14085)
[880] (Kendall, Buckingham, Ferguson, Hewitt, & Pinnock, 2014)
[881] (Pinnock et al., 2011)
[882] (Kendall et al., 2014, p.14031)
[883] (Giacomini, DeJean, Simeonov, & Smith, 2012)
[884] (Kendall et al., 2014, p.14031) quote abridged (Giacomini, DeJean, Simeonov, & Smith, 2012, p.26)
[885] (Epiphaniou et al., 2014a)

early use of palliative care alongside disease-oriented care." Instead of uncertainty leading to prognostic paralysis, Epiphaniou et al. proposed that uncertainty become a motivator for action, as their title suggests, to "just get ahead and plan and co-ordinate care."[886]

This conversation between these research groups highlights several important themes. First, it reveals the tendency to gravitate towards ignorance-focused strategies which, in theory, may seem to show promise in resolving uncertainty with more knowledge, but may, in practice, have detrimental effects on patients. The story also shows a turn in attention towards action, as suggested by Kendall's question (how can we develop supportive care for those with COPD?) and by Epiphaniou et al.'s reply, "avoid 'prognostic paralysis'—just get ahead and plan and co-ordinate care." They demonstrate a pragmatic turn towards action that—while leaving much uncertainty unresolved—relies on relationships among generalists, specialists, family carers, patients, and palliative care teams to hold that uncertainty together and support patients with COPD in living with the prognostic uncertainty of their condition.[887]

Prognostic uncertainty is perceived by many to be a barrier to end-of-life care.[888] Kimbell et al., however, suggest that for palliative care, "uncertainty may, in fact, be more friend than foe."[889] They argue that "an unpredictable but evident risk of deteriorating and dying should be a trigger for planning care with all people who have an advanced illness and in all care settings" and that "uncertainty offers a trigger for starting conversations with people that explore their concerns, values."[890] They summarize their article with the conclusion, "We should be helping people plan for possible future needs rather than trying to provide

[886] (Ibid., p.14085)
[887] (Ibid., p.14085)
[888] (Kimbell et al., 2016, p.1; Scheerens et al., 2018, p.2)
[889] (Kimbell et al., 2016, p.1)
[890] (Ibid., p.2)

certainty."[891] By shifting the focus of uncertainty from a gnostic domain and considering a plurality of other domains of life, the uncertainty that causes a gnostic prognostic paralysis can be transformed into an uncertainty that inspires a plurality of actions.

Pluralistic Universe of Palliative Care

The case of Barry is an untraditional presentation of prognostic uncertainty. In Barry's story, prognostic uncertainty is present in the background, but the attention is not on the uncertainty itself. The case of Barry is, itself, a turning of attention from uncertainty to action. Barry's story focuses on how North London Hospice creates opportunities to manage uncertainty with person- and response-focused strategies and shows how the hospice helps Barry to live with the uncertainty of COPD.

Han's taxonomy of uncertainty regulation strategies offers a plurality of ways to turn towards action in the face of uncertainty. While not exhaustive, it underscores the possibility of pragmatically responding with person- and response-focused strategies.[892] According to Han, response-focused strategies regulate psychological responses to uncertainty.[893] Barry *compartmentalizes:* the hospice music therapy group "allows him to be in the moment." His symptoms are managed so that he can *pursue other engagements* outside medicine, such as making music with his son. He has *adjusted* behaviorally and learned to "do it in stages," take breaks, and put it together at the end. Through the hospice's "Breathlessness and Fatigue sessions," he has learned "coping strategies that *uncouple responses* of panic to breathlessness and help him to continue to sing. Barry says that the hospice helps "support my mental

[891] (Ibid., p.1)
[892] (Han, 2021, p.8) For others see (Danczak, Lea, & Murphy, 2016; Gheihman, Johnson, & Simpkin, 2020; Ilgen, Eva, Bruin, Cook, & Regehr, 2019)
[893] (Han, 2021, pp.75-79)

wellbeing," and in adversity, Barry shows *resilience*. He has *adjusted goals;* he trains with his physiotherapist to "go just that little bit further." He recognizes that though there are things he can no longer do (such as run around the block), he can still live his life. Studies confirm what Barry's story shows.[894] A randomized controlled trial (RCT) of COPD patients demonstrated that cognitive-behavioral interventions that taught uncertainty management strategies to COPD patients led to significant improvement in anxiety, depression, mental health, and quality of life in patients with COPD.[895]

Person-focused strategies concentrate on the individual who experiences uncertainty and the interpersonal relationships that support them in the midst of uncertainty.[896] The hospice *acknowledges personal values* that are important to Barry, such as his identity as a reggae band drummer, father, and extrovert. They help Barry *cultivate virtues,* such as courage, when he experiences panic due to breathlessness. In Han's words, they "directed [his] attention to higher level ideals that that give meaning to [his] actions—and away from [his] uncertainty."[897] By *sharing experiences* and working through breathlessness with other patients, Barry feels that he is not alone. A multidisciplinary care team *shares responsibility* for both medical and mental health support. They help Barry with practical tasks (organizing medications) and emotional ones (providing someone that Barry can talk with outside of his family). While others care for Barry, Barry is *caring for others.* He encourages other patients in the hospice music group and, by sharing his story with Hospice UK, inspires others to have courage in the uncertainty of their conditions, too.

[894] (Hoth et al., 2013; Jiang & He, 2012; Small & Graydon, 1993)
[895] (Jiang & He, 2012)
[896] (Han, 2021, pp.79-83)
[897] (Ibid., p.81)

Barry's future is uncertain, but he has a community of people around him who help him to live with that uncertainty. He is creating memories with his son that his son will take with him into the future. He makes a difference in the lives of other hospice patients through his music and "encouraging passion" that leaves other patients "feeling better than when they arrived." At North London Hospice, someone is "always there if I need to talk:" the experts who manage Barry's care, nurses who monitor his medications and help him manage his anxiety, the physiotherapist who strengthens him, the "Breathlessness and Fatigue" patient group which teaches him coping strategies, and other patients who "make me feel like I'm not alone." Barry says that hospice has been a lifesaver: "My world was crumbling around me." He goes on to describe that crumbling as a "risk of becoming a hermit." This image is important. The condition of COPD threatened to cut Barry off from relationships, leaving him socially isolated and suffering alone. The North London Hospice may not have removed the uncertainty of his illness trajectory or answered the question, "How long do I have left?" but they brought him into a community that could hold his uncertainty with him and help him to live his life, however long it may be.

Earlier, I cited a study by Lamont and Christakis on prognostic disclosure.[898] The study begins with a story of a physician disclosing prognosis to a cancer patient. The physician predicted that the patient would die in three months, and the article reviewed the good practice of "breaking bad news" emulated by this physician. As the closing step of conversations on prognostic disclosure, the authors recommend summarizing the disclosed information, making a short-term plan with follow-up, assuring the patient of the physician's continued involvement, and affirming that they will not be abandoned. In the story, it turns out that the physician's prognosis was wildly inaccurate. The patient went on to live not just for three but

[898] (Lamont & Christakis, 2003)

for thirty-three months. In the conclusions, the physician reflects, “Really the purpose of our offering a prognosis to a patient is to help them live their life the way they want to live it…[I don’t know where] we got this idea that our being “right” about prognosis [is] tied to our abilities.”[899] Good prognostication is not just about being right (which may be a good thing, considering how hard it is to prognosticate correctly). Turning to gnostic, ignorance-based strategies has its place, but there are a plurality of other ways in which we can palliate uncertainty pragmatically, in responses and relationships.

At the beginning of this case discussion, I also quoted Rousseau: “The question ‘Doctor, how long do I have?’ demands an answer.”[900] The community at North London Hospice answered this question not with a number but with themselves.[901] They answered by being an answer, and in doing so, they helped to palliate Barry’s uncertainty.

The next case, the story of the 'woman who wouldn’t die,' shows how much more there is to our patients than what can be captured by science. James relates this elusive “more” to the notions of vagueness and mystery and suggests what he calls a “reinstatement of the vague.”

[899] (Ibid., p.103)
[900] (Rousseau, 2013, p.2029)
[901] Saunders writes, “we give ourselves with our pills” (Saunders, 2006, p.31).

Case 4

The Woman Who Wouldn't Die:

Mysticism & Reinstatement of the Vague

Mary was a woman in her mid-eighties who had come into our community hospice program with a diagnosis of cholangiocarcinoma. She had a rapid terminal decline. She had been living in her home on her own but had gotten to the point where she couldn't live by herself anymore and moved into our inpatient hospice facility. Shortly after, she stopped eating and drinking completely. And shortly after that, her son and a grandson came in from out of state to visit and to be by her side as she went through her final few days. Now, I usually have told folks that a week and a half or so after no food and water is typically how long a person lives, a few days plus or minus. It took her two weeks before she entered an actively dying phase. Her heart rate was thin, barely palpable, irregular, and very rapid; her blood pressure dropped to 60/0; she was breathing four times a minute, totally unresponsive, and stopped making urine. And the men asked me, "Well, how long do you think, doc?" I hate that question, but I answered it to the best of my ability. You know most people when they enter the actively dying phase, two, three, maybe four days is what it is, plus she has two weeks no food and water, so I was pretty confident. Two days…three days…four days…five days…six days [later], the grandson asked me, "Is there something we can do to put her out of her misery?" And I looked at her. I said, "She is pretty comfortable. We can talk about how to put you out of your misery, but at this point, she is doing just fine." But they were becoming exhausted, they were becoming frustrated. Seven days…eight days…nine days…ten days, I'd wake up in the morning and realize I'd have to go back into the facility and encounter these two young men again who were not happy how this was progressing. Two weeks into the actively dying phase, four weeks after

she had stopped having any food or water, she had long since closed the book on physiology; she definitely never read that textbook. She was just defying every mode of that. And I was walking down the hallway, and there was a lady who I didn't recognize standing outside the door. Her arms were folded in this defensive posture, and she looked at me with a scowl and said, "Are you the doctor?" I was tempted to just ignore her and walk on past, but sooner or later, I was going to have to encounter her, so I said, "I am." And she said, "What's going on in there?" and I said, "I don't know, she won't die." And I said, "Who are you?" and she explained that she's a friend of the family, of the patient's son. He told her what was going on, so she came to pay her respects and to be with the son and the grandson as they went through this. And I said, "I just don't know. We've gone through all the things that we like to do in hospice in terms of reconciling relationships, you know, right with God and all these things that we do with our team, and I've got nothing." And she said, "Did you know that she had a daughter?" "What?" I said, "I had no idea." "Yeah, they parted ways about twenty-five years ago. I don't know why. I don't think anybody remembers why. But they haven't seen each other in twenty-five years. Do you think that would have something to do with it?" And I said, "I'm certainly intrigued. Do you have any way of getting ahold of her?" And she said, "Sure." Reaches into her purse and pulls out this tiny corner of a piece of paper with a penciled number on it. "I haven't talked with her in ten years, but this is the last number that she had." I responded to her, "I'm fascinated with your filing system." But went into the room, dialed the number, and a woman answers, and I said, "Is this so and so?" And she said, "Yeah." And I said, "This is Dr Mulder from Alive Hospice in Nashville, and I just wanted to let you know that I've been caring for your mom for the last several weeks. She developed cancer earlier in the year and has declined as we had expected, and she is very, very close to the end of her life. I know you separated from her at some point years ago, I don't know why, I don't need to know why, but what I do know is that when there are fractures like that in the family and we are

getting near the end-of-life, sometimes there are things left unsaid that you really would like to share. If you'd like to do that, I can put the receiver next to her ear, and you can tell her what you want to tell her." And she said, "I'd like that." So, I did and heard the little chitter-chatter at the end of the receiver. I was tempted to hit the speaker so I could hear what was going on, but I resisted the temptation. About two minutes after this started, we see a tear coming down [Mary's] cheek. Which is followed by another, until there was a flood of tears. In the room, my staff that were there, they were sharing those tears. The son, grandson, their eyes were open wide, their mouths dropped. They couldn't believe what they were seeing. My scientific mind kicked in and said, "Where are these tears coming from? She has no substrate from which to make tears." But of course, these are tears from the heart. Five minutes later, the chitter-chatter at the end of the receiver stopped, and I pulled the thing back and I told the daughter what we had all witnessed and thanked her for what she said. She said she heard. And it meant a lot to her. Thank you very much. I hung up the phone, and Mary took her last breath about two minutes later.[902]

Uncertainty and Vagueness in Medicine

The story of the woman who wouldn't die (WWWD) reminds us that our patients hold depths far beyond what science can measure. James relates this elusive and uncertain "more" to the notion of vagueness and advocates for what he terms a "reinstatement of the vague."[903] In *PoP,* he writes, "It is, in short, the reinstatement of the vague to its proper place in our mental life which I am so anxious to press on the attention."[904]

[902] (Dempsey & Mulder, 2023a, 18min)
[903] (Gavin, 1976, p.245) cites (James, 1890, p.320; 1908, p.177; 1909, p.287; 1912, p.71)
[904] (James, 2008ak, p.246)

Vagueness is a recognized form of uncertainty in medicine. In Mishel's famous taxonomy of patients' experiences of uncertainty in illness, "ambiguity" is defined as "vague or "unclear."[905] Vagueness is a category of its own in Smithson's uncertainty taxonomy and consists of a range of possible values on a continuum.[906] Han describes the uncertainty that arises from vagueness as "fuzziness (lack of fine-graded distinctions or boundaries)" and "non-specificity (imprecision of information)."[907] Hofmann considers vagueness as that which makes it "difficult to decide to what degree something…falls within a conceptual category." He applies this to medicine's disciplinary, ontological, conceptual, and epistemic categories and defines uncertainty as "epistemic vagueness."[908] For James, the vague is that which cannot be contained and which overflows the boundaries of concepts.[909] While these medical definitions of vague are not exactly synonymous with James' use of the word vague, to reinstate the vague is to reinstate uncertainty. This case turns attention to action in the uncertainty of vagueness and introduces a way to live with uncertainty through the concept of vagueness.

Much in the story of the WWWD remains vague and unknown. There is vagueness in prognostication (imprecise and inaccurate predictions regarding the length of the actively dying stage). Vagueness regarding the woman's level of conscious awareness. Vagueness in ambiguous relationships with family members. Vagueness in the unclear reasons why she would not die and difficulty deciding to what degree these reasons were biological or crossed indistinct boundary lines into something more. There is vagueness in the interpretation of the story. Finally, the WWWD is an embodiment of vagueness as she lived for some time at the border of life and death.

[905] (Mishel, 1983, p.358)
[906] (Han et al., 2011, p.831; Smithson, 1993, 2012)
[907] (Han, 2021, p.36)
[908] (Hofmann, 2022, p.1158) references (Hampton, 2007)
[909] (Gavin, 1976)

A “reinstatement of the vague” may sound to some like the opposite of “doctor’s order.” Hofman, for instance, emphasizes the importance of reducing and limiting vagueness in medicine, and many of the practical reasons he lists for doing so (for instance, miscommunication) are justified.[910] Hofman represents a common sentiment; in medicine, vagueness is seen as a threat.[911] There is an assumption that vagueness in medicine should be reduced and that problems caused by vagueness are solved by vagueness reduction. James’ writings serve as a reminder that vagueness itself is vague, and vagueness is not always a bad thing.

After listing varieties of vagueness in medicine, Hofman concludes with a quote by HG Wells. “Every term goes cloudy at its edges…Every species waggles about in its definition, every tool is a little loose in its handle, every scale has its individual.”[912] There is a temptation in medicine to exclude the cloudy edges (the patient experiences such as Mary’s that do not fit the accepted constructs and that are exceptions to the rules). James goes right into the cloud and elevates that which is often excluded. He reinstates the vague. This has a special relevance for the field of palliative care, which itself is often on the cloudy edge of medicine.

In a sense, it could be said that the hospice movement itself was a reinstatement of the vague. Saunders founded St Christopher’s Hospice to provide care for cancer patients who did not fit into the category of the curable and found themselves on the borderline. In conversation with dying patients, she witnessed the indiscrete boundaries of physical, psychological, social, and spiritual pain.[913] Caring for these patients on the edge led Saunders to develop the concept of

[910] (Hofmann, 2022, pp.1152, 1157, 1164)
[911] (Engebretsen, Heggen, Wieringa, & Greenhalgh, 2016, p.596; Gavin, 1992, p.169; He & Smit, 2021, p.1)
[912] (Hofmann, 2022) quotes (Wells, 1908)
[913] (Ong & Forbes, 2005)

"total pain" care, which recognized the vague continuity of physical, psychological, social, and spiritual pain and included elements of experience that were often excluded by biomedical models.[914]

Figure 21) Saunder's diagrammatic representation of "Total Pain"[915]

Saunders championed that which was considered vague, and in response to it, she turned to action and developed a multi-faceted approach to pain that became the multidisciplinary and multi-faceted ethos of palliative care today.[916]

James introduces the "reinstatement of the vague" in *PoP* in a famous chapter on the "Stream of Thought," which draws an analogy between the experience of consciousness and a flowing river with tides and eddies.[917] Reinstatement of the "vague" is a recurring theme in James' work. He develops this theme significantly in the context of his reflections on religion and spirituality.[918] Considering James' relationship with religion, his biographer Gerald Myers writes, "Psychologists and religious mystics alike understand that any experience, when we reflect upon it has no definite boundary but radiates from its center into a surrounding *more.*

[914] (Clark, 1999, 2000)
[915] (Collier, James, & Bath, 2021, p.11)
[916] (Richmond, 2005)
[917] (James, 2008ak, p.246; 2008al, p.150)
[918] (Gavin, 1976, p.225)

(The word *more* was a favorite of James' for it expressed his belief that we should never cease our moral striving.)"[919] I would add "physicians" to this list of those who understand that experience radiates out without definite boundaries and that this vagueness demands action.

Whereas James' exemplar of vagueness is mystical, his exemplar of reductionism is medical.[920] Before considering the reinstatement of the vague in religious mysticism, let us first consider a reduction of it through what James terms "medical materialism."

Reductionism and Medical Materialism

In *VRE,* James illustrates reductionism through the concept of "medical materialism," which diminishes religious experience by explaining and evaluating its content solely in terms of the organic state supposed to have caused it. For example, James writes,

> Medical materialism finishes up Saint Paul by calling his vision on the road to Damascus a discharging lesion of the occipital cortex, he being an epileptic. It snuffs out Saint Teresa as an hysteric, Saint Francis of Assisi as an hereditary degenerate… All such mental over-tensions, it says, are, when you come to the bottom of the matter, mere affairs of diathesis (auto-intoxications most probably), due to the perverted action of various glands which physiology will yet discover.[921]

Medical materialism reduces religious experience to "nothing but" organic disposition.[922] James, in reply to this reduction, points out that all mental states (even the mental states of the medical materialist) are dependent upon bodily conditions.[923]

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[919] (Myers, 2001, p.471)
[920] (James, 2008af; Slater, 2015, p.35)
[921] (James, 2008av, p.20)
[922] (Ibid., p.19)
[923] (Ibid., p.20)

> In the natural sciences…it never occurs to anyone to try to refute opinions by showing up their author's neurotic constitution. Opinions here are invariably tested by logic and by experiment, no matter what may be their author's neurological type…Saint Teresa might have had the nervous system of the placidest cow, and it would not now save her theology, if the trial of the theology by these other tests should show it to be contemptible. And conversely if her theology can stand these other tests, it will make no difference how hysterical or nervously off her balance Saint Teresa may have been when she was with us here below.[924]

The above quotes frame medical materialism as the opposite of an attitude of pragmatism. Medical materialism looks backward towards causes to evaluate religious experience; pragmatism looks forward to evaluating it by its fruits. The above quotation considers mental states to be conditioned by bodily processes. In *PoP,* James explains that "mental phenomena are not only conditioned *a parte ante* by bodily processes, but they lead to them *a parte post.* That they lead to *acts*…"[925] In pragmatism, the attention is on the leading. The bodily state by which an idea is judged is less its bodily origin and more the bodily changes it makes in life and action.

Patients today experience medical materialism. Their experiences are explained and evaluated by their cause and bodily state. This is not always a bad thing. For some, naming a bodily explanation/cause is the reason they went to the doctor in the first place, and insofar as such explanations from causes (*a parte ante* by bodily processes) contribute to patient care (*a parte post* bodily states), they are good. Studies show, however, that this practical reduction, which can be so helpful, can also contribute to dehumanization in medicine—especially when this reduction turns from a heuristic in leading and is elevated to the status of the "really real."[926] In terms of medical materialism, the story of the WWWD is "nothing but" an exceptional

[924] (Ibid., p.23)
[925] (James, 2008ak, pp.18-19)
[926] (Goldenberg, 2006; Howick et al., 2023; Sultan & Adam, 2012)

extension of the actively dying phase—perhaps explained by long-released cortisol, slowed metabolism, or other mechanisms that physiology will yet discover.[927] In *PoP,* James explains that explanation is reductive. If X is explained by A, the only part of X that has been explained is the part explainable by A.[928] There are parts of the story of the WWWD that are explainable by physiology, but pragmatism reminds us that there is always a vague "more" overflowing any conceptualization. In *Pragmatism,* James suggests that "profusion, not economy, may after all be reality's key-note."[929]

Gavin describes the medical student's journey as one that moves from the fixed, through the vague, and into the increasingly "real." He quotes Dr. McGraw, The first 'patient' the student is introduced to is the cadaver...understanding the cadaver is often easier than trying to understand the living, responding, feeling persons…" Next, the student is introduced to mechanisms, the "heart and lung preparations" and "specimens of blood and urine." The first living patients that the student examines in the clinic function as mannequins on which to pin understanding, and many of these relationships are quite "perfunctory." Finally, "in clinical work, the student moves progressively from perceiving or diagnosing his patient as a case of pneumonia (no small feat in itself) to understanding him in human terms—first as a feeling human being and then as a part in a complex fabric or network of family, marital, social, and occupational contexts.[930] Medical education gradually draws students into a world of increasing vagueness. Yet some hold tightly to the less ambiguous clarity of their early training, as if that were the 'really real.'

[927] (James, 2008av, p.20)
[928] (James, 2008ak, pp.464-468)
[929] (James, 2008ai, p.93)
[930] (Gavin, 1981, pp.61-62) quotes (McGraw, 1973, pp.48-49)

Who could blame them for doing so? In the dynamic flux of experience and demands for action, it is natural to desire something fixed to hold on to, and concepts are needed as a practical guide. James was a scientist and understood the value and necessity of concepts, mechanisms, and explanations. Yet, he warned that our sciences "should not be held for literally real…as if they existed; (as if they were the 'really real')." James explains, [The concepts of our sciences] are like co-ordinates or logarithms, only artificial short-cuts for taking us from one part to another of experience's flux. We can cipher fruitfully with them; they serve us wonderfully; but we must not be their dupes."[931] We must not be their dupes in medicine either. Many health professionals presume that the "facts," reductions, or "objective" part of a SOAP (Subjective, Objective, Assessment and Plan) note are the "really real."[932] James inverts this assumption. "At the primordial level, the "really real" is vague, ambiguous, incomplete, and essentially so."[933]

Slater,[934] Croce,[935] Putnam,[936] Pihlstrom,[937] Greenhalgh[938] and many others cite "anti-reductionism" as one of the important contributions of pragmatism. Anti-reductionism is heralded in James' philosophy, especially in his work on religious experience. Yet *VRE* itself is a "science of religion" that employs some of the reductionist methods of science. Croce says,

> [James] was eager to engage in the scientific method, and deeply respectful of scientific facts, but unwilling to accept the claims of scientific enthusiasts ready to reduce religion to materialist phenomena; yet he welcomed their focus on naturalistic ways to understand religious experiences, since their physical focus presented a first step toward understanding the life of the spirit.[939]

[931] (James, 2008ai, p.92)
[932] (Pearce, Ferguson, George, & Langford, 2016)
[933] (Gavin, 1981, p.62)
[934] (Slater, 2011, p.65)
[935] (Croce, 2012)
[936] (Putnam & Putnam, 2017)
[937] (Pihlström, 2014)
[938] (Greenhalgh & Engebretsen, 2022)
[939] (Croce, 2012, p.3)

James' approach to religion provides a helpful model for us as physicians. James is not against reductionist methodologies of science, so long as these methodologies do not become totalizing. One can respect, value, learn, and practice methods of medical science as these tools become "helpful first steps" for a limited scope of purposes and a small range of experiences. They are not the "really real," but they do help to organize some experiences into workable forms and (as they are part of experience) add to it.[940] For James, "the "really real" is beyond any linguistic formulation," yet James continued to write his books.[941]

There is plenty of literature on reductionist tendencies in medicine.[942] My purpose here is not to dwell on reductionism. There is more to our patients than we can know. Most physicians already intuit this. The "moreness" of our patients is part of the problem. There is so much "more" that, practically speaking, we need to reduce if we are going to act at all.[943] Or do we? Does action always require reduction? James' reinstatement of the vague (especially the vague in religious experience) might suggest otherwise.

I argue that a reinstatement of the vague does not necessarily terminate in vagueness. Saunders' turn towards action in response to the vagueness of total pain illustrates that vagueness itself can become a stimulus to act and can open up new and constructive ways of responding. As mentioned above, medicine was James' reductionistic exemplar; his exemplar of vagueness is mysticism.

[940] (Rasmussen, 2014, p.161)
[941] (Gavin, 1981, p.46; 1992, pp.191-193)
[942] (Beresford, 2010; Carlson, 1979; Federoff & Gostin, 2009; Goldenberg, 2006; Haslam, 2006; Haslam & Stratemeyer, 2016; Sultan & Adam, 2012)
[943] (Sultan & Adam, 2012, pp.178-179)

Vagueness in Religion/Spirituality: Richness & Intensity

James develops the relationship between vagueness and action in his discussions on religious experience and mysticism. Gavin explores this connection. He introduces his essay "William James and the Importance of the Vague" with James' plea that the "quest for certainty and objectivity be rejected and that life be lived as 'richly' and 'intensely' as possible."[944] The words "richness" and "intensity" are keywords in this quotation. What does reinstating vagueness do? What difference in experience does the reinstating of vagueness make? Gavin suggests two functions. "As 'vague,' experience is richer than any given formula. It overflows all logical systems. In addition, vagueness demands involvement, decisions or, in brief, intensity. The vagueness of life, its unfinished aspect, forces us to be creative."[945] In short, reinstating vagueness contributes to a life lived both "richly" (anti-reductionistically) and "intensely" (turned towards action). Gavin argues that these two pragmatic effects of vagueness can be seen in James' approach to religion/spirituality, and furthermore that James' religious concerns shaped the paradigm through which he approached vagueness in general.[946] The following sections show how the vagueness of religious experience, in its richness and intensity, can help to reframe the uncertainty of vagueness in medicine.

Richness (anti-reduction)

For James, religion/spirituality is vague, and its vagueness is part of its richness. For example, in a famous passage of *VRE*, James lists four characteristics of mystical experience and each characteristic reflects vagueness. The first marker of a mystical experience is *ineffability*: the inability to contain or communicate the experience in words. The second is *noetic quality,* a sense that a great truth of profound importance has been revealed by the mystical experience,

[944] (Gavin, 1976, p.245)
[945] (Ibid., p.247)
[946] (Gavin, 1992, p.13)

even if that revelation in its fullness is inarticulable. The third is *transiency:* the mystical experience is a temporary state that cannot be sustained. The fourth is *passivity*: a sense that the mystical state is not within one's control but that one has been "grasped" by a superior power.[947] In *ineffability* and *noetic quality*, there is a vague sense of significance, but the vagueness of the experience overflows words. In *transiency* and *passivity,* the experience is vague and ungraspable, fleeting in time and beyond our power.

James was fascinated by the "unacknowledged richness of life" and was inclined towards that which "incorporates or assimilates most completely the richness encountered in experience."[948] In *VRE* James writes, "Although some persons aim most at intellectual purity and simplification, for others richness is the supreme imaginative requirement."[949] Gavin points out that richness, not reduction, was James' imaginative preference.[950] James was fascinated by religious experience, in part because of its richness in reaching towards the edge of experience. As a psychologist, he saw conscious experience fringed by a subconscious "more," and within this "more," James locates a nexus of religious experience.[951]

James envisions a world in which the sensible world is vaguely continuous with the religious/spiritual. James, as a psychologist, locates religious experience on the edge, in the transmarginal, subliminal consciousness.[952] James, as a mystic, suggests that this edge may be vaguely continuous with a greater more, perhaps God. In his words, "this higher part [of man]

[947] (James, 2008av, pp.302-303)
[948] (Gavin, 1976, p.246)
[949] (James, 2008av, p.362)
[950] (Gavin, 1976, p.246)
[951] (Capestany, 1967; Croce, 2012; James, 2008av, p.381; Taves, 2004)
[952] (Croce, 2012)

is coterminous and continuous with a MORE of the same quality, which is operative in the universe outside of him and which he can keep in working touch with..."[953]

It is important to make clear that James by no means reduces religious experience to the human subconscious. Religious experience is, rather, an expansion of the horizon of consciousness.[954] The last chapter of *Pragmatism* is devoted to the topic of God and religion. In it James writes,

> I firmly disbelieve, myself, that our human experience is the highest form of experience extant in the universe. I believe rather that we stand in much the same relation to the whole of the universe as our canine and feline pets do to the whole of human life. They inhabit our drawing-rooms and libraries. They take part in scenes of whose significance they have no inkling.[955]

In the reinstatement of vagueness, James models an important intersection between science and religion. Religion and spirituality awakened in him a sense of a vague "moreness" that was elusive to the grasp of a single methodology.[956] The sense of more, both within and beyond a person, led James to approach science with humility.[957]

Reinstatement of the vague inspires a posture of humility.[958] As the moreness of experience expands, the territory of our understanding becomes comparatively small. Uncertainty increases. James embraced religious experience as a legitimate subject of inquiry despite its vastness and vagueness. In religion, he saw the pragmatic value of vagueness in its encompassing the inclusive richness of "more," a "more" that reminds us to remain humble.

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[953] (James, 2008av, p.139)
[954] (James, 2008aq)
[955] (James, 2008ai, pp.143-144)
[956] (Croce, 1995, pp.49-66)
[957] (Croce, 2012; Goodson, 2010)
[958] (Goodson, 2010)

For James, this humility calls for courage. As Gavin explains, vagueness is the "harrowing and humbling fact that the universe will never be completely known." James invites us to "rise to the occasion," to embrace the moreness of reality—"unfinished and wild and sometimes threatening as it is." Gavin writes, "[James'] texts, in short ask us to act heroically, that is, exhibit courage. Courage is usually defined as having to do with how an individual faces death. And since James constantly asks us to be courageous or heroic, we might say that James's texts are about how we deal with death."[959]

Gavin wrote these words less than a decade before his own death. His obituary makes special mention of the people who cared for him in his final days at the Hospice of Southern Maine, specifically naming Jay, Leslie, and Edie, who supported him and his wife. A memorial to Gavin's life states,

> Running like a dark thread through Bill's writings are the themes of finitude and death. He emphasized that our beliefs in the secure and the permanent—our delusional expectations of control, our excessive demands for clarity, our hopeless quest for certainty—are all misguided…By means of his work, Bill shows us that all of this is delusional. He helps us to grasp what it is to live our lives without an adequate understanding of what we are doing, and to face the tragedy of having to endure when our choices prove mistaken. His view of life, and his approach to philosophy, are thus existential in the deepest sense.[960]

It takes courage to act in vagueness without full understanding and to risk making mistakes.

[959] (Gavin, 2013, p.114)
[960] (Campbell, 2023, p.107)

Intensity (turn to action)

For James, religion/spirituality is vague, but it does not terminate in vagueness. Vagueness can motivate a turn to action. In the following section, I draw attention to three aspects of this turn to action in the vagueness of religious experience. First, the turn to action is one in which we are involved as participators, not spectators. Second, vagueness can be a stimulus for action and, furthermore, can stimulate action without resolving the vagueness. Third, it is not only possible for the vague to motivate action, but it can perhaps be one of the deepest driving forces behind our actions.

Participators, Not Spectators

Gavin explains that "richness by itself is not enough."[961] The vagueness of religious experience is also "intense" because we are involved in the experience—"participators *in* rather than spectators *at* the game of life."[962] On a psychological level, we, as agents, play active roles in creating experience as we select from the vague stream which aspects of experience to attend to. Furthermore, these selections add to and become experienceable parts of that stream.[963] Gavin quotes James' diary from April 30, 1870 (the entry on James' spiritual crisis in which his first act of free-will was to believe in free-will). "Life, young James reflects 'shall [be built in] doing and suffering and creating.'"[964] Intensity is a turn to action, and furthermore, one in which we are involved, "doing and suffering and creating."

This idea of "participators *in* rather than spectators *at"* is seen clearly in James exposition of religious experience and mysticism. Less often quoted than the four markers of mystical

[961] (Gavin, 1976, p.246)
[962] (Ibid., p.246)
[963] (Ibid., pp.17-55)
[964] (McQuade, 2008, p.xxvi)

experience listed above are what James lists as “ripe fruits of religion,” which are manifest in inner conditions of a character, i.e., “saintliness.”[965]

1. A feeling of being in a wider life than that of this world's selfish little interests; and a conviction, not merely intellectual but as it were sensible, of the existence of an Ideal Power…

2. A sense of the friendly continuity of the ideal power with our own life, and a willing self-surrender to its control.

3. An immense elation and freedom, as the outlines of the confining selfhood melt down.

4. A shifting of the emotional centre towards loving and harmonious affections, towards 'yes, yes,' and away from 'no,' where the claims of the non-ego are concerned.[966]

These fruits of religion are the epitome of vagueness. There is a feeling of a wider “more” in the ordinary doings of life. The buffered boundaries break down, and there is a sense of vague continuity and involvement in loving, harmonious affections between God, ourselves, and others.

Stimulating Action without Resolving the Vagueness

Though not present in James’ famous list of four markers of mystical experience, *VRE* puts forward another characteristic of mystical experience. Repeatedly in *VRE,* James shows that vague religious experiences lead to changes in life and action (*a parte ante* bodily change). James points out that in the history of Christian mysticism, the validity of a religious experience is known by its effects. James quotes scripture, “By their fruits, ye shall know them, not by

[965] (James, 2008av, p.219)
[966] (Ibid., pp.219-220)

their roots,"[967] and the great American preacher, Jonathan Edwards, "The degree in which our experience is productive of practice, shows the degree in which our experience is spiritual and divine."[968] Throughout *VRE* James examines religious experience by asking, "What may the practical fruits for life have been?"[969] He shows case after case of religious experience changing conduct and experience and invigorating moral energy.[970] As practical consequences of the "ripe fruits of religion in character," James lists: *asceticism,* which finds positive pleasure in sacrifice and suffering; *strength of soul,* which replaces fears and anxieties with patience and fortitude and blissful equanimity ("Come heaven, come hell, it makes no difference now!"); *purity,* which cleanses and lets go of all that inhibits the spiritual life; and *charity,* which acts out of tenderness and love for human beings and reaches to depths normally inhibited.[971]

Throughout his corpus, James returns to the fact that religious experience (although vague) serves an important pragmatic function in strengthening moral intensity.[972] Religion motivates the strenuous moral life ("the universe no longer an *It* to us, but a *Thou,* if we are religious"),[973] and is a source of energy and endurance for that strenuous moral life ("[religious experience] overcomes temperamental melancholy and imparts endurance to the subject, or a zest, or a meaning, or an enchantment and glory to the common objects of life").[974] In *VRE* he writes, "Here, if anywhere is the genuinely strenuous life."[975] This intensity can be seen in the conclusion of *Pragmatism:* through trust and cooperation with others, our actions may contribute to the possibility of salvation, cooperating not only with fellow men and women but

[967] (Ibid., p.25)
[968] (Ibid., p.25)
[969] (Ibid., p.210)
[970] (Ibid., p.229)
[971] (Ibid., pp.230-231)
[972] (James, 2008ac, pp.160-163)
[973] (James, 2008ax, p.31)
[974] (James, 2008av, p.398)
[975] (Ibid., p.210)

even with "superhuman forces...such as religious men...have always believed in."[976] Gavin argues that "James' Pragmatism lectures close with a view of God as a mysterious Thou who becomes more and more real insofar as we respond to his invitation."[977] In short, religious experience models a turn to action without resolving or reducing the vagueness.

Vagueness as a Driving Force Behind Action

James goes one step further, saying that the vague not only can motivate action but is perhaps one of the deepest driving forces behind our actions.[978] He contrasts rationalism with its "(1) definitely statable abstract principles; (2) definite facts of sensation; (3) definite hypotheses based on such facts; and (4) definite inferences logically drawn," with mysticism and its "vague impressions of something indefinable [which] have no place in the rationalistic system."[979] Yet, these vague mystical experiences can convey a sense of being the "really real." "They are as convincing to those who have them as any direct sensible experiences can be, and they are, as a rule, much more convincing than results established by mere logic ever are."[980] James argues that "If we look on man's whole mental life…we have to confess that the part of it of which rationalism can give an account is relatively superficial."[981] Rationalism remains unconvincing if our intuitions oppose its conclusions. If not from rationalism, from where do intuitions come? James answers, "If you have intuitions at all, they come from a deeper level of your nature than the loquacious level which rationalism inhabits. Your whole subconscious life, your impulses, your faiths, your needs, your divinations, have prepared the premises, of which your consciousness now feels the weight of the result."[982] The vague underlies actions in ways that

[976] (James, 2008ai, p.143)
[977] (Gavin, 1976, p.255)
[978] (James, 2008q, p.55)
[979] (James, 2008av, p.66)
[980] (Ibid., p.66)
[981] (Ibid., pp.66-67)
[982] (Ibid., p.67)

are vague. Earlier, I suggested that action is a response to the vague. Perhaps an even bolder claim could be made: that all action is inspired by it. My point, however, is simply that a reinstatement of the vague can also reinstate action.

Through religious experience, James demonstrates that vagueness can contribute to life lived both richly (anti-reductionistically) and intensely (turned to action). This dynamic is evident in James' own engagement with religious experience, as well as in the case of the WWWD. For James, the vagueness of religious experience became a lens through which he approached uncertainty more broadly. This "more" can likewise inspire a different way of thinking about vagueness in medicine. I now return to the story of the WWWD and its vagueness to explore its richness, intensity, and the possibilities it opens.

Vagueness and the Woman Who Wouldn't Die: Richness & Intensity

Richness

I began this case by saying that there is more to the story of the WWWD than can be captured by our sciences. Her story is rich with "more." She defied physiology textbooks and resisted being reduced to its theorems. Her story shows sensible biological phenomena vaguely continuous with relational, existential, and spiritual concerns. She is on the edge, but she is also a center point vaguely fringed by relationships. Her care extends vaguely outwards into "more," into the care of her family (the son and grandson at her bedside) and of the estranged daughter who is so far on the fringe that her identity was not even known to the physician. The story of her care radiates outwards into the story of her life and perhaps into larger stories still.

The WWWD overflows beyond the concept of vagueness itself. She reached the vague edge of experience, on the edge of consciousness, and even the edge of death. The reality of what

was witnessed as tears came down her cheeks and she peacefully passed to death cannot, in its fullness, be contained in words. There was a clear sense that something profoundly important had happened even if inarticulable. It was an event that lasted only a moment, and one which was beyond the understanding of the physician and those who witnessed it. In the story of WWWD, one can see the pragmatic value of vagueness in its encompassing, inclusive richness of "more," and that "more" of her story reminds us to remain humble. Like James' canine and feline pets, the physician and those providing her care "take part in scenes of whose significance they have no inkling."

As the saints and mystics testify, there is an unacknowledged richness in all life; it is just that at certain times we are more acutely aware of it. James understands religious experiences as rare momentary expansions of the horizon of consciousness to include awareness of this ever-present "more." This story of the WWWD is challenging and resists easy placement within a biomedical paradigm.

Many of the stories that James records in *VRE* are like the story of the WWWD. They are experiences that "exceeds either conceptualization or verbalization"—the types of experiences that are often excluded because they just do not fit our expectations.[983] James encourages us to take such events seriously.[984] He closes *PU* with an entreaty to his students to thicken up philosophy with the particulars and anomalies, the "wild beasts of the philosophic desert"[985] that are untamed by our rationalistic systems. Stories that linger on the edge. In one sense, the WWWD is an exception. In another sense, she is every patient. All our patients are more than

[983] (James, 2008af, p.131)
[984] (James, 2008aw, pp.222-223)
[985] (James, 2008ag, p.149)

can be captured by our sciences. To reinstate the vague is courageously to acknowledge the richness and more beneath the surface of medicine and to remain humble.

Intensity

The story of the WWWD is vague, but it does not terminate in vagueness. It is a story that is built in "doing and suffering and creating."[986] Like James, physicians understand that the "more" has moral implications that demand action and motivate a "genuinely strenuous life."[987] The "more," and the vague, indefinite number of days of her active dying required the hospice to make provisions to manage her care. The physician attended her every day to manage symptoms and to keep her comfortable. The "more" and indefinite boundaries of bio-psycho-social-spiritual care required the palliative care team to go through "all the things that we like to do in hospice in terms of reconciling relationships, you know, right with God and all these things that we do with our team." The "more" necessitated an expansion of care for the dying to include care for their family and loved ones. One can see the effort this physician made to care for the son and grandson as they kept vigil, the family friend, and estranged daughter.

The physician and other healthcare providers were participants, rather than spectators, in the story. The actions of the physician and the risks he took contributed to the creation of a story that could have had a very different ending had he reduced his management role to monitoring morphine and scopolamine levels. The "more" required a humility that could honor the tears of an unconscious woman, share in those tears, and thank the daughter for what she had said. Perhaps one could reduce the case of the WWWD to a biological phenomenon, but allowing

[986] (McQuade, 2008, p.xxvi)
[987] (James, 2008av, p.210)

there to be uncertainty, vagueness, and “more” pragmatically led to better care for both the patient and her family.

For James, vagueness can stimulate action without resolving the vagueness. This important point is illustrated in many ways in the story of the WWWD. When asked by the family friend, “What is going on?” The physician honestly confessed, “I don’t know.” He had been brought to the edge of his understanding of physiology. When the physician saw the threatening family friend, the one who would bring “more” into the situation, he was tempted to ignore her, pass by, and busy himself with other things. The family friend mentioned that the woman had a daughter, that twenty-five years ago something had happened, though she did not know what, and that the woman and her daughter had become estranged. The physician reached to the edge. He dialed a number written on a ten-year-old scrap of paper from a filing system he did not understand to call a woman he did not know. The daughter answered the phone, and he explained to her that her mother was dying, that he knew they had separated years ago, and that he did not know why and did not need to know why. He offered her an opportunity to speak to her mother and share with her anything she did not want to leave unsaid. When the daughter said “yes,” he held the phone to the ear of an unconscious woman. He heard the vague chitter-chatter on the end of the phone receiver and was tempted to listen to what was being said, to learn what had happened, and finally know why the woman would not die. He resisted the temptation and let it remain vague. When those in the room witnessed the tears, they saw something unarticulated and inarticulable, but they knew they had witnessed something of great significance. It passed in a moment and, like the passing of the woman herself, was beyond their understanding. It was a situation in which they had somehow come to take part. In the end, the physician did not need to know what had happened to estrange the woman and her daughter, what was said between them as they reconciled, or the source of the tears. He did not

need to resolve that vagueness to know what to do. He witnessed the tears down the woman's cheeks, the gratefulness of the daughter, and the peaceful passing of the woman who finally died.

Conclusion: Palliating Uncertainty

The reinstatement of vagueness is an example of Palliating Uncertainty. The physician resisted the pressures to remove uncertainty by reducing the vagueness through medical materialism. He accepted the experience in its richness. He allowed the uncertainty and vagueness to stimulate a plurality of actions that alleviated suffering, and in the end, he lived with the uncertainty.

The reinstatement of vagueness shows the three themes to which I have been pointing throughout these case studies. The management of expectations: vagueness (i.e., uncertainty) is a starting point. Conceptual reductions may be useful, but "there is an incompleteness to all levels of explanation. The "really real" is richer, i.e., more vague than any conceptualization, or indeed richer than all conceptualizations added together"[988] and acknowledgement of such requires humility and courage. The turning of attention to action in uncertainty: vagueness does not terminate in vagueness because, as James shows in religion, reinstating vagueness can reinstate action. Finally, living with uncertainty: as exemplified by the physician in the story of the WWWD.

This case emphasized the importance of humility in the palliation of uncertainty. The next section continues to develop the role of courage and applies James' "faith ladder" in the context of caring for a patient with end-stage brain cancer who desires to end his life.

[988] (Gavin, 1981, p.63)

Case 5

Climbing James' Faith Ladder:

Is Intensive Caring Worth Doing?

I [Chochinov] recall one such patient early in my career, who struggled with feelings of futility and hopelessness in the face of end-stage brain cancer. He'd been admitted to an inpatient neuro-oncology ward, where he felt a burden to his healthcare team and wanted me to help him die. He saw little point in continuing his life, which had been marked by bipolar disorder, polysubstance abuse, and family estrangement; he emphatically felt he no longer mattered. I told him that I could not and would not hasten his death, but was prepared to support him in any way that I could until the very end. We began to meet weekly, occasionally twice a week, while I delved into learning more about who he was, including the origins of his chronic self-loathing. He would often complain about things such as hospital routines, the medical staff—and one day began to berate me and the futility of my efforts to help him. Being young and naïve, I suggested that if our meetings were not helpful, neither of us was under any obligation to continue. He responded as if I had gone mad. "Are you crazy?" he said. "These appointments are the only thing that keep me going![989]

The issues raised by the patient—terminal brain cancer, a lifetime of bipolar disorder, polysubstance abuse, family estrangement, and deep self-loathing—are among issues that are, in many cases, beyond the ability of medicine to "fix." The patient complained of the futility of efforts to help. Although appointments with Chochinov were not "fixing" the problems, the

[989] (Chochinov, 2023c, p.2884)

non-abandonment was doing something important. In the patient's words, "These appointments are the only thing that keep me going." Chochinov's committed care communicated to him that he mattered.

Chochinov, a psychiatrist in palliative care and inductee into the Canadian Medical Hall of Fame, developed a model of medical care called "intensive caring." In this case, I apply James' faith ladder to the uncertainty of intensive caring and the question, "Is intensive caring worth doing?"

Introduction to Intensive Caring: Reminding Patients that they Matter

Chochinov's model of "intensive caring" is an approach to medical care that "reminds patients that they matter." It offers empirically informed guidance for ways to "be with" patients whose problems are beyond fixing and who have lost hope, meaning, purpose, and the sense that their presence matters.[990] There are two elements of intensive caring that I will focus on: "non-abandonment" and "therapeutic humility."

Chochinov writes that the foundational element of intensive caring is non-abandonment, "Committed, ongoing care even when patients no longer care about themselves."[991] Twycross, a founder of palliative care, goes further and calls non-abandonment the foundation of palliative care itself: "What-ever happens, we will stay beside you every step of the way. Together we will get through this."[992]

[990] (Ibid., p.2884)
[991] (Ibid., p.2885)
[992] (Twycross, 2024, p.6)

Intensive caring requires what Chochinov calls "therapeutic humility." He explains that the standard medical paradigm is "examine, diagnose, and fix." [993] While this paradigm has been remarkably successful in the treatment of some types of illnesses, there are problems in the realm of human suffering that "simply defy repair." Chochinov defines therapeutic humility, first and foremost, as "relinquishing the need *to fix"*[994] and notes the relation between relinquishing the need to fix and uncertainty. He writes,

> There are cancers that cannot be cured, depressions that resist treatment, and suffering whose intensity seems impenetrable. In those instances, the goal to fix can lead to feelings of failure and an inclination to withdraw…Tolerating ambiguity is not easy as it means walking a clinical path fraught with uncertainty, in the absence of our usual therapeutic tools aimed at fixing.[995]

Relinquishing the need to fix requires a "tolerance of ambiguity" and willingness to "walk a clinical path fraught with uncertainty." Coping with uncertainty lies at the root of therapeutic humility and is central to intensive caring itself.

Chochinov recommends asking the "patient dignity question (PDQ)" as part of intensive caring: "What do I need to know about you as a person to give you the best care possible?"[996] The PDQ has been empirically studied and shown to improve empathy and clinical outcomes and to help patients feel that they are seen as people who are more than their disease or disability.[997] When Chochinov met the *patient* in this case, this man disclosed that he saw no point to his life. When Chochinov invited him to share more about who he was as a *person*, this man chose to reveal that he struggled chronically with self-loathing. He shared stories

[993] (Chochinov, 2023c, p.2885)
[994] (Ibid., p.2885)
[995] (Ibid., pp.2885-2886)
[996] (Chochinov, 2023c, p.2884; Chochinov et al., 2015)
[997] (Chochinov et al., 2015)

about the origins of this self-loathing, which was entangled with his bipolar disorder, polysubstance abuse, and family estrangement.

Time and resource limitations often hinder questions like the PDQ—but perhaps a deeper barrier is uncertainty. What can of worms will this question open?[998] What if the patient opens up something that I cannot fix, do not have the resources to fix, or do not know how to deal with? Can I accept powerlessness to fix it? One response to this uncertainty is to withdraw from the circumstance and the patient.[999] Yet, this response to uncertainty can add to the suffering. As Saunders writes, "Suffering is only intolerable when nobody cares."[1000] Though perhaps overstated, the sentiment of this quote, I think, speaks something true. When fear of uncertainty leads to withdrawal, it can seem to the patient that "no one cares," and this can add to the suffering.

At the 2024 Dignity in Care: The Human Side of Healthcare workshop in Belfast, Northern Ireland, Chochinov said in response to a question:

> A person is dying and feels suicidal and hopeless. You sit there afraid that if the conversation goes there, you won't know what to say or do. 'I'll feel useless.' And that's okay. Life will give you lots of situations in which you feel useless, so get used to it. But if you stay there, you will do something useful.[1001]

Studies show, by and large, that Chochinov is right. Terminally ill patients are more likely to desire death when they feel abandoned and without care.[1002] For example, studies report that a positive relationship with an oncologist is more protective against suicidal ideation than

[998] (Chochinov, 2024b)
[999] (Chochinov, 2023c, pp.2885-2886)
[1000] (Saunders, 2006, p.31)
[1001] Personal records
[1002] (Allebeck & Bolund, 1991; Chochinov et al., 1995)

psychotropic medications and mental health interventions.[1003] A plethora of studies show that family support, relational connection, and sustained quality connections with physicians can help alleviate suffering at the end of life.[1004]

Chochinov concludes, "While trying to fix what is intrinsically broken can leave health care professionals feeling helpless and like they are failing, intensive caring provides an opportunity to target achievable goals, focused on myriad ways of affirming that patients matter."[1005] In short, intensive caring turns attention from uncertainty towards action by changing the focus from that which cannot be fixed towards what we can do, i.e., affirming to patients that their presence matters.

However, sometimes in the face of the incurable and unanswerable, this does not feel like enough. Sometimes, there is no guarantee that non-abandonment will be accepted or appreciated. Sometimes, well-intentioned affirmation and relinquishment of the need to fix can unintentionally make things worse. In Chapter 1, I discussed the uncertainty of applying generalized RCT studies to individuals. It may be true that, in general, intensive caring can help alleviate suffering, but that does not guarantee that this will be the case in *this* interaction, with *this* patient*, this* person. Uncertainty remains. Lucky are the people who come to their dying and have a community of support or even access to palliative care.[1006] And lucky are those whose lives have not damaged them so much that they are still able to take the hand that reaches out to them and accept care. It can be challenging to deal with rude, ungrateful, and difficult patients, and palliative care staff can struggle when it seems that a person is not dying a "good death." It is great when it looks like a good death, and everybody in the room has

[1003] (Trevino et al., 2014)
[1004] (Chochinov, 2022a, 2023c, 2024a)
[1005] (Chochinov, 2023c, p.2886)
[1006] (Baruth, Geske, & Lapid, 2024; Sítima, Galhardo-Branco, & Reis-Pina, 2024)

acceptance and peace. Palliative care physicians need skills to act when it is not neat and when patients die, taking their loose ends with them.[1007] Pragmatism takes pluralism, and all its loose ends, as a serious hypothesis. James writes, "I find myself willing to take the universe to be really dangerous and adventurous, without therefore backing out and crying 'no play'…I am willing that there should be real losses and real losers, and no total preservation of all that is."[1008] This is part of the uncertainty. Like our patients, physicians act without guarantee. Intensive caring requires courage. Here, James' "faith ladder" can help inspire courage to act in the midst of such uncertainty.

James' Faith Ladder

In an interesting turn, James couples faith not with certainty but with uncertainty. In James' philosophy, faith is a risk—a working hypothesis upon which one acts.[1009] In "SoR," James writes,

> Faith means belief in something concerning which doubt is still theoretically possible; and as the test of belief is willingness to act, one may say that faith is the readiness to act in a cause the prosperous issue of which is not certified to us in advance. It is in fact the same moral quality which we call courage in practical affairs.[1010]

In the paragraph above, James attributes three elements to faith: uncertainty, since faith is "belief in something in which doubt is still possible;" action, as faith is a readiness to act though the outcome "is not certified in advance;" courage, since faith is a "moral quality which we call courage in practical affairs." In uncertainty, faith turns attention towards action and courageously lives with uncertainty. The movement that I have returned to repeatedly in the

[1007] Personal records, discussion with Mary Miller, Consultant in Palliative Medicine, Oxford University Hospital NHS. See (Sulmasy, 2010)
[1008] (James, 2008ai, p.142)
[1009] (James, 2008ao, p.79)
[1010] (Ibid., p.76)

dissertation—starting in uncertainty, turning to action, living courageously with uncertainty—is derived from James' ladder of faith.

James' faith ladder is complex and interwoven with the larger vision of his pragmatism. The ideas of the ladder are dispersed throughout his work, and he discusses it explicitly in multiple places in his corpus. It appears in early, middle, and late writings such as "Reason and Faith," "Faith and Right to Believe," "WtB," "SoR," *PU,* and in the last appendix of the last book he was writing at the time of his death, *Some Problems in Philosophy.*[1011] James' faith ladder takes the following form in *PU.*

> A conception of the world arises in you somehow, no matter how. Is it true or not? you ask.
> It *might* be true somewhere, you say, for it is not self-contradictory.
> It *may* be true, you continue, even here and now.
> It is *fit* to be true, it would be *well if it were true,* it *ought* to be true, you presently feel.
> It *must* be true, something persuasive in you whispers next; and then—as a final result—
> It shall be *held for true,* you decide; it *shall be* as if true, for *you.*
> And your acting thus may in certain special cases be a means of making it securely true in the end.[1012]

Notice that uncertainty is at the first rung of the ladder. The faith ladder begins with a question and considers the probability that something might be true. As one moves up the ladder, attention is turned from uncertainty towards action. Certainty is not the final rung of the ladder. The final rung, the best that can be done, is to act in courage. James writes, "Reason claims certainty and finality for her conclusions; faith is content if hers seem probable and practically wise."[1013] Briefly, I comment on the steps.

[1011] (James, 2008k, p.415; 2008ag, p.148; 2008am, pp.125-126; 2008ao, p.80; 2008ap, p.113; 2008ax)
[1012] (James, 2008ag, p.148)
[1013] (James, 2008am, p.125)

"Is it true or not? you ask."

The ladder starts in uncertainty.

"It *might* be true somewhere, you say, for it is not self-contradictory."

The faith ladder is not a license to believe anything.[1014] For James, reality, though it can be construed in a plurality of ways, constrains the hypotheses that can be successfully made about it. James uses the analogy of beans spilled on a table. The beans can be organized in many ways (by color, shape, size, texture), but the beans themselves resist certain types of organization.[1015] The world is not infinitely plastic, but "fits the beans," or "beings."[1016] As James makes clear in "WtB," the faith ladder applies to situations of probabilities in which the evidence is ambiguous, inconclusive, and underdetermined, but not impossible.[1017]

It *may* be true, you continue, even here and now.

In "WtB," James refers to this "*may*" as a "live hypothesis," one that seems likely not only in general but *to the one whom it is proposed.*[1018]

[1014] (James, 2008ab)
[1015] (James, 2024, pp.410-411)
[1016] (H. Putnam, 2024, p.xxxvi)
[1017] (Clark, 1990, pp.106-107)
[1018] (James, 2008ax, p.14)

It is *fit* to be true, it would be *well if it were true,* it *ought* to be true, you presently feel.

James proposes that in the psychology of human opinion, our passional and volitional nature (our fears, hopes, desires, values, and temperaments) lie at the root of our convictions.[1019] He argues that in genuine options that cannot be determined on intellectual grounds, the passional nature not only *may* but *must* decide between options.[1020]

It *must* be true, something persuasive in you whispers next; and then—as a final result—

Rationality, James writes, "has at least four dimensions, intellectual, aesthetic, moral, and practical."[1021] The decision "it must be true" is not just due to the persuasion of intellectual faculties from a chain of inferences but is a result of rationality considered broadly by a whole and dynamic person—body, mind, self in relation to a larger community, passional nature, and all.

It shall be *held for true,* you decide; it *shall be* as if true, for *you.*

This final step of the ladder is the turn to action in uncertainty. "Reason and Faith" describes this step by saying, "I will treat it as if it *were* true so far as my advocacy and actions are concerned."[1022] Faith, here, is a willingness to act even though doubt is still possible and the outcome is not certified in advance. The uncertainty of the backwards-looking question, 'is it true?' is replaced by the action of the forwards-looking answer; 'I shall act as though it were true, I shall act to make it true.'

[1019] (Ibid., p.15)
[1020] (Ibid., p.20)
[1021] (James, 2008ag, p.55)
[1022] (James, 2008am, p.125)

What is at stake here, for James, is living. Most of life is lived on this "slope of good-will."[1023] The faith ladder is, in James' words, "life exceeding logic."[1024] "Real life laughs at logic's veto."[1025] His reply to those who demand certainty before action is that a rule which forbids us to act beyond evidence forbids us to live at all.[1026] As he writes in "ILWL," "not a deed of faithfulness or courage is done, except upon a maybe...It is only by risking our persons from one hour to another that we live at all."[1027] Climbing the ladder requires courage, and this courage to act is courage to live with uncertainty.

The last two words of James' final rung, "*for you*," are important. The person who walks up the faith ladder is kept in clear sight. The ladder is not the ascension of an idea or conclusion of a chain of inferences, but it is ascended by an agent who is actively involved in the ascent. As we climb, our persons and faith play active roles in the creation of results, and our persons are involved in the risk.

> And your acting thus may in certain special cases be a means of making it securely true in the end…

This last statement develops the notions that our actions in faith can be vital and formative factors in the character of the world we create, and that our persons are involved in the risk. With regard to the first point, James explains that there may be situations in which faith (a person's willingness to act courageously despite uncertainty) may help to create the possibility of the reality that person assumes.[1028] He writes in the "SoR,"

[1023] (James, 2008ap, p.113)
[1024] (James, 2008ag, p.148)
[1025] (Ibid., p.115)
[1026] (James, 2008am, p.126)
[1027] (James, 2008q, p.53)
[1028] (James, 2008ao, p.76)

> Now I wish to show what to my knowledge has never been clearly pointed out, that belief (as measured by action) not only does and must continually outstrip scientific evidence, but that there is a certain class of truths of whose reality belief is a factor as well as a confessor; and that as regards this class of truths, faith is not only licit and pertinent, but essential and indispensable. The truths cannot become true till our faith has made them so.[1029]

In a certain class of truths, faith is essential because, in truths dependent on personal actions, faith in a fact can help to create that fact.[1030] In "WtB," James expands on this idea by pointing to personal relations as an example of this class of truths.

> [Consider] questions concerning personal relations…*Do you like me or not?*—for example. 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, until you shall have done something apt…ten to one your liking never comes.[1031]

Personal relations require a willingness to act in advance of conclusive evidence, with faith playing a role in bringing into being the very possibilities upon which it acts. In "WtB," James applies the faith ladder to religion by suggesting that the "eternal aspect of the universe is represented in our religion as having a personal form."[1032] His interest in panpsychism and later writings hint that personal relations and intimacy may be analogous to our relations with the world itself.[1033]

[1029] (Ibid., p.80)
[1030] (James, 2008ax, p.29)
[1031] (Ibid., pp.28-29)
[1032] (Ibid., p.31)
[1033] (Gale, 1999, p.252; James, 2008an, pp.101-106; 2008ax, p.3; Lamberth)

Though called the faith ladder, it is not just a method of religion or metaphysics, but also a method of science, beginning with the probability that a hypothesis might be true, and acting on that hypothesis to test the results. James points out that some hypotheses can be refuted in five minutes, while others, such as the morality of the universe, may take generations and ages.[1034]

Furthermore, in some hypotheses, such as evolution, we are not just observers; we ourselves are part of the experiment and contribute to the shape it takes by the actions we make and risks we take.[1035] With regard to the point of personal risk, James' faith ladder preaches courage, but it is "courage weighted with responsibility." He prefaces his book, *The Will to Believe and Other Essays,*

> What *should* be preached is courage weighted with responsibility—I do not think that anyone can accuse me of preaching reckless faith. I have preached the right of the individual to indulge his personal faith at his personal risk. I have discussed the kinds of risk; I have contended that none of us escape all of them; and I have only pleaded that it is better to face them open-eyed than to act as if we did not know them to be there.[1036]

James' faith ladder emphasizes risk. It is not a probability ladder in which the probability increases at each rung (from possible, to unlikely, to 50:50, to likely, to most likely) as each step increases evidence and certainty.[1037] Only one of the steps pertains to probabilities. In the iteration of the faith ladder in *SPP,* James' primary interest in probabilities lies in how we act. James points out that whereas probabilities deal in fractions, sometimes one cannot act fractionally.[1038] In decisions that are "forced," it is functionally the same to withhold a decision

[1034] (James, 2008ao, p.79)
[1035] (Ibid., pp.81-82)
[1036] (James, 2008ay, p.8)
[1037] (Wernham, 1990, p.107)
[1038] (James, 2008ap, p.114)

as not to act at all.[1039] "Not to act on one belief, is often equivalent to acting as if the opposite belief were true."[1040] "Inaction also often counts as action."[1041] Whether one acts or withholds action, risk is inescapable.[1042]

James' applies his faith ladder to a range of metaphysical, religious, scientific, therapeutic, moral and existential questions.[1043] For instance, the essay "ILWL" seems to be structured according to the faith ladder, moving from questions to possibilities, probabilities, and desirability and concluding by advocating for a risk of action in faith.[1044] James also applies the ladder to questions such as "the *character* of the world, of life being moral in its essential meaning, of our playing a vital part therein."[1045] In faith he poses the character of the world to be neither pessimistic nor optimistic but melioristic; in faith he chooses to act on the hypothesis that this is a moral universe; in faith he believes that his small contribution might make a significant difference, in the way that a feather can tip the scale or the three small letters n-o-t can reverse a clause.[1046] This acting in faith contributes to the possibility of creating such a world. "[Faith] may be regarded as a formative factor in the universe, if we be integral parts thereof, and co-determinants, by our behavior, of what its total character may be."[1047] James turns his attention from uncertainty to action. He starts in uncertainty ("Is it true?") and courageously climbs the ladder: "I shall act and perhaps even in acting I will contribute to making it so."

[1039] (James, 2008ax, pp.14-15)
[1040] (James, 2008ap, p.112)
[1041] (Ibid., p.115)
[1042] (James, 2008ax, p.20)
[1043] (James, 2008ag, p.148; 2008ap, p.115)
[1044] (James, 2008q)
[1045] (James, 2008ap, p.115)
[1046] (James, 2008q, pp.54-55)
[1047] (James, 2008ap, p.113)

In “ILWL,” James applies the faith ladder to the pessimism of nihilism. In response to the question “Is life worth living?” he poses another question, ‘How will you act?’ He describes those who are overwhelmed by the suffering of the world and who, deeming futile all efforts to do anything, recognize that the suffering cannot be “fixed” and respond by abandoning the situation and removing themselves through suicide. To them James says, “If you surrender to the nightmare view and crown the evil edifice by your own suicide, you have indeed made a picture totally black. Pessimism, completed by your act, is true beyond a doubt, so far as your world goes.”[1048] In other words, you take your risk, add to the tragedy, and thus make it true.

James offers another way forward, in which a person indulges in the faith that life is worth living and plays their part in making it so. They stay in the face of the unfixable, holding faith in the possibility of that which is unseen and in the possibility of “unexpected life succeeding upon death.”[1049] Without a guarantee, they act as though it were true and cooperate with others, and even with God, to make a world in which life is worth living—adding to the moral quality of the world by their acts.

James’ answer to “Is life worth living?” is that “it depends on the liver.”[1050] In one sense, the answer is a joke as it refers to the liver organ—James explains that an ill-balanced constitution can dispose some to melancholy. Yet for James, this was not a laughing matter. James was of this ill-balanced constitution, temperamentally disposed to despair to the extent that he suffered crippling depression and contemplated suicide. Following the faith ladder, he believed in free-will by faith. He reasoned that it was possible that his actions were not entirely determined by his biological and psychological constitution. It may be true; it would be fitting to be true.

[1048] (James, 2008q, p.54)
[1049] (James, 2008q, pp.48-56; 2008am, p.127)
[1050] (James, 2008q, p.36)

Belief in free-will, to him, meant that he was not destined to succumb to his melancholic constitution.[1051] It must be true. It ought to be true. He could succumb to the pessimism of the world by ceding to it and crowning the surrender with suicide, or by faith believe that there was more than what was biologically determined, that there existed a world of unseen possibilities in which actions contributed to the making. In James' "spiritual crisis," he concluded that he would act as though it were true. For James, the question "Is life worth living?" was not just a metaphysical or existential inquiry but a moral imperative. His answer, "It depends on the liver," does not just refer to the organ but also to the person doing the living, emphasizing the formative role of our actions in contributing to the creation of the answer.

James' faith ladder also expands beyond the individual. The iteration of the faith ladder in *SPP* places emphasis on the *social* role of faith in contributing to a melioristic world (as opposed to *personal* salvation or therapy).[1052] Meliorism is conceived in a social analogy and is thus dependent on trusting a plurality of independent powers to cooperate and contribute their part.[1053]

> It may be true that work is still doing in the world-process, and that in that work we are called to bear our share. The character of the world's results may in part depend upon our acts...on our not-resisting our faith-tendencies, or on our sustaining them in spite of 'evidence' being incomplete. These faith tendencies in turn are but expressions of our good-will towards certain forms of result[1054]

> …We can *create* the conclusion, then. We can and we may, as it were, jump with both feet off the ground into or towards a world of which we trust the other parts to meet our jump—and *only so* can the *making* of a perfected world of the pluralistic pattern ever take place. Only through our precursive trust in it can it come into being…[1055]

[1051] (Kaag, 2020b, pp.42-67; Sutton, 2023, pp.13-45)
[1052] (James, 2008ap, p.xxxiv)
[1053] (Ibid., p.115)
[1054] (Ibid., p.112)
[1055] (Ibid., p.116)

Earlier, I referenced personal relations as an example of a class of truths dependent upon faith and personal actions. Acting in the uncertainty of personal relations takes on a new significance in the context of social meliorism, in which the world that is created depends upon the trust that the other parts "meet our jump." James' faith ladder expands into medicine too—especially in the context of personal relations and social meliorism. In medicine, "possibilities, not finished facts, are the realities with which we have actively to deal," not just individually but also collectively.[1056] In the following section, I show an application of this faith ladder to intensive caring in regard to the uncertainty of personal relations and social meliorism.

I note first, however, that the faith ladder is not without its critics. For example, Wernham argues that the ladder is descriptive, not prescriptive.[1057] Others point to the differences between acquiring, entertaining, and accepting beliefs, as well as differences between beliefs, hypotheses, and decisions.[1058] Accusations against James' *Pragmatism* and "WtB" are directed towards the faith ladder as well.[1059] These characterize James as sanctioning belief in whatever is desirable or useful. James replies to many of these mischaracterizations in *The Meaning of Truth*.[1060]

My interest is less in the criticisms; what is clear is that insofar as James applies the faith ladder to personal relations and the belief that one's actions can be a vital and formative factor in the character of the world we create, the ladder can be useful for medicine. Critiquing the faith-ladder, GE Myers says that it looks less like an argument and "more like a pep talk in preparation for a gamble."[1061] The faith ladder can be more than a philosophical concept—it

[1056] (James, 2008q, pp.54-55)
[1057] (Wernham, 1990)
[1058] (Wernham, 1990) references Schiller (I. K. Skrupskelis, 1977, p.95)
[1059] (Miller, 1975)
[1060] (James, 2008ab)
[1061] (Myers, 2001, p.460)

can serve as a pep talk, offering encouragement and inspiring courage in a life lived amid probabilities. That, I believe, is its strength. In the following section, we "climb" the faith ladder in terms of the story of intensive caring with which this case began.

Climbing the Ladder of Intensive Caring

As stated in the introduction of this case, Chochinov's model of intensive caring is an approach to medical care that "reminds patients that they matter." James' faith ladder reminds physicians that, in the face of problems that are beyond fixing, their presence matters too.

> Is it true?

The ladder starts in uncertainty. Imagine entering the room of the man with terminal brain cancer who wants to end his life. Walking into a patient's room has been likened to being "blindfolded and parachuted into the middle of a crowded market square in some part of the world that you know nothing about."[1062] Who is this man who says his life is futile? What life has he lived, in which this moment is only a glimpse, the crossing of one point in a stream and larger network of relationships? He says his life is futile and that he wants to die. How will you help him? On difficult conversations, Chochinov writes,

> One cannot entirely predict how these difficult conversations will go. Will the patient or their family become inconsolably distraught? Will someone try to hijack the agenda? Will anger, pain, and confusion derail the process entirely? Will everyone understand the information being provided, allowing for decision-making that will lead to the best quality-of-life outcomes? Despite these unknowns, in order to enter into such a clinical encounter, one needs to give up the idea of having total control of the outcome.[1063]

[1062] (Chochinov, 2022a, p.76)
[1063] (Ibid., p.89)

Reading the quote above, it is no wonder that James uses personal relations as an example of courage to act in faith in the midst of uncertainty.[1064] The tasks of therapeutic humility and therapeutic presence are daunting and uncertain. Based on study of healthcare communication, Chochinov includes in the domain of therapeutic humility, "don't avoid emotion," "explore difficult topics," "accept and honor the client as expert," "trust in process," "sit with the client in emotional distress," "avoid the urge to have to fix."[1065] Even if one does take the risk, is it true that presence and non-abandonment with *this* patient will really make a difference? Will it be worth the time, resources, and energy even in a futile and unfixable situation? Many stop on this rung of the ladder.

> It *might* be true somewhere, you say, for it is not self-contradictory.

Is it possible? Yes, it is not an impossibility. Chochinov's research suggests that intensive caring can and does make a profound impact. There are many testimonies of the differences that have been made by therapeutic presence and non-abandonment in the experience of patients whose situations seemed hopeless.[1066] Studies suggest that even unconscious, comatose patients can recognize presence, and testimonies of near-death experiences suggest that far more is occurring than we might realize even after death.[1067] Empirical research demonstrates that the difference made by non-abandonment is not merely possible, but indeed probable. To cite just a few findings: one study found that women with incurable breast cancer felt that reassurance of non-abandonment decreased their uncertainty and anxiety and helped them maintain realistic hope.[1068] Another study reported that seriously ill patients and their

[1064] (James, 2008ax, pp.28-29)
[1065] (Chochinov et al., 2013, p.1707)
[1066] (Chochinov, 2022a; Quill & Cassel, 1995)
[1067] (Allison, 2022; Bennett & Bennett, 2000; James, 2008aw; Lawrence, Ramirez, & Bauer, 2023)
[1068] (Van Vliet, Van Der Wall, Plum, & Bensing, 2013)

families highly valued physician accessibility and continuity of care and regarded relationships as essential to quality end-of-life care.[1069] Literature reviews demonstrate that isolation correlates with a desire for death and that presence can decrease patient existential and spiritual distress.[1070] Some researchers go so far as to argue that non-abandonment is an ethical obligation of physicians.[1071]

It *may* be true, you continue, even here and now.

But what about here? What about now? What about *this* patient with incurable brain cancer, who feels like a burden to the healthcare team, struggles with self-loathing, has had a difficult life of bipolar disorder, poly-substance abuse, relational estrangement, and believes his life is futile? The patient is complaining about the medical system and berating you, saying that all your attempts to help him are futile. What about *this* interaction and all its unique contextual variables? The answer is maybe. It *may* be true, even here. In the words James uses in "WtB," it becomes a live hypothesis.

It is *fit* to be true, it would be *well if it were true,* it *ought* to be true, you presently feel.

What if there is a way to hold or "contain hope" for this hopeless patient: to provide psychological, spiritual, and physical comfort; to help him find meaning and purpose, even reconciliation; and to care for him even when he no longer cares about himself?[1072] What if taking an interest in him as a person by listening to the stories of the origins of his self-loathing; showing ongoing support and continuing to meet with him despite the fact that nothing seems

[1069] (Curtis et al., 2001)
[1070] (Boston, Bruce, & Schreiber, 2011)
[1071] (Quill & Cassel, 1995)
[1072] (Chochinov, 2023c, p.2884)

to change; sitting with him in uncomfortable emotions and unfixable situations; or a compassionate, respectful, genuine, fully present tone of care, could actually affirm to him that he matters?[1073] "It would be well if it were true."

It *must* be true, something persuasive in you whispers next; and then—as a final result—

It must be true. This is the conclusion of Saunders: "You matter because you are you. You matter to the last moment of your life, and we will do all we can to help you not only to die peacefully, but also to live until you die."[1074] The conclusion is more than intellectual; it is also aesthetic, moral, and practical.[1075]

It shall be *held for true,* you decide; it *shall be* as if true, for *you.*

This final step of the ladder is the turn to action in uncertainty. In the case, Chochinov turned to action in uncertainty by being with this patient even though the outcome was not certified in advance. He declined this man's wish to hasten his death, promised to support him in any way he could, met with him weekly or biweekly, invested in learning more about who he was, listened to his complaints, and maintained a dignity-affirming tone of care and therapeutic presence to the best of his ability.

In the most literal sense, Chochinov's therapeutic presence with the patient was a turn to action. He did not respond to statements such as "I am worthless, my life is futile, I am just a burden" with quick cliches, attempts at intellectual refutation, or by emotional collusion with the

[1073] (Ibid., p.2885)
[1074] (Saunders, 2006, p.137)
[1075] (James, 2008ag, p.55)

hopelessness.[1076] He did not reply, for instance, "life is what you make it," or "your family doesn't think you are a burden," or "yes, your life is futile because you feel it is so." Chochinov's actions spoke louder than words. He acted as though this patient mattered. Leaning in, listening in attention, his tone of care, his embodied presence was an answer—if this man truly was worthless, if helping him was futile, if he was just a burden, why would Chochinov act this way? His answer was embodied, and his actions communicated something deeper than words.

Outwardly, being with this patient did not "look" like it was doing or fixing anything. The patient himself complained of the futility. Yet, when Chochinov suggested terminating the meetings, the patient's response revealed that this being with was doing more than it seemed. "These appointments are the only thing that keep me going." In response to the question, "Will presence and non-abandonment with *this* patient really make a difference?" Chochinov's answer was to *act* as though it could. His intensive caring was a turn to action in uncertainty and, in this case, affirmed to this man that he mattered.

> And your acting thus may in certain special cases be a means of making it securely true in the end.[1077]

Chochinov's research on dignity shows that a perceived loss of dignity, the belief that one does not matter, is strongly associated with a desire to die.[1078] Furthermore, it shows that a large determinant of a patient's self-perceived dignity is how others see them.[1079] It is not uncommon for patients at the end of life to feel like a burden (even when those caring for them reassure

[1076] (Chochinov, 2023c, p.2886)
[1077] (James, 2008ag, p.148)
[1078] (Chochinov et al., 2002; Van der Maas et al., 1991)
[1079] (Chochinov, 2004)

them that they are not).[1080] If treated like a burden, patients believe this to be even more true about themselves.[1081] If those who care for them do so in a way that does not acknowledge their personhood, it communicates that who this person is does not matter. How we, as physicians, see and treat a patient affects how they see and value themselves. In a pithy phrase, Chochinov captures the idea with the phrase, "dignity is in the eye of the beholder."[1082] Furthermore, Chochinov's research shows that the "beholder" is not just patients' families and communities but also includes healthcare providers. In the case of dignity, acting as though a patient matters can help to make it true, or at the very least, help a patient to believe it to be true to the end. The conclusion of the faith ladder, then, seems the most logical: "I will treat it as if it *were* true so far as my advocacy and actions are concerned and acting thus may make it true in the end." In Chochinov's words, "…Dignity? Dignity!"[1083]

Let us return to Saunders promise, "You matter because you are you. You matter to the last moment of your life."[1084] To the patient who has lost a sense of dignity and has a desire to die, this promise ends with a question mark. The clause is uncertain. Saunders replaces the question mark with a full stop. She turns to action, to doing "all we can to help you not only to die peacefully, but also to live until you die." She acts as though this person matters. She takes the risk of intensive caring. Doing so affirms to the patient that it really could be true. Empirical data shows that such affirmation of dignity is protective against a desire to die and can play a formative role in both quality and duration of life, helping a person to live until they die.

[1080] (Gudat, Ohnsorge, Streeck, & Rehmann-Sutter, 2019; Leroy, Fournier, Penel, & Christophe, 2016; Rodríguez-Prat, Balaguer, Crespo, & Monforte-Royo, 2019)
[1081] (Chochinov, 2022a, p.146)
[1082] (Chochinov, 2004)
[1083] (Chochinov, 2008)
[1084] (Saunders, 2006, p.137)

James, however, does not preach a reckless faith. Likewise, Chochinov does not advocate for reckless intensive caring. Therapeutic presence does not mean simply sitting in a room for an hour or increasing the frequency of patient visits. Chochinov's research shows that what matters most in dignity-affirming care is not necessarily the amount of time spent with the patients (time of care) but the way in which that time is spent (tone of care).[1085] There is a vast body of empirical research on the skills necessary for therapeutic presence and non-abandonment.[1086] However, even armed with such skills (and backed by good intentions), mistakes will be made. James' fallibility and Chochinov's therapeutic humility are essential. Medicine acts on probabilities, and mistakes are inevitable, but the dynamicness of life and relationships means that mistakes may not be the end of the story.

Even without mistakes, there is no guarantee that the patient will accept the affirmation that they matter. Sulmasy writes,

> …Giving someone the freedom to die in the belief that life has no intrinsic value, the universe is absurd, and there are no right relationships can be very painful. Caring for such patients can be particularly difficult…Yet one can still believe in that dying patient's dignity; hold out hope for that patient; and remain steadfast in the belief that a compassionate, loving, patient-professional relationship has a transcendent term, even if the patient never acknowledges that any of this might be true.[1087]

The patient's faith that they do not matter, alongside the physicians' faith that they do, are personal risks upon which each acts—cast in the universe as hypotheses, whose true natures will be known only in the long run and on the whole.[1088]

[1085] (Chochinov, 2007; Chochinov et al., 2013; Twycross, 2022a, p.10)
[1086] (Chochinov, 2007; Chochinov et al., 2013)
[1087] (Sulmasy, 2006b, pp.210-212)
[1088] (James, 2008ai, p.106)

Sometimes healthcare can tend towards therapeutic nihilism, especially when our assumptions about what types of lives are worth living are projected onto patients[1089] and when patients themselves feel hopeless.[1090] When unable to find a clinical path forward, clinicians can be drawn into therapeutic nihilism, and patient abandonment can be a way to avoid feelings of helplessness and impotence.[1091] To the question "is intensive caring worth doing?' the answer is also, "it depends on you, the liver." [1092] How will you act? What kind of healthcare system will your actions help create? Here, the social meliorism of James' faith ladder has profound implications.

Is intensive caring worth doing? Imagine acting as though it is not. Deem it not worth the time or effort. Design healthcare systems that do not support intensive caring in practice as they are driven by values of "competition, rationalization, productivity, efficiency, and even profit."[1093] Affirm it with lip service rather than service resources. Contribute to a culture in medicine that fails to acknowledge the personhood of patients and communicates—through actions—that who a patient is as a person does not matter. Such loss of dignity contributes to a wish for death. Then, offer death as a solution to "fix" suffering. Is intensive caring worth doing? Imagine acting as though it is. Create healthcare systems that value it, allocate time and resources to it, reward it, reimburse it, promote it, and teach it. We take a risk.

James writes that "the character of the world's results may in part depend upon our acts" and "that in that work we are called to bear our share." The word "share" is a key for James. The task of intensive caring is not solely for the individual physician but requires the cooperation

[1089] (Chochinov, 2022b, 2022c)
[1090] (Chochinov, 2022a, p.C3.P57; 2022b; James, 2008ad)
[1091] (Chochinov, 2024b)
[1092] (James, 2008ap, p.113)
[1093] (Twycross et al., 2021, p.12) cites (Youngson & Blennerhassett, 2016)

of individuals, systems, and communities—effecting change both top-down and bottom-up.[1094] James would say that this, too, requires faith that such change is possible, even here and now, desirable, ought to be, must be, and shall be made true by our actions, as we act together courageously in the uncertainty of intensive caring.

At times, the relational elements of intensive caring cannot be seen as easily as the transactional elements of care. James explicitly states that one of his goals in "ILWL" is to make those who are listening feel that they have a right to believe in that which is unseen, especially if assuming it on faith helps make their lives worth living again.[1095] He ends his speech,

> But will our faith in the unseen world similarly verify itself? Who knows? Once more it is a case of *maybe;* and once more *maybes* are the essence of the situation…For my own part, I do not know what the sweat and blood and tragedy of this life mean, if they mean anything short of this. If this life be not a real fight, in which something is eternally gained for the universe by success, it is no better than a game of private theatricals from which one may withdraw at will. But it *feels* like a real fight—as if there were something really wild in the universe which we, with all our idealities and faithfulnesses, are needed to redeem; and first of all, to redeem our own hearts from atheisms and fears. For such a half-wild, half-saved universe our nature is adapted…For here possibilities, not finished facts, are the realities with which we have actively to deal; and to quote my friend William Salter, of the Philadelphia Ethical Society, "as the essence of courage is to stake one's life on a possibility, so the essence of faith is to believe that the possibility exists." These, then, are my last words to you: Be not afraid of life. Believe that life *is* worth living, and your belief will help create the fact…[1096]

Will faith in intensive caring verify itself? Both individually and collectively, as a healthcare system, it takes courage to stake risks in the possibility of intensive care. James' faith ladder is a call to act courageously in uncertainty.

[1094] (Chochinov, 2022a)
[1095] (James, 2008q, p.49)
[1096] (Ibid., pp.55-56)

Conclusion

As is the pattern of these cases, the answer to the question, “Is intensive caring worth doing?” starts with uncertainty. The person who seeks to answer the question must climb James’ faith ladder by turning attention from uncertainty to action in the domain of personal relations. I emphasized a social meliorism rooted in communal action, courageously living with uncertainty and co-creating intensive caring that is truly worth doing. Part III continues this communal theme and discusses the role of relationships in the palliation of uncertainty.

PART III

LIVING WITH UNCERTAINTY

4

The Anaesthetic Revelation

"*All these essays call for the Anaesthetic revelation—the insight that Mystery —THE MYSTERY—as such, is the final, the hymnic word.*"

James, quoting a letter from Benjamin Paul Blood[1097]

Introduction

Part III: Living with Uncertainty seeks a place that acknowledges uncertainty and enables a meaningful life. In Chapter 3, I summarized James' pragmatism as turning attention from uncertainty to action and explained the notion of a relational fringe around the focus. If Part I focused on uncertainty, and Part II focused on action, then Part III is focused on the relational fringe surrounding actions of care.

At the center of this chapter is James' reflection on the "anaesthetic revelation" as outlined in "A Pluralistic Mystic (PM)." This image of the anaesthetic revelation brings together the three themes of this dissertation: managing expectations (embracing the uncertainty inherent in life's mysteries); turning attention to action (recognizing the ability to act in relation to that which is not fully understood); and living with uncertainty (through relationship with others). In short, James advocates for a disposition towards uncertainty that parallels a religious/spiritual approach to the mystical, one that is relational and humbly open to mystery.

[1097] (Blood, 2008, pp.199-200; James, 2008af, p.187)

The Anaesthetic Revelation: A Pluralistic Mystic

Anaesthesia palliates pain and is a well-established tool of palliative care.[1098] The medical use of anaesthesia developed significantly in Jame's lifetime and his work includes multiple references to it—from his early work, "Rationality, Activity and Faith," written in 1879, to "PM," written in 1910.[1099] In "PM," James describes what he calls the "anaesthetic revelation."[1100]

"PM" was James' last work, published only a month before his death. Struggling with exacerbations of chronic heart problems, angina, dyspnea, anorexia, and fatigue, James knew that his time was short.[1101] This last essay was a review of the work of Benjamin Paul Blood, a little-known philosopher, self-proclaimed mystic, and long-time friend.[1102] On June 29th, 1910, James wrote in a letter that this essay on Blood would be his last, and in his last weeks of life, James' correspondences make numerous references to it.[1103]

James introduced his review of Blood's work with a startling comment, "[Blood's] philosophy, however mystical, is in the last resort not dissimilar from my own."[1104] To James' knowledge, most records of mystical experiences tended towards monism. He was struck by Blood's work because he found in Blood's anaesthetic revelation a mysticism of a pluralistic type.[1105] Upon reading Blood's work, James writes, "I feel now as if my own pluralism were not without the kind of support which mystical corroboration may confer. Monism can no longer claim to be

[1098] (Lau, Flamer, & Murphy-Kane, 2020)
[1099] (James, 1882; 2008c, p.336; 2008af; 2008ak, p.749; 2008ao, p.73; 2008ar, p.119; 2008av, p.75; 2008aw, p.229) See (Sutton, 2023, p.3)
[1100] James' anaesthetic revelation has striking resemblance with the experiences of patients with Near-Death-Experiences (NDE). See (Allison, 2022; Fenwick & Fenwick, 2008; Greyson, 2021; Renz, 2015)
[1101] (Blood, 2008, pp.563-575)
[1102] (Boren, 1983, p.6)
[1103] (James, 2008t, p.573; 2008u, p.565)
[1104] (James, 2008af, p.174) For differences between Blood's philosophy and James' see (Barnard, 1997, p.34)
[1105] (Barnard, 1997, pp.29-34; Moon, Kuza, & Desai, 2018) Some suggest that Blood was not as pluralistic in his mysticism as James interpreted him to be (Bricklin, 2010, p.78).

the only beneficiary of whatever right mysticism may possess to lend *prestige*."[1106] In his youth, James left the Swedenborgian monistic mysticism of his father.[1107] In his last days, he returned to mysticism of a pluralistic sort and believed that Blood was, like himself, a pluralistic mystic.

The anaesthetic revelation is expressed well in the final paragraphs of "PM." These last paragraphs of James' last work seem an especially appropriate focus, as they provide a fitting summary of James' life and work.[1108] They are as follows (the quotations in the excerpt are James' quotations of Blood).

> "Certainty is the root of despair. The inevitable stales, while doubt and hope are sisters. Not unfortunately the universe is wild—game flavored as a hawk's wing. Nature is miracle all. She knows no laws; the same returns not, save to bring the different. The slow round of the engraver's lathe gains but the breadth of a hair, but the difference is distributed back over the whole curve, never an instant true—ever not quite."
>
> "Ever not quite!"—this seems to wring the very last panting word out of rationalistic philosophy's mouth. It is fit to be pluralism's heraldic device. There is no complete generalization, no total point of view, no all-pervasive unity, but everywhere some residual resistance to verbalization, formulation, and discursification, some genius of reality that escapes from the pressure of the logical finger, that says, 'hands off,' and claims its privacy, and means to be left to its own life. In every moment of immediate experience is somewhat absolutely original and novel. "We are the first that ever burst into this silent sea." Philosophy must pass from words, that reproduce but ancient elements, to life itself, that gives the integrally new. The 'inexplicable,' the 'mystery,' as what the intellect, with its claim to reason out reality, thinks that it is in duty bound to resolve, and the resolution of which Blood's revelation would eliminate from the sphere of our duties, remains; but it remains as something to be met and dealt with by faculties more akin to our activities and heroisms and willingnesses, than to our logical powers. This is the anaesthetic insight, according to our author. Let *my* last word, then, speaking in the name of intellectual philosophy, be *his* word:—"There is no conclusion. What has concluded, that we might conclude in regard to it? There are no fortunes to be told, and there is no advice to be given.—Farewell!"[1109]

[1106] (James, 2008af, p.173)
[1107] (Boren, 1983, p.8; Croce, 1995, pp.49-66; 1997)
[1108] (Moon et al., 2018, p.6)
[1109] (James, 2008af, pp.189-190)

From this anaesthetic revelation, I expand upon the three themes central to this dissertation: managing expectations, turning attention to action, and living with uncertainty. Each theme is to be examined in its own section.

The Anaesthetic Revelation: Managing Expectations about Uncertainty

The Mystery

The anaesthetic revelation begins with honesty about the uncertainty of life. Rather than cloaking uncertainty (in the sense of hiding it), James makes uncertainty pluralism's "heraldic cry." No view, no formulation captures reality. He calls it "not unfortunate" that the universe is "wild"—beyond understanding and control. "Certainty" he considers "the root of despair" because uncertainty is necessary for hope, novelty, and other goods—after all, "doubt and hope are sisters." James moves from uncertainty to mystery. He speaks about the inadequacy of words, a mystery "inexplicable to the intellect," "a silent sea" in which one must "pass from words" into "life itself," and live with questions unanswered and duties to be met with more than "logical powers." The anaesthetic revelation shows that for James, uncertainty is not always something to fight but can even be part of what makes life worth living.

In "ILWL," James suggests that the "entire vital function" of man—novelty, productivity, originality, victory, faithfulness, courage, generosity, scientific exploration, experimentation, and life itself—depends upon uncertainty.[1110] In some of his writings, James describes uncertainty with a negative valence, for instance, the terror of the mountain climber who is stuck on the ledge and must make a "terrible leap."[1111] Yet, he also describes uncertainty with

[1110] (James, 2008q, p.53)
[1111] (Ibid., p.53; 2008ax, p.33)

a positive valence, for instance, the joy of the climber who spends holidays in the mountains, exhilarated by the terrifying ledges. Borrowing from Hinton, James suggests that "[risks, exertions, pains] are the only things in which we rightly feel our life at all…So it is men engage in athletic sports, spend their holidays in climbing up mountains, find nothing so enjoyable as that which taxes their endurance…"[1112] Why choose uncertainty? In the words of philosopher Martha Nussbaum, "[uncertainty] is constitutive of what makes a human life beautiful or thrilling."[1113] However, in considering what makes life worth living, James moves further than uncertainty and goes into mystery.

Instilled in James' philosophy is a mystic religious/spiritual view, in which the heart of the world is mystery. Some might associate religion/spirituality with certainty and reference the subjective "certainty" of religious experiences that James discusses in *VRE.*[1114] *VRE a*lso reveals that a significant aspect of mystical faith and religious experience lies in accepting uncertainty as an inherent part of life—and in finding comfort and assurance within it, despite the inability to fully understand or control everything.

Contrasting rationalist certainty and the mystery of the anaesthetic revelation, James comments,

> …The contrast of the two securities, [Blood's mystery] and the rationalist's [certainty], is plain enough. The rationalist sees safe conditions. But Mr. Blood's revelation, whatever the conditions be, helps him to stand ready for a life among them…"Simply," he writes to me, "*we do not know*. But when we say we do not know, we are not to say it weakly and meekly, but with confidence and content…Knowledge is and must ever be *secondary*—a witness rather than a principal…Therefore mysticism for me!"[1115]

[1112] (James, 2008ao, pp.83-84)
[1113] (Nussbaum, 2001, p.53)
[1114] (Gale, 1999, p.259)
[1115] (James, 2008af, p.189) See (Blood, 2008, pp.199-200)

The mystery of Blood, the uncertainty of the anaesthetic revelation, did not promise security but offered James a way to stand ready for a life amidst uncertainty. With Blood James says, "Simply…we do not know." This honest acknowledgement of uncertainty is not weak and meek, but is confident because knowledge is secondary. In mysticism, there is an acknowledgement of mystery, yet also a turn to action and a call to live courageously with that which is beyond our understanding and control. For James, the universe, life itself, is a mystery but one which we can have relations with.[1116] He speaks of the universe in relational analogies of "intimacy" and "foreignness."[1117] Furthermore, this living with uncertainty is not held alone, but perhaps in relationship with something beyond ourselves.

James explains in *TTT&S* that one of the most effective ways to initiate change is through imitation and emulation of models.[1118] In the face of medical uncertainty, imagine being able to say 'we don't know' with the confidence and content of Mr. Blood. As models, I turn now to five practitioners who, in their own ways, embody that posture of humility and courage.

Joan Halifax, a Zen-Buddhist abbot, palliative care anthropologist, and hospice caregiver, has spent a lifetime alongside the dying. In her book, *Being with Dying,* she explains three tenets for being with those at the end of life. The first is that "being with dying" begins with "not-knowing." She writes, "In being with dying, we will encounter this not-knowing no matter how we try to map everything out or control it…This is the nature of dying: letting go into the

[1116] For James, the universe itself might be understood in analogies from personal relations (Gale, 1999, p.252; James, 2008an, pp.101-106; 2008ax, p.3).
[1117] (James, 2008ag, pp.16-19, 145)
[1118] (James, 2008ar, pp.38-40, 126)

unknown, casting off our mooring and opening to the vastness of who we really are."[1119] In short, being with dying is being with a mystery.

Daniel Sulmasy, a Franciscan friar and physician, argues that "health care is essentially paradoxical" and draws on resources of religion and spirituality to understand and engage with medicine's "paradoxes and mystery."[1120] In a paraphrase of Gabriel Marcel, Sulmasy says that a patient is not "a problem to be solved, but a mystery in whose presence the clinician is privileged to dwell."[1121] In some ways, holding uncertainty with our patients, recognizing and acknowledging without trying to resolve it, is like holding a silence—as mystics do.

Robert Twycross, a pioneer in the field of palliative care who worked with Saunders, likewise describes palliative care as a call into the unknown. In a reflection on decades of practice, he writes that his professional life as a palliative care specialist forced him "to move from certainty to paradox and doubt."[1122] He explains,

> Caring for the dying is…'extremely harrowing but very rewarding.' It is difficult but, paradoxically, there is generally a positive 'spin-off.' This helped me to appreciate that truth itself is paradoxical: Cross and Resurrection, suffering and joy, trouble and peace, doubt, and certainty. Another paradox: the end is always a new beginning. This is both liberating and threatening because I find that I am constantly being called into the unknown by the God who is all-knowing.[1123]

Monica Renz, a hospice psychotherapist and theologian who studies transitions in consciousness and experiences of those approaching death, writes,

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[1119] (Halifax, 2024, pp.1-2)
[1120] (Sulmasy, 2006b, pp.60-62) Some paradoxes Sulmasy lists include: tension between universal and particular; subjective and objective; infinite and finite.
[1121] (Sulmasy, 1997, p.180)
[1122] (Twycross, 2022b, p.1)
[1123] (Ibid., pp.2-3)

> The more we honor the lived life…and the greater our knowledge about the laws and workings of life near death, the greater our astonishment. In spite of everything we know about experiences approaching death, the event of death itself and afterlife remain secret[1124]…Those of us gathered at the deathbed remain behind in two ways: (1) we survive the deceased, and (2) even if we look toward the mystery, we cannot partake in it. And we are left to our sense of reality, which forbids ecstatic embellishment and reminds us of our limits and limitations. Yet we are also left astonished, marveling at what the dying, and their transition, teach us.[1125]

Matt Morgan, an intensive care doctor who cares for many at the end of life, calls "I don't know" the three most important words in medicine.[1126]

In "PM," James quotes a letter from Blood: "All these essays call for the Anaesthetic revelation—the insight that Mystery —THE MYSTERY—as such, is the final, the hymnic word."[1127] The anaesthetic revelation is one of mystery at the heart of all things—including the practice of medicine.

"Greater-goods" of Uncertainty

Literature on uncertainty in medicine tends to conclude by pointing towards the positive aspects of uncertainty.[1128] As a dissertation on palliation of the suffering of uncertainty, much of this text has focused on uncertainty's negative aspects, and it is worth taking a moment to acknowledge the positive roles that uncertainty plays in medicine.

[1124] (Renz, 2015, p.11)
[1125] (Ibid., p.116)
[1126] (Morgan, 2019, p.1)
[1127] (Blood, 2008, pp.199-200; James, 2008af, p.187)
[1128] E.g., (McCormick, 2002, pp.130-131)

For patients, uncertainty may be a source of hope.[1129] Prognostic uncertainty can be protective in allowing patients to "look on the bright side," [1130] and some patients may actively strive to increase prognostic uncertainty as a coping strategy.[1131] Qualitative studies of patient experiences of uncertainty in advanced illness reveal that uncertainty can be "a second chance at life."[1132] To quote some patients, "You take time to smell the roses,"[1133] "You become more appreciative of the little things in life."[1134] Even the "negative" states that are associated with uncertainty, such as anxiety, vulnerability, feelings of fear, and decision avoidance, can play important roles in promoting caution and preventing reckless decisions.[1135] Shared decision-making intentionally increases uncertainty in order to allow clinicians and patients to collaborate on the basis of potential risks, harms, and benefits.[1136] Diagnostician Jerome Groopman argues that suppression of uncertainty is a leading cause of clinical error. He recommends that skepticism and uncertainty be increased in order to counter cognitive bias and to prevent latching on to a diagnosis too quickly.[1137] Eivind Engebretsen and colleagues argue that uncertainty plays a crucial role in making clinical decisions and identify four aspects of uncertainty (imagination, reflective questioning, surprise, and critical judgment) that contribute to clinical reasoning.[1138] For physicians, uncertainty can elicit curiosity, which furthers research and professional satisfaction.[1139] Finally, uncertainty can evoke a sense of wonder and be part of what makes clinical work rewarding.[1140]

[1129] (Han, 2021, pp.5-6)
[1130] (Etkind et al., 2017, p.172)
[1131] (Han, 2016; Han, 2021, p.74; Helft, 2005; Innes & Payne, 2009; Lamont & Christakis, 2001)
[1132] (Fleury, Kimbrell, & Kruszewski, 1995, p.478)
[1133] (King, 1993, p.103)
[1134] (McCormick, 2002, pp.130-131; Nyhlin, 1990, p.1026)
[1135] (Han, 2021, p.90)
[1136] (Elwyn et al., 2014; Han, 2021, p.74)
[1137] (Groopman, 2008)
[1138] (Engebretsen et al., 2016)
[1139] (Han, 2021, pp.5-6)
[1140] (Petersen, 2014)

Han calls uncertainty a "precondition for a meaningful life"[1141] and explains its usefulness:

> Uncertainty, however, is not only constraining but liberating. It frees us from the tyranny of unrealistic expectations about the existence of singular, definitive answers, and our ability to find them. It increases, rather than decreases, the precision of clinical work by helping us know when to refocus our medical lens away from problems it lacks the resolution to address. How an individual dying person should confront the ponderous prospect of nonbeing is one such problem. Uncertainty enables us to let go of our blinding preconceptions and to simply be silent, open to new possibilities and experiences of meaning.[1142]

At times, reminders of the positive dimensions of uncertainty can offer significant comfort, reframing situations in meaningful ways and opening space for new perspectives. Yet, what about those who suffer because of uncertainty?

In the Introduction of this dissertation, I drew an analogy between problems of uncertainty in medicine and the problem of evil in the philosophy of religion. "*Evidential* problems of evil" consider whether the existence of evil is evidence against the existence of an all-loving, all-knowing, all-powerful God, and various "theodicies" provide theoretical answers to reconcile the existence of such a God with the existence of evil and suffering. One is that of a greater-good theodicy, in which the experience of the sufferer is outweighed by the benefits that suffering confers and by other goods in the universe that depend upon it. Some examples of greater-good theodicy are offered by Leibniz and FH Bradley, and James critiques them fiercely in the opening chapter of *Pragmatism*.[1143] "*Experiential* problems of evil" are more concerned with individual, personal experiences of suffering and the existential questions that suffering raises, such as, "Why did God allow this horrible thing to happen to me?" Answering

[1141] (Han, 2021, p.140)
[1142] (Han, 2016, p.573)
[1143] (James, 2008ai, pp.20-23)

this question with compelling evidential arguments of greater-good theodicy does not always help alleviate the concerns of the person who is suffering. If, for instance, God is supposedly allowing this suffering to enable growth in my character, I might rather choose not to have the growth in character. Also, as Stump points out, how can my suffering be justified on the basis that it provides benefit to someone else?[1144] I spoke of probabilities as miserable comforters in the context of uncertainty. There are likewise times when pointing to the "greater goods" of uncertainty can be a miserable comforter too.

James begins *Pragmatism* with a discussion of theodicy. He summarizes the history of philosophy as a clash between temperaments (those of rationalists and empiricists) and illustrates both in terms of the problem of suffering.[1145] Representing the rationalist, he quotes an excerpt from Leibniz's "charmingly written Theodicee,"

> The evil will appear as almost nothing in comparison with the good, if we once consider the real magnitude of the City of God…*a very few instances and samples suffice for the utility which good draws from evil.* Moreover, since there is no reason to suppose that there are stars everywhere, may there not be a great space beyond the region of the stars? And this immense space, surrounding all this region…may be replete with happiness and glory...What now becomes of the consideration of our Earth and of its denizens? Does it not dwindle…the evils may be almost-nothing in comparison with the goods that the Universe contains.[1146]

James' reply to Leibniz is that "no realistic image of the experience of a damned soul had ever approached the portals of [Leibniz's] mind…What he gives us is a cold literary exercise, whose cheerful substance even hell-fire does not warm."[1147] Dissatisfied with Leibniz's rationalism,

[1144] (Stump, 2010, p.13)
[1145] (James, 2008ai, pp.11-14)
[1146] (Ibid., p.18)
[1147] (Ibid., p.20)

James turns the problem of suffering into the hands of an empiricist, "Mr. Swift." Swift's realistic depiction of suffering is chilling.

> After trudging through the snow from one end of the city to the other in the vain hope of securing employment, and with his wife and six children without food and ordered to leave their home in an upper east side tenement house because of non-payment of rent, John Corcoran, a clerk, to-day ended his life by drinking carbolic acid. Corcoran lost his position three weeks ago through illness, and during the period of idleness his scanty savings disappeared. Yesterday he obtained work with a gang of city snow shovelers, but he was too weak from illness and was forced to quit after an hour's trial with the shovel. Then the weary task of looking for employment was again resumed. Thoroughly discouraged, Corcoran returned to his home late last night to find his wife and children without food and the notice of dispossession on the door.' On the following morning he drank the poison...[1148]

James' offers the philosophy of pragmatism as an option mid-way between rationalism and empiricism—remaining "religious like the rationalisms, but at the same time, like the empiricisms, [preserving] the richest intimacy with facts."[1149] Describing pragmatism, he writes, "You want a system that will combine both things, the scientific loyalty to facts and willingness to take account of them...and the old [religious/romantic] confidence in human values."[1150] Borrowing from James' quote above, when it comes to uncertainty in medicine, we also want an approach that can acknowledge the confusing, chaotic, concrete facts of experience while still supporting meaning and hope.[1151]

Heath quotes Nussbaum, echoing that "[Uncertainty] is constitutive of what makes a human life beautiful and thrilling."[1152] As a patient, I may think, "To hell with all the 'beautiful' or 'thrilling,' I just want life to be normal again and would be quite happy with something less

[1148] (Ibid., p.21)
[1149] (Ibid., p.17)
[1150] (Ibid., p.17)
[1151] (James, 2008aj, pp.6-7)
[1152] (Heath, 2014, p.2) quotes (Nussbaum, 2001, p.53)

thrilling." That uncertainty drives science or leads to a sense of wonder and awe, may be of little comfort to me when, as a last resort, I subject myself to the uncertainties of clinical trials and new treatments with unknown and unregulated side effects. As a patient, I could not care less whether uncertainty leads to new discoveries or makes a physician's job more enjoyable. I just want to feel less anxious and not fear the future. The brightly romanticized positives of uncertainty should not blind us to the suffering of those who, like the clerk in James' story, are "trudging through the snow from one end of the city to the other in the vain hope." However, neither should the darkly romanticized negatives of uncertainty blind us to the experiences of hope and meaning that uncertainty can also occasion. There is real hope, joy, opportunity, wonder, and intimacy, too.[1153] As James says of the anaesthetic revelation, "doubt and hope are sisters."[1154] Pragmatism meets a mixture of both needs.[1155]

Mishel, McCormick, Babrow, Brashers, Nanton, and others similarly argue that uncertainty is not inherently good or bad but that its effects are mediated by appraisals and responses to it.[1156] Han writes of the "dual, paradoxical nature of uncertainty" that produces "a variety of psychological responses both negative and positive..."[1157] Babrow says, "Uncertainty can be a door to hope, an opportunity or challenge, or a threat."[1158] McCormick suggests that "uncertainty can be transformed into an opportunity."[1159] For James, in the uncertainty of what the nature of uncertainty is, we can turn our attention to action. Uncertainty may be part of the suffering. How can we act to transform it into part of the healing, too?

[1153] (James, 2008ag, pp.19-22 ,145; 2008av, p.155)
[1154] (James, 2008af, p.189)
[1155] (James, 2008ai, p.17)
[1156] (Babrow et al., 1998; Brashers, 2001; Etkind et al., 2017, p.172; McCormick, 2002; Mishel, 1988; Nanton et al., 2016)
[1157] (Han, 2021, pp.5-6)
[1158] (Babrow et al., 1998, p.9)
[1159] (McCormick, 2002, p.130)

In regard to the problem of evil and suffering, James writes, "For a pragmatist, the problem of evil presents only as 'the practical problem of how to get rid of evil.'"[1160] Pragmatism, for instance, turns attention from the uncertainty of explaining "why" God allows suffering to what we can do to alleviate it and how we can live courageously with it. Saunders suggests something similar.

> Many things we see are hard to reconcile with our faith in a loving God. There is no complete or easy explanation but there are some clues to the full answer which we will find only in eternity…
>
> The fullest consideration of the problem of innocent suffering is given in the book of Job. Job was not given any answer to his questions, but instead was given a vision of God which silenced his asking. We are given the vision of Jesus, 'bearing our griefs and carrying our sorrows.' That vision brings us to the point where we change our questions. 'Why should this happen …?' changes to 'How can I help—with God's grace?' or 'What can I do in this situation—which He shares with me?'[1161]

Notice that Saunders begins by acknowledging uncertainty—there are "some clues," but the "full answer" is to be found only "in eternity," the long run, and on the whole. James writes that "the existence of evil forms a mystery"[1162] and Saunders echoes this comment through reference to the story of Job, who was given no "answer." She changes the question (changes attention) from the uncertainty of "why should this happen?" to action: "How can I help…What can I do in this situation?" Suffering and uncertainty may be mysteries, but they are mysteries into which we can still act. For Saunders, even this uncertainty is not a burden carried alone but shared with God and others.

[1160] (James, 2008ap, p.72)
[1161] (Saunders, 2006, p.135)
[1162] (James, 2008ao, p.34)

Living with uncertainty can make life "beautiful" and "thrilling,"[1163] but it can also be hard. And it is even harder alone. Listing positive aspects of uncertainty may not be enough; we may need each other to help create the positive possibilities that uncertainty holds.

The Anaesthetic Revelation: Turning Attention to Action

The anaesthetic revelation reveals a world which resists all formulations, escapes all logical categories, and is inexplicable by cognitive faculties. The first insight of the anaesthetic revelation is one of mystery. The second is that one can still act in the midst of that mystery.[1164]

The last lines of "PM" contain the suggestion that the mystery "remains as something to be met and dealt with by faculties more akin to our activities and heroisms and willingnesses, than to our logical powers." This can be a source of great hope: though the mystery may be less suited to "our logical powers," it can be met with our "activities and heroisms and willingness." We may still be able to act even while uncertainty remains unresolved, and sometimes, in a world more akin to our actions than to our logical powers, being able to act (even with the uncertainty unresolved) may be enough.

In *PU* and *SPP,* James revitalizes the age-old conundrum of Zeno's paradox—the race between Achilles and a tortoise. Theoretically, if the tortoise is given a head start in the race, Achilles will never overtake him because by the time he has travelled to where the tortoise was, the tortoise will have moved further. James says,

[1163] (Nussbaum, 2001, p.53)
[1164] James critiques Spencer's attempts to unify science and religion through mystery. For Spencer, mystery is a termination and closure, whereas for James, mystery and moreness draw us further into experience and action. (Carrette, 2013, pp.156-161)

> Give that reptile ever so small an advance and the swift runner Achilles can never overtake him, much less get ahead of him; for if space and time are infinitely divisible (as our intellects tell us they must be), by the time Achilles reaches the tortoise's starting-point, the tortoise has already got ahead of that starting-point, and so on ad infinitum, the interval between the pursuer and the pursued growing endlessly minute, but never becoming wholly obliterated.[1165]

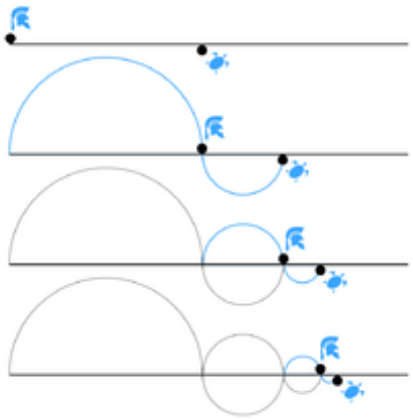

Figure 22) Zeno's paradox.[1166]

Drawing on the philosophies of Bergson and Fechner, James explains that our concepts, like Achilles in the paradox, jump along from one discrete point to another and lose the dynamic relations of experience. Explaining "why concepts are inadequate,"[1167] James says that when we substitute concepts for percepts, we replace dynamic relations of perceptual flux with static relations between concepts and turn dynamic relations to static concepts, which need further relations between them. The conceptual scheme consists of discontinuous terms, and from no amount of discreteness can you manufacture the continuous. "When you have broken the reality into concepts you never can reconstruct it in its wholeness…it slips through their

[1165] (James, 2008ag, p.102)
[1166] (Grandjean, 2014)
[1167] (James, 2008ap, pp.45-50)

intervals and is lost."[1168] James concludes, "We can see how great a number of the troubles of philosophy come from assuming that to be understood (or 'known' in the only worthy sense of the word) our flowing life must be cut into discrete bits and pinned upon a fixed relational scheme."[1169]

Conceptually, Achilles will never overtake the tortoise. But experience teaches that Achilles *does,* in fact, catch the tortoise. "Real life laughs at logic's veto."[1170] Unlike concepts, experience is not bound by discrete points; it is a continuous stream that ebbs and flows in dynamic relations and overflows concepts that cannot contain it. Concepts bound along the surface like the saltatory conduction of myelinated nerves. Two practical consequences follow. Since experience is more dynamic than concepts, problems arise which we never expected, but in the act of living, new solutions emerge that we could not have conceptually anticipated in advance.

James points out that it is in the living that the unsolvable conceptual problems lose their hold. "The immediate experience of life solves the problems which so baffle our conceptual intelligence."[1171] Expounding upon the philosophical vision of Bergson, he explains that "intellectualist conundrums" are solved by pointing back to our actual lived sense experiences. He says, quoting Bergson, "Lo, even thus; even so are these other problems solved livingly."[1172]

[1168] (James, 2008ag, pp.116-117) See (James, 2008ap, p.46)
[1169] (Gavin, 1992, pp.170-174; James, 2008ap, p.48)
[1170] (James, 2008ag, p.115)
[1171] (James, 2008ag, p.116)
[1172] (Ibid., p.116)

The anaesthetic revelation testifies that "what *is*" remains a mystery, but James reminds us that "at every moment" we continue to act, nonetheless. James writes, "What *is* actual at every moment of our lives is the sort of thing which I now proceed to remind you of."[1173] Remarkably, despite all the uncertainty in science, religion, medicine, and life in general, the empirical fact is that human beings can and still do act—and, even more remarkably, sometimes even act successfully. Arthur Kleinman writes, "[In the] insecurity of moral life and terrible inadequacy of our usual fumbling efforts to change or fully comprehend who we are and where our world is taking us. Yet, in the midst of it all, we make a life."[1174] There is great hope in the fact that we are creatures made to act in the midst of that which we do not understand.

Appealing to psychology, physiology, and evolution, James argues that emphasis on the mind's purely rational function (with which much of the history of philosophy has been concerned) has been replaced with emphasis on its "long neglected practical side."[1175]

> Man, we now have reason to believe, has been evolved from infra-human ancestors, in whom pure reason hardly existed, if at all, and whose mind, so far as it can have had any function, would appear to have been an organ for adapting their movements to the impressions received from the environment, so as to escape the better from destruction…Man, whatever else he may be is primarily a practical being whose mind is given him to aid in adapting him to this world's life.[1176]

In other words, in both James' science and religion, human beings are designed (or evolved) not primarily to know the world through "logical powers" but primarily to act in relation to the world. James explains in *"*RA&T*"* that "it is more than probable that to the end of time our power of moral and volitional response to the nature of things will be the deepest organ of

[1173] (Ibid., p.119)
[1174] (Kleinman, 2007, p.26)
[1175] (James, 2008ar, p.24)
[1176] (Ibid., pp.23-24)

communication therewith we shall ever possess."[1177] To act in uncertainty might not be just some second-best, last resort to unresolved logical reasoning, but might, in James' worldview, be an even deeper communication with the nature of things than could be accessed by logical reasoning alone.

In "RA&T," James continues to explain that there is much about God that cannot be grasped. "God's being is sacred from ours," James writes, "To co-operate with his creation by the best and rightest response seems all he wants of us. In such co-operation with his purposes, not in any chimerical speculative conquest of him, not in any theoretic drinking of him up, must lie the real meaning of our destiny."[1178] Reflecting on the anaesthetic revelation, anesthesiologist Jane Moon writes, "[the anaesthetic revelation is that] the mystery of life cannot be solved with reason or science alone but must be wrestled with in the great amphitheatre of human will and action."[1179] Influenced by James' philosophy, Osler concludes something similar. His answer to the question, "What is life?" is "I do not think—I act it; the only philosophy that brings you in contact with its real value and enables you to grasp its hidden meaning."[1180]

In one sense, action cloaks—hides—the uncertainty, the mystery. The very success of being able to act in the world can hide how truly uncertain and mysterious the world is. One can see this clearly in medical terms. Fox titled her pioneering work on uncertainty "Training for Uncertainty."[1181] In reply to Fox, Paul Atkinson wrote "Training for Certainty," in which he argues that uncertainty and certainty coexist within medical practice.[1182] He explains that the medical practitioner is a pragmatist, not a theoretician or detached observer. He challenges

[1177] (James, 2008an, p.111)
[1178] (James, 2008ak, p.1182)
[1179] (Moon et al., 2018, p.6)
[1180] (Kleinman, 2007, p.26)
[1181] (Fox, 1957)
[1182] (Atkinson, 1984)

Fox's portrayal of practitioners distressed by the deep uncertainty that is inherent to medicine. Quoting Bosk, he writes,

> There are many decisions which surgeons are forced to make in the absence of scientifically established criteria. Great uncertainty surrounds much medical behavior. From their own clinical experience and from medical journals, attendings marshal evidence to support one approach to a particular problem as opposed to another. However, the evidence is far from conclusive, debate continues, and a consensus fails to emerge. Some attendings approach a problem in one fashion with very good results; others have equally good results with a competing approach. Despite the open-ended nature of the question 'Which approach is better?', attendings in their everyday behavior can be quite dogmatic.[1183]

Appealing to Schutz, Atkinson argues that practitioners rely on "recipes for action" with faith in the "stability and predictability of the world" that gives them confidence that "I can do it again" and that dogmatic certainty is a response to the uncertainty of medicine.[1184] The ability to act successfully in a world that is not fully understood lends itself to such cloaking of uncertainty. This cloaking can be useful, like the wooden path that crosses the surface of the bog mentioned in Chapter 1. But it can also have a dark side of losing sight of the mysteries in which medicine deals.

In another sense, action cloaks—alleviates—the suffering of uncertainty. When paralyzed by uncertainty, one can continue doing what one usually does in its midst—act. In the end, as the anaesthetic revelation reveals, the point might not be to achieve complete understanding. James' pluralism reminds us that certainty is only one among many things that can be valued, and sometimes, the best that can be done is to palliate the uncertainty and get on and live according to that which we may value more.

[1183] (Ibid., p.953) quotes (Bosk, 2003, pp.61-62)
[1184] (Atkinson, 1984, p.953)

The palliation of uncertainty has different goals than curing uncertainty with more knowledge and technology. As Saunders says with regard to theodicy and suffering, the "why" is replaced with "How can I help…What can I do in this situation?" The "why" can still be important, interesting, and useful, but it is secondary and subservient to "what can I do?" In a world more akin to our activities than our logical powers, the "why" does not always need an answer. Uncertainty might not be about understanding, but it might help teach us how to live. And conversely, maybe how we live might have something to teach us about uncertainty.

The Anaesthetic Revelation: Living with Uncertainty

When James wrote "PM," he knew he was approaching the end of his life. He closes his reflections on the anaesthetic revelation with the following:

> Let my last word, then, speaking in the name of intellectual philosophy, be [Blood's] word:—'There is no conclusion. What has concluded, that we might conclude in regard to it? There are no fortunes to be told, and there is no advice to be given.—Farewell!'[1185]

James ends his philosophy in a place of uncertainty, with no guaranteed "fortunes to be told," no security of "advice to be given," and no "conclusion" because nothing has yet concluded; things must unfold "in the long run and on the whole."[1186] Pluralism presents "a universe unfinished."[1187] James begins his philosophy in uncertainty and "ends" it there, too.

Those unfamiliar with James might read his closing lines pessimistically with a Schopenhauer-like nihilism (which James opposed strongly).[1188] In the context of James' broader philosophy,

[1185] (James, 2008af, p.190)
[1186] (James, 2008ai, p.106)
[1187] (James, 2008ap, p.73)
[1188] (James, 2008q)

I read his words melioristically. The unfinishedness of the universe (even of James' philosophy) becomes a call to act courageously and to co-operate as agents in the creation of it. As is characteristic of James, in his last words, there is no pretense of finality. "Mystery" and "ever not quite" is the final word, an ending that, in the shadow of death's uncertainty, offers not despair but a quiet invitation to hope.

In his youth, James wandered through Europe in pursuit of a cure; in his final days, he travelled through it once more—this time, journeying home to face the mystery of his own dying. His letters show ordinary tasks of dying: saying goodbye to loved ones, managing exacerbations of symptoms, coordinating finances and practicalities, and comforting friends.[1189] Growing weaker each day, James longed for home and made a long and difficult journey back to America with his sick and depressed brother, Henry, and his exhausted wife, Alice. Worn and weary, they travelled from Italy, through France and England, then set sail on *The Empress of Britain*, arriving in Quebec on August 18th, 1910. From there, they took a train to New Hampshire and finally arrived home to the mountains of Chocorua. Alice's diary notes that on August 24th, James remarked, "It has come so rapidly, rapidly." He was treated with digitalis and morphine and lingered for several days on the edge of life. At 2:30 p.m. on August 26th, he died in the arms of his wife.[1190]

"What has concluded, that we might conclude in regard to it?"[1191] Such a question seems especially poignant for James as he penned the final lines of his philosophy and approached the end of his life.

[1189] (James, 2008f, pp.563-575)
[1190] (Ibid., pp.p575, fn.571)
[1191] (James, 2008af, p.190)

Linda Boren describes James' tribute to Blood as "a romantic dash of bravado," "a leap into the unknown as a departing gesture of faith," a "courageous leap back into uncertainty," and a "spiritual victory."[1192] Blood, referring to death, writes, "My gray gull lifts her wing against the nightfall, and takes the dim leagues with a fearless eye."[1193] James' letters reveal a softer character, discouraged by weakness, chest pain, and breathlessness, supported by his wife, and supporting his invalid brother, as they made an arduous and uncertain journey home.

A leading physician who has worked in palliative care for decades once commented after a presentation of this dissertation,

> My experience [is] that the vast majority of humans do not fight against the dying, what they struggle to do is be courageous in the living before the dying. I've often wondered that people don't rail against the dying. That's relatively unusual; humans seem to just go, "Well, it's happening." But the courage is to live until you die and live through the uncertainty.[1194]

Who knows with what courage James faced death? Undoubtedly, he showed courage as he lived to the end of his life with the uncertainties of his medical conditions. His letters reveal, however, that it was courage balanced with weakness and fear, sensitive to the fact that one cannot be courageous all the time. To have to act courageously in uncertainty is a heavy burden to bear, and sometimes one needs just to be held in relationship. As James stepped into the uncertainty of death, he was held in the arms of his wife.

[1192] (Boren, 1983, p.9)
[1193] (James, 2008b, p.286)
[1194] Personal records, discussion with Miller.

One Cannot be Courageous All the Time

Acting courageously in the midst of uncertainty is illustrated powerfully in the following passage from *PoP:*

> The huge world that girdles us about puts all sorts of questions to us, and tests us in all sorts of ways…But the deepest question that is ever asked admits of no reply but the dumb turning of the will and the tightening of our heartstrings as we say, "*Yes, I will even have it so!"* When a dreadful object is presented, or when life as a whole turns up its dark abysses to our view, then the worthless ones among us lose their hold on the situation altogether, and either escape from its difficulties by averting their attention, or if they cannot do that, collapse into yielding masses of plaintiveness and fear. The effort required for facing and consenting to such objects is beyond their power to make. But the heroic mind does differently. To it too, the objects are sinister and dreadful, unwelcome, incompatible with wished for things. But it can face them if necessary, without for that losing its hold upon the rest of life. The world thus finds in the heroic man its worthy match and mate; and the effort which he is able to put forth to hold himself erect and keep his heart unshaken is the direct measure of his worth and function in the game of human life. He can *stand* this Universe. He can meet it and keep up his faith in it in the presence of those same features which lay his weaker brethren low. He can still find a zest in it, not by 'ostrich-like forgetfulness,' but by pure inward willingness to take it with those deterrent objects there. And hereby he makes himself one of the masters and the lords of life. He must be counted with henceforth; he forms a part of human destiny…"*Will you or won't you have it so?"* is the most probing question we are ever asked; we are asked it every hour of the day, and about the largest as well as the smallest, the most theoretical as well as the most practical, things. We answer by *consents or non-consents* and not by words. What wonder that these dumb responses should seem our deepest organs of communication with the nature of things!...What wonder if the amount which we accord of it were the…contribution which we make to the world![1195]

When the dread dark abyss of uncertainty rises to view, the courageous and heroic face it. They honestly acknowledge the uncertainty and do not bury their heads with “ostrich-like forgetfulness.” They turn to action (“will you or won’t you have it so?”) and make their contribution to the unfinished world. They act courageously in the midst of uncertainty.

[1195] (James, 2013, pp.1181-1182)

However, "there is more to James than the espousal of the uncertain" and more than a call to courage.[1196] Gavin writes, "[For James] there is also the tacit realization that certainty is, or can be, very tempting—that asking us to embrace uncertainty may indeed be asking too much from too many of us."[1197] "No one is a hero or heroine all the time."[1198] "Heroism," James writes in a letter, "is always on a precipitous edge…(being a bad neurasthenic myself) I can easily sympathize. We are all human!"[1199] James' struggle with illness reminds us how difficult the morally strenuous life can be. He permitted "moral holidays" (i.e., "breathing spells" from the endless striving and demands of the strenuous mood) and admitted to the appeal of absolute monism with its comforting promises of certainty, security, and rest.[1200] In an exposition of James, Gavin writes, "Life has its 'unheroic days,'…or at least its bad moments. It may be that only some of us can live in this [heroic] fashion and also that, even if we do live it, we must continually reaffirm it and that we will fail in this endeavour..."[1201] One cannot be courageous all the time.

Gavin continues, "realizing that the really real is broader than the knowable is difficult and demanding; it takes courage."[1202] James acknowledges, "The pragmatism or pluralism which I defend has to fall back on a certain ultimate hardihood, a certain willingness to live without assurances or guarantees."[1203] He bids us set sail on uncertain seas without the promise of a safe voyage, and as consolation, he offers the epigram of a shipwrecked sailor who did not make it.

[1196] (Gavin, 2013, p.113)
[1197] (Ibid., p.113)
[1198] (Ibid., p.109) references (Royce, 1897, p.385)
[1199] (James, 2008y, p.26)
[1200] (James, 2008ab, p.124) For James, a "moral holiday" is not permission to act immorally but a break from the demands of the strenuous mood.
[1201] (Gavin, 2013, p.109)
[1202] (Ibid., p.114)
[1203] (James, 2008ab, p.124)

A shipwrecked sailor, buried on this coast,
Bids you set sail.
Full many a gallant bark, when we were lost,
Weathered the gale.[1204]

Depending on our constitutions, to some, such a bidding excites courage; to others, sheer terror, paralysis, and despair.[1205] James writes,

> Pluralism is a view to which we all practically incline when in the full and successful exercise of our moral energy. The life we then feel tingling through us vouches sufficiently for itself, and nothing tempts us to refer it to a higher source…[But] to suggest personal will and effort to one "all sicklied o'er" with the sense of weakness, of helpless failure, and of fear, is to suggest the most horrible of things to him. What he craves is to be consoled in his very impotence, to feel that the Powers of the Universe recognize and secure him.[1206]

James knew that monistic absolute idealism, with its assurance that "all was already well," met the need for consolation, comfort, and certainty and, pragmatically speaking, might be more appealing than pluralism's uncertainty. He recognized that his pragmatic pluralism was "bound to disappoint many sick souls whom absolutism can console"[1207] and was unlikely to have a 'definitive triumph' over monistic absolute idealism because of its inherent risks, dangers and strenuous demands.[1208] Recognizing different temperamental needs for certainty (or for uncertainty), he says, "In the end it is our faith and not our logic"[1209] that decides between affirming the dangerous and uncertain universe of pluralism or the security of absolutism.[1210]

[1204] (James, 2008ai, p.142)
[1205] (James, 2008av, p.215)
[1206] (James, 2008p, pp.61-63)
[1207] (James, 2008ab, p.124)
[1208] (Stuhr, 2015, p.172)
[1209] (James, 2008ai, p.142)
[1210] (Gavin, 2013, p.107)

James posits his pluralism not as "the way the universe is" but as a hypothesis—a faith venture that he is inclined to make and act upon. Reflecting on the anaesthetic revelation, Moon writes, "[James] leaves open the possibility that the idea of a monistic absolute may ultimately be true. Until the very end of his life, James was comfortable with uncertainty and maintained an attitude of openness before the unknown."[1211] His pluralism left "the door open" for both pluralistic and monistic commitments and accepted that, in the long run and on the whole, the monists' hypothesis and faith venture might succeed.[1212]

James' is a philosophy for human strength. James' is also a philosophy with compassion for human weakness. He does not demand that one be courageous or even suggest that one can be courageous alone. The passage that introduced this section described courageous action in the midst of uncertainty. This passage goes on to explain that it is from relations with others that we derive support, "courage in someone else' courage, faith in someone else's faith," and that even the energy of effort might be a gift from within and beyond ourselves.[1213] James espouses courageous action in uncertainty, but he recognizes that courage sometimes falters, and he invites us to hold uncertainty together, with the help of God and one another.

[1211] (Moon et al., 2018, p.5)
[1212] (James, 2008ag, pp.19-11, 147-150)
[1213] (James, 2013, pp.1181-1182)

Conclusion

Chapter 4 has drawn out the three key themes from James' image of the anaesthetic revelation:

1) Managing expectations about uncertainty: The anaesthetic revelation begins with honesty about the uncertainty of life and its mysteries, which surpass all formulations. James describes some of the positively valanced "greater-goods" of uncertainty. Drawing an analogy to theodicy, I suggested a pragmatic response to the suffering of uncertainty, which shifts attention from questions of "why" to "what can I do?"

2) Turning attention to action: The first conclusion of the anaesthetic revelation is one of mystery. The second is that one can still act in the midst of that mystery. I discussed James' notion that the world may be more akin to "activities and heroisms and willingness" than to our "logical powers." James' philosophy, his science of psychology and evolution, and his religious mysticism affirm that we are creatures made to act in the midst of that which we do not understand, and the very fact that we can (and do) act palliates and cloaks uncertainty.

3) Living with uncertainty: James calls us to live courageously with uncertainty but also acknowledges that no one can be courageous all the time. Through James' discussion of pluralism and monism, I showed that James also has compassion for human weakness. We do not act courageously in isolation but in relation to others as uncertainty is held together in community.

The next chapter explores a conclusion towards which this dissertation has been moving—that of "holding uncertainty together" in James' pragmatism and in palliative care.

5

Holding Uncertainty Together

"So the science of medicine has now become the science of relationship understood in terms of probability. And the art of medicine remains what it always has been—…the carrying out of therapeutic actions under conditions of uncertainty in the setting of a relationship of trust."

~Daniel Sulmasy, *Healers Calling*[1214]

Introduction

In this chapter, I explore the idea that living with uncertainty entails holding uncertainty together with our patients, with each other, and with broad communities. I consider a tension in James' philosophy between acting courageously in uncertainty and surrendering the ability to act and relying on relationships with others, and I show how this tension is useful to navigate a similarly experienced dynamic in palliative care.

Holding Uncertainty Together: Reflections from James

Chapter 4 ended with the recognition that nobody can be courageous all the time. James reminds us of the need for some sort of comforting security. The monistic offer is the assurance of the absolute; the pluralistic offer is a community of which a theistic God may be a part.[1215]

At the conclusion of *SPP*, James depicts this idea with the image of a circle of poles, each balanced upon the others. The sticks are not supported by anything, and the foundation of

[1214] (Sulmasy, 1997, p.31)
[1215] (James, 2008i, p.99; 2008ai, p.143)

uncertainty remains. Yet they are supported by upholding one another in the uncertainty, each contributing its part.[1216] The community is uncertain and liable to collapse if its members do not carry their share. This image of the circle of sticks is an image of uncertainty held together in a community.

Another image that James uses is that of a "circle of dancers, revolving by holding each other's hands." They rotate, trusting each other's grip as the momentum pulls them around. Though the dancers hold the uncertainty together, the uncertainty remains—there is no guarantee that the other dancers will hold their part of the circle. James argues that the best we can do is to contribute to the circle by holding the hands we need to, and if we all do that together, there is a chance that the circle will spin.[1217] He writes, "The melioristic universe is conceived after a social analogy, as a pluralism of independent powers…Its destiny thus hangs on an if, or on a lot of ifs."[1218] This image shows both the active mood (each hand holding its part) and the passive mood (surrendering in trust, joining the hands of others). Acting courageously in uncertainty is not a solitary act but one carried out in connection to others.

Some scholars applying James' philosophy to medicine draw inspiration from his emphasis on relationality. In bioethics, Lisa Bellantoni focuses on the way in which James' pragmatism begins in lived experiences that are located among social relations and proposes an "ethic rooted in our communal resources," which includes the shared resources of theology.[1219] In social work, Kathryn Beringer (drawing on Christian Beels) discusses how the notion of the "fundamentally social nature of self" in social work theory is attributed to pragmatism's influence on the field and explores how James' conception of the social self includes spiritual

[1216] (James, 2008i, p.99; 2008ap, p.116)
[1217] (James, 2008ap, p.116)
[1218] (Ibid., p.115)
[1219] (Bellantoni, 2003)

selves.[1220] In healthcare police, Greenhalgh calls for a "pragmatist turn," which recognizes that experience is relational, personal, and particular and "recognizes humans as social beings" who transform intersubjective social realities through collective action.[1221] Hester, in *Community as Healing*, constructs a pragmatist bioethics and proposes that the means and ends of medical encounters should be healthy living in community. He explores the notion of "participation in community as healing."[1222]

James himself, in a speech delivered in defense of his local mind-cure community, scolded physicians for being too closed-minded, blinded by the constraints of their medical philosophy, and so wedded to "chemical, anatomical [and] physiological information" that they failed to grasp that the biomedical was only one portion of the social truth about healing. James recognized that the mind-curers' key contribution lay in demonstrating that "therapeutic regulation may be what we can at present describe only as a relation of one *person* to another *person,"* and that these "vital mysteries…these personal relations of doctor and patient…these infinitely subtle operations of Nature," could be their own "department of medical investigation."[1223] Oliver, although not applying pragmatism to medicine, shows how James understood that "growth is organically fused with the life around it…and the hope that sustains our growth could never be only ours alone."[1224] Hope is not ours alone, and neither is uncertainty.

In Chapter 2, I discussed James' experience with serious illness and how his philosophy of pragmatism emerged from, and was part of, how he dealt with the uncertainty of his medical

[1220] (Beels, 2002; Berringer, 2019, p.618)
[1221] (Greenhalgh & Engebretsen, 2022, p.3)
[1222] (Hester, 2001, p.68)
[1223] (James, 2008a, p.59)
[1224] (Shook, 2006, p.135)

conditions. In sickness, James experienced the unexpected, new possibilities for life which arose from "giving up our own will and letting something higher work for us." "What," James asks, "are the other forces which [humanity] trusts to co-operate with?" He answers, "They are at least his fellow men...But are there not superhuman forces also, such as religious men…have always believed in?"[1225]

James believed that a relationship with God and others could help the sick to endure pain and suffering and could be a source of energy in exhaustion, strength in weakness, and comfort in uncertainty—in other words, it could help palliate. In his invalidism and inability to act, James recognized a need for help from a power beyond himself. Furthermore, he came to believe by faith that this power might even value help from him, help offered from his own weakness. James began to see his own self as part of a continuous "more" with God. On this view, God inflows energy and activity to us, and our actions may even cooperate with God. As Sutton demonstrates, James believed that religious faith in an "unseen world" could "validate the invalid," "make sense of their suffering and raise it to the level of a heroic act."[1226] He likened the work of the sick to those on the frontline of battle or the edge of the American frontier, working with "human nature *in extremis*."[1227] This implied that individuals who outwardly seemed incapable of action could, in fact, engage in courageous deeds.[1228] Part of this courageous action was a restoration of harmonious relationships. As Lamberth explains, remedying disconnection and creating intimacy in individual streams of experience contributes to the intimacy of the larger stream of experience of which we are a part.[1229] Gale writes that James was on a "quest for intimacy" within himself and "with the inner life of other persons,

[1225] (James, 2008ai, p.143)
[1226] (Sutton, 2023, pp.156-157)
[1227] (Ruetenik, 2005, p.244)
[1228] (Sutton, 2023, p.136)
[1229] (Lamberth, 1997, p.256)

both natural and supernatural, even with the world at large."[1230] In short, in the midst of sickness, James' courageous action in uncertainty was supported by the personal and relational.

In Chapter 3, I discussed James' notion of attention and showed how relationality was embedded in James' spirituality, metaphysics, and psychology. Using the spotlight model of attention, I discussed the relational fringe, which cannot always be clearly seen but changes the way in which the focus is perceived.[1231] The fringe is temporally modal, bridging what is and the possibility of what could be, and (like a flowing stream) the fringe is transitive and introduces what flows next.[1232] James' scholar Dickinson Miller says, "All James's cherished theories, free will, will to believe, pluralism, pragmatism, radical empiricism, meant for him…'newness of life'…They meant the possession of 'genuine novelty.'"[1233] The relational fringe is, for James, an origin of transition source of novelty. "Luther," James writes, "[broke] through the crust of all this naturalistic self-sufficiency...You cannot live on…self-sufficingness." Speaking from his and others' experiences, James describes "new ranges of life" that emerge in the face of death through relationship—"possibilities that take our breath away, of another kind of happiness and power, based on giving up our own will and letting something higher work for us…these seem to show a world wider than either physics or philistine ethics can imagine...They soften nature's outlines and open out the strangest possibilities and perspectives."[1234]

[1230] (Gale, 1991, p.246)
[1231] (Galin, 1994, p.377)
[1232] (Broniak, 1996, pp.451-452)
[1233] (Bixler, 1925, p.74) cites (Miller, 03/1921)
[1234] (James, 2008ag, p.138)

A distinctive feature of James' pragmatism is his receptiveness to mystery and his recognition of the role that relationship and community play in holding uncertainty together. In the words of Arthur Petersen,

> The universe is still in the making. One of the ways humans can realize that they make the universe is by engaging in science and/or religion. What those who take up the challenge offered by James will experience is that they can share their uncertainty and ignorance with their God—who they can intimate and connect with in a social relation—and share their suffering.[1235]

Petersen mentions science and religion as a way in which humans share uncertainty and make the universe together. I might add to this quote that one way in which humans can contribute to "the universe still in the making" and share their uncertainty together is through the practice of medicine.

James teaches that we must hold uncertainty together in community. This is not a "cure" for uncertainty; James' pluralism does not offer that. The holding of uncertainty together might not take away the uncertainty, but it can help palliate it, cloak it, alleviate its burden, and help us live with it. James embodied the holding of uncertainty together by letting his last words be those of another—Blood. The mystical security of the anaesthetic revelation is not the guarantee of answers, but the solace that we do not hold that uncertainty alone.

A Tension in James' Thought

James' philosophy can be represented in the image of the courageous man on the edge of the precipice who summons strength and energy beyond what he knew he had and leaps. Another way his philosophy can be portrayed is in the man who, in utter weakness, surrenders the ability

[1235] (Petersen, 2014, p.827)

to do anything at all except surrender, trust in a higher power, and rely on others. Some suggest there is a tension between these two moods: the active mood (acting courageously in uncertainty) and the passive mood (surrendering ability to act and relying on relationships).[1236] Perry makes a distinction between the "fighting-faith" of "WtB," which "springs from strength" with its courage, and the "comforting-faith" of *VRE,* which "springs from human weakness and asks for refuge and security" in God and others.[1237] Proudfoot points to the "religion of effort" of "WtB," with its disciplined, daily practice of reworking attention and habit,[1238] and to *VRE*, which he calls the "religion of surrender and empowerment" that is a floodgate of new energy when "effort has been exhausted."[1239] Croce, contrasting these moods, writes, "WtB is filled with a fighting spirit of voluntarism, moralism, and readiness to struggle, and *VRE* chronicles and honors the comforting spirituality that accepts transcendent powers."[1240] Barnard, in *Exploring Unseen Worlds*, reflects on James' "oscillation between the necessity of religious self-surrender and the value of moralistic self-assertion."[1241] Croce maintains that these are not just two competing worldviews but "alternative impulses within James himself."[1242] Theologian Julius Bixler agrees, writing that James was "a victim of the alteration of these two [active and passive] moods."[1243] In Chapter 2, I discussed ways in which this tension played out in James' personal life as he came to terms with his philosophy of strength alongside his experiences of weakness and dependence in illness.

There are two points I wish to make. First, I am not convinced that the split is as sharp as some make it. For James, the active and passive moods might not be opposite but exist in relations

[1236] (Croce, 2012; Gavin, 2013; Perry, 1948, p.324; Proudfoot, 2021)
[1237] (Croce, 1997, p.212) cites (Perry, 1948, p.324)
[1238] (Proudfoot, 2021, pp.191-193)
[1239] (Ibid., pp.193-195)
[1240] (Croce, 2007, p.497)
[1241] (Barnard, 1997, p.83)
[1242] (Croce, 1997, p.212)
[1243] (Bixler, 1925, p.73)

of continuity and discontinuity. The "passive" surrendering of *VRE* was often preceded by a lifetime of effort in disciplined attention and holiness (for example, in the religious experiences of the saints), and it inspired a strenuous moral life and action.[1244] The activity of "WtB" is described by James with neural analogies, and the crossing of the threshold is portrayed as a type of surrender which "let[s] loose" energies from sources whose origins lie within and beyond ourselves.[1245] The blurred boundary between active and passive is seen in *PU*, where, as Bixler says, "God is described both as that spiritual agency which will evoke in men the highest, most co-operative response, and also as the source of those saving experiences."[1246] In linguistic terminology, there are active, passive, and middle verbs (which have both active and passive elements because, in acting, they are also acted upon). James' mood seems both active and passive because it is middle.

Second, Croce, Perry, Gale, and others emphasize James' oscillation from one mood to the other as if this is a problem.[1247] In contrast, I find it useful for navigating a complex dynamic that is experienced in end-of-life care. James calls for courage but accounts for weakness; he acknowledges that one cannot be courageous all the time and that we need support from others. James' pragmatism challenges dualisms and is made to "meet a mixture" of both needs.[1248]

A Tension in Palliative Care

This tension between action and the surrendering of the ability to act is a well-acknowledged aspect of James' thought, and a well-acknowledged experience in palliative care. Some might suggest that there is a tension between the active mood ("doing something," such as an

[1244] (Ibid., p.76)
[1245] (James, 2008al, p.367)
[1246] (Ibid., p.73)
[1247] (Croce, 1997, p.212 fn.254)
[1248] (James, 2008ai, p.144)

intervention to improve quantity/quality of life) and the passive mood ("doing nothing," which might take the form of being with a patient and supporting them relationally through non-abandonment). Part of what I find so helpful in James' work is that he challenges this duality. As discussed in Chapter 2, James expands the notion of "acting courageously" to include the relational. So, likewise, I expand "action" in medicine to include the relational.

Affirming non-abandonment through therapeutic presence and building a relationship with the patient is a way of taking action, requires action, and sometimes demands tremendous courage. In Chapter 3, I described turning attention towards action and emphasized that a relational fringe surrounds each action of care. This relational fringe changes the way in which actions are experienced and influences whether or not they succeed. (For example, the same act may mean different things and have different effects when performed in a trusting physician-patient relationship compared with one of distrust). Furthermore, the relational fringe is modal, and as an origin of transitions, relationships can open new and unexpected ways to palliate uncertainty.

The approach of Palliating Uncertainty reorients "uncertainty" from the center and reinstates the value of the vague relational. As stated earlier, Palliating Uncertainty turns attention to action: 1) taking action to support patients in the uncertainty by alleviating its effects; and 2) taking action by building a partnership, a relationship of trust with patients. Like James' pragmatism, the approach of Palliating Uncertainty has compassion for human weakness and recognizes that living with uncertainty is sometimes too much to ask. No one can be courageous all the time, and living with uncertainty in both James' pragmatism and palliative care requires holding uncertainty together in community.

Holding Uncertainty Together: Reflections from Palliative Care

I began Chapter 1 by showing a published advertisement for the U of M Healthcare system, "Michigan Answers." Here, I share a video called "Bill United," which is an advertisement for the Milford Care Center, a community hospice program in Ireland. "Bill United" shows clearly the role of community in the palliation of uncertainty and offers an answer to uncertainty that is quite different from Michigan Answers.

[Please watch]

https://www.youtube.com/watch?v=wh3wuPYjeDM

Figure 23) Bill's Story[1249]

Gentle piano music plays in the background as the video tells the story of Bill, a man who is diagnosed with an incurable condition.

This is Bill
This is Bill's world
where he lives
where his family is
where his children go to school
where he plays

[1249] (McLoughlin, Rhatigan, Richardson, & Lloyd, 2014)

where he works
Bill has been seeing a doctor
The test results are back
The news isn't good…
Incurable…
Bill is going to die.
He is devastated
So is his family
Bill tells his world
neighbours, friends, parents & teachers, work colleagues
They are all shocked and sad
<u>but</u> all want to help
and although not experts, they know <u>they love</u> Bill the most
They are "Bill United"
"Bill United" harness Bill's care in his community
ideas, love, support, caring, together
Bill United will listen when Bill needs to talk
when Bill is angry
when Bill is sad
Bill United will provide him with <u>strength</u>
Bill United will do what needs doing
To help Bill live in the best possible way
Bill knows Bill United will support his family
Now and when he is gone…
as Bill will die
but he will die holding lots of hands
with the people he loves
and Bill United…?
<u>will</u> go on to help others
creating a <u>legacy</u>
that will go on
and on…

Bill is given a terminal diagnosis and the world he once thought stable becomes fragile and uncertain. His friends and family are not experts with certainty or "answers," but they turn their attention to action and "do what needs doing," and they surround Bill in love and relationship like a cloak. Though they cannot take away the uncertainty, their presence with Bill palliates it.

"Bill United" shows clearly that we are not just individuals bravely acting alone in uncertainty but are held in community—surrounded, enfolded, cloaked. In uncertainty, our patients (we ourselves) need something to hold on to. We may not be able to offer our patients the certainty of answers, but we can promise to be with them. Furthermore, "being with them" is not a weight that we have to carry ourselves, but that too we hold with a whole community. "Bill United" shows the value of the relational fringe that surrounds actions of care.

Saunders writes,

> The care of the dying should not be an individual work but one that is shared. Shared with the relations; with all the various members of the staff, spiritual, medical, and lay; and as far as we can, with the patient himself. Where this is so we are left with a sense of fulfilment which makes this such a rewarding branch of medical and nursing care.[1250]

A defining characteristic of palliative care is its strong emphasis on teams and relationships. The WHO's description of palliative care includes: "Palliative care involves a range of services delivered by a range of professionals that all have equally important roles to play—including physicians, nursing, support workers, paramedics, pharmacists, physiotherapists and volunteers—in support of the patient and their family."[1251] NCHPC guidelines include "interdisciplinary teams" and "uses a team approach to address the needs of patients and their families." Furthermore, the guidelines encourage "handoffs and referrals to local/community service providers."[1252] The IOM extends delivery of palliative care from those who are certified in it (physicians, nurses, social workers, and chaplains) to other healthcare professionals (primary care clinicians, oncologists, cardiologists, etc.) who care for patients nearing the end

[1250] (Saunders, 2006, p.19)
[1251] (WHO, 2020)
[1252] (NCHPC, 2018, p.iv)

of life.[1253] Teams are essential to palliative medicine, including those who may not be recognized health professionals, such as the hospice housekeeper, administrative staff, medical students, community volunteers, etc. Also included on this team are those featured in "Bill United:" neighbors, friends, work colleagues, and others who play their vital roles in holding uncertainty with a patient and their family.

Saunders' advice regarding caring for the dying applies to uncertainty too. Living with uncertainty is also work that is shared. Many empirical studies, narrative reviews, and physician reflections on uncertainty testify to the role of "sharing uncertainty" and the work of holding uncertainty together. I list a few:

Patients/Family/Caregivers

Studies by Sand,[1254] Öhlen, Joakim et al.,[1255] Carlander,[1256] Friberg et al.,[1257] and others[1258] demonstrate that being in community and relationship with others helps to alleviate the suffering of uncertainty that palliative care patients experience. Going back to some of the original studies on uncertainty, Mishel's theory of uncertainty in illness proposes that social support influences the development of illness uncertainty, and this is particularly pertinent to palliative care.[1259] A phenomenological study of existential uncertainty among cancer patients who were receiving palliative care treatment reported that companionship with others provided relief from the distress of uncertainty. "The participants described how important it was to have friends who shared their difficulties and gave support, as well as affirmed their continued value

[1253] (IOM, 2015)
[1254] (Sand, 2008)
[1255] (Öhlen, Bengtsson, Skott, & Segesten, 2002)
[1256] (Carlander, 2011)
[1257] (Friberg & Öhlen, 2007)
[1258] (Mistry, Bainbridge, Bryant, Toyofuku, & Seow, 2015; Nordman, 1996)
[1259] (Arias-Rojas et al., 2019, p.6; Mishel, 1988)

to others…supportive friends and family members provided a sense of context and greater certainty in belonging to a community."[1260] Community and companionship could not completely remove the uncertainty but did help to palliate it. Lack of community was associated with increased distress from uncertainty.[1261] The study reported,

> These vast and complex questions have no obvious answers but like most people in a vulnerable situation, the individuals in this study had a need to share their questions and experiences with others. Different forms of companionship are important and relief…can occur through a shared community with other people.[1262]

In another phenomenological study of those living with life-threatening cancer, patients said that one of the very meanings of "alleviation of suffering" was "feelings of connectedness." Patients who described alleviation of suffering mentioned family members, friends, fellow patients, healthcare professionals, God, nature, time, media, cultural notions, and public authorities. Many words that they used to describe alleviation of suffering were relational, such as "help, support, trust, comfort, consolation, care, consideration, community…"[1263] Palliative care physician Michael Kearney wrote of his experiences, "Healing is when we come into connection with ourselves, others, and the world. The wound is still there, but coming into a bigger world of experience can change it."[1264]

In "Intensive Caring: Reminding Families They Matter," Chochinov reminds families and caregivers of the irreplaceable role they play in helping patients to live with the uncertainty of their conditions.[1265] Carlander conducted a study of the everyday lives of families and their experiences as their loved ones neared death. One way in which these patients and families

[1260] (Karlsson et al., 2014, p.4)
[1261] (Ibid., p.4)
[1262] (Ibid., p.7)
[1263] (Öhlen et al., 2002, p.320)
[1264] (Kearney, 2018, p.127)
[1265] (Chochinov, 2024a)

handled the uncertainties of everyday life was "to seek togetherness."[1266] Extensive research underscores the role of families and caregivers in bearing the uncertainty of serious illness with their loved ones.[1267] Furthermore, studies report that families and caregivers experienced less distress from uncertainty when they perceived support from health professionals.[1268] A study on "What matters most for end-of-life care?" observed that relational values such as establishing trust with physicians, providing care options, and supporting their family were among what mattered most to patients at the end of life.[1269] Tarbi et al. advise palliative care clinicians on the importance of interdisciplinary teams in attending to patients' existential concerns (such as uncertainty) and of the importance of a patient's community in holding those concerns with them. The authors emphasize the role of physicians in supporting caregivers and the potential to enable healing effects during healthcare encounters and to build therapeutic relationships: the "act of bearing witness, creating nonjudgmental and psychologically safe spaces for individuals and care partners to share their suffering and experience [and uncertainties], and supporting this expression…is, in and of itself, therapeutic."[1270] Heath reflects, "It is only within relationships of trust that fear [of uncertainty] can be in any way contained."[1271]

Physician/Healthcare System

Sulmasy reflects on the way physicians collectively bear uncertainty, drawing on the legacy of those who preceded them. He writes,

[1266] (Carlander, 2011, p.3)
[1267] (Bottorff, 1991; Morse, Bottorff, Anderson, O'Brien, & Solberg, 1992; Norinder, Goliath, & Alvariza, 2017; Öhlen et al., 2002; Van Hope, Booth, & Rosa, 2023)
[1268] (Arias-Rojas et al., 2019)
[1269] (Mistry et al., 2015)
[1270] (Tarbi et al., 2024, p.7) cites (Van Hope et al., 2023)
[1271] (Heath, 2014, p.2)

> The good clinicians recognize that their practices are part of a great tradition of scientific and artistic knowledge. Lots of people have shared in the uncertainty before and they have taught today's clinicians lessons in how to act in such circumstances. Biomedical knowledge is part of a network of knowledge that dates back to Hippocrates. One learns in relation to that network. One can find a basis for rational action through connection to that network. Even the solo practitioner…is part of a tradition…the uncertainty becomes easier to deal with once one recognises that one is not alone.[1272]

Han also considers uncertainty relationally. He suggests that "sharing uncertainty" with colleagues and patients is a person-focused response to it.[1273] Some examples of the sharing of uncertainty with colleagues and patients can be seen in interview quotations from his study, "How Physicians Manage Medical Uncertainty: A Qualitative Study and Conceptual Taxonomy,"

> Sharing uncertainty with colleagues:…yes, I find myself sharing that [uncertainty] with my patients much more so than I did 10 years ago. And also sharing that with colleagues…'This is what I have. I've got a 60-year-old with chest pain. Everything is looking okay here. But something just does not seem quite right. I'm a little worried about letting this person go home. I can't give you a definitive reason for why they definitely need to stay in the hospital. But let's talk about it and see if we can come up with a reasonable plan.' And, personally, I have found that being able to say not only to your patients, but to your colleagues, ''I don't know, I've tried my best to get to an answer, but I need your help,'' has been very, very fruitful.[1274]

Han describes multiple ways of sharing uncertainty together. He lists: sharing the experience of uncertainty which protects against negative psychological burdens, decreases existential loneliness, increases subjective well-being and helps people cope; sharing the responsibility of uncertainty by distributing the moral, legal, and practical responsibilities and sharing the caring

[1272] (Sulmasy, 1997, p.34) See (James, 2008x, p.36)
[1273] (Han, 2021, pp.79-83, 126)
[1274] (Han et al., 2021, p.283)

for a patient as a person of value and worth.[1275] He further suggests that the sharing of uncertainty fosters courage for "uncertainty tolerance."[1276]

Danczak and Murphy, in their book *Mapping Uncertainty in Medicine: What to do when you don't know what to do?* also take a relational approach to uncertainty among healthcare practitioners. They classify functional and dysfunctional ways to manage uncertainty that arises from the doctor-patient dyad or healthcare teams/family networks.[1277] They illustrate many examples of holding uncertainty and write,

> Relationships can help clinicians be more resilient to uncertainty. Creating opportunities to talk about uncertainty, whether informally over coffee or more formally in meetings or supervision sessions, helps clinicians to articulate their thought processes, to acknowledge the emotional effect of uncertainty and to learn that others also have similar experiences.[1278]

In a systematic review of how diagnostic uncertainty can be managed, Alam and colleagues likewise conclude that building a supportive environment and network of colleagues is a way to deal with uncertainty.[1279] Dowd and Salama, in "Sitting with you in uncertainty: a reflective essay on the contribution of social work to end-of-life care," also illustrate the value of holding uncertainty in multidisciplinary teams which contain many knowledge- (and uncertainty-) sharers.[1280]

As a strategy to manage uncertainty, Scott et al. also recommend sharing it with colleagues and patients.[1281] They close their literature review with an emphasis on the importance of sharing

[1275] (Han, 2021, pp.129-131)
[1276] (Ibid., p.126)
[1277] (Danczak et al., 2016) See (Danczak & Lea, 2014)
[1278] (Danczak et al., 2016, p.183)
[1279] (Alam et al., 2017)
[1280] (Dowd & Salama, 2024)
[1281] (Scott et al., 2023, p.423)

uncertainty through communication with patients and open discussion with peers, and they highlight the need for system reforms to make these conditions possible:

> The current design and funding of health care favour investigations and procedures over potentially lengthy and cognitively demanding discussions between clinicians and patients and shared decision making in the context of irreducible clinical uncertainty. Clinicians and managers must together advocate for system of care reforms that support the recognition, acceptance and management of uncertainty, and the means for minimising its potentially harmful effects on patient care and clinician wellbeing.[1282]

Han also points towards system reforms that are necessary to facilitate such relationships. He writes, "[Uncertainty tolerance] needs to be not only cultivated in individual interactions between clinicians and patients but also somehow built into the routine structures, processes, and culture of healthcare. In other words, [uncertainty tolerance] needs to be systematized."[1283] He proposes system changes through medical practice, education, and research.[1284] Such system-level changes are ways to hold uncertainty in community—in larger healthcare systems, culture can contribute to the palliation of uncertainty.

Communities Beyond Healthcare

The specialty of palliative care is required not just in healthcare settings but also in the community, as many patients wish to live and die at home or in a non-institutional setting.[1285] End-of-life care is supported in hospitals, hospices, long-term care facilities, and patient homes. Furthermore, as palliative care is (or should be) involved in the early stages of serious illness, it also affects life in the community. James extended his definition of communities that held uncertainty beyond those that were visible to include the religious/spiritual. Analogously,

[1282] (Ibid., p.424)
[1283] (Han, 2021, p.110)
[1284] (Ibid., pp.111-141)
[1285] (Gomes, Calanzani, Gysels, Hall, & Higginson, 2013; Hoare, Morris, Kelly, Kuhn, & Barclay, 2015)

communities that hold uncertainty expand beyond the hospital into the less visible, unnamed, informal, grass-roots networks of support such as those seen in "Bill United."

Communities outside healthcare can also be intentionally organized to support people in the uncertainties of the end of life. Healthcare chaplain Victoria Slater and psychologist Joanna Collicutt, for example, have piloted work that supports churches' engagement with death and dying among the elderly in their congregations.[1286] They developed a course that brought people together in the context of their faith community to reflect on practical and spiritual questions that were raised by death and dying and provided resources and recommendations for supporting the elderly in the uncertainties of the dying process. In their work, the uncertainties are held in the community (i.e., outside healthcare), in a community (i.e., the local church), and created a community (i.e., the group exploring these questions together). Studies report the importance of religious/spiritual groups in helping people to live with uncertainty at the end of their lives, "providing support in the process of coping with the disease and provid[ing] accompaniment, help, financial support, tranquility to the caregiver and the patient, as well as sense and meaning."[1287] The role of religion/spirituality in helping palliative care patients and their caregivers live with uncertainty has been demonstrated by researchers Harold Koenig, Christina Puchalski, and Karen Steinhauser. Patients and caregivers share uncertainty in church communities as well as in perceived relationships with God/other higher powers.[1288] In personal reflections on the management of uncertainty in medicine, Sulmasy writes, "Illness grips us body and soul. None has all the answers but collectively we work in concert."[1289]

[1286] (Collicutt, 2015)
[1287] (Arias-Rojas et al., 2019, p.5)
[1288] (Steinhauser et al., 2017)
[1289] (Sulmasy, 1997)

Sulmasy describes a medical anthropology of the human person as "a being in relationship" from the bio-psycho-social-spiritual viewpoint. "Life is essentially relationship," he says.[1290] He describes disease as the disruption of relationships and healing as the restoration of relationships, which are intrapersonal (within the body and mind), extrapersonal (within the physical environment), and interpersonal (within the social environment and in connection to the transcendent).[1291] Hester, drawing on James and other pragmatists, also understands illness and healing as fundamentally relational. He likewise describes illness as a disruption of relationships and adds that illness interrupts how individuals usually contribute to their chosen communities. In his view, healing is restoration to a community. Hester writes, "Healthy living is the common *participation* in, with, and by community. It is the significant, meaningful *engagement* in one's pursuits within a social context. Therefore, living significantly in community should be both the end and means of most medical encounters."[1292] Such a view is reminiscent of James' notion of fruitful leading in harmonious relationships. Importantly, Hester insists, first, that not just clinicians but patients and others outside of healthcare contribute to the creation of healthcare communities. Second, he argues that the medical encounter is a means and end to the goal of healthy living in participation with a community because relationships in a medical encounter can be an instance of real community, in whose participation is healing.[1293]

In the story of Bill, his dying is supported *by* a community, and *creates* a community, i.e., "Bill United." Uncertainty, likewise, is supported *by* and *creates* a community. Holding uncertainty together can create communities of healing that, like the legacy of "Bill United," go on and on.

[1290] (Sulmasy, 2006b, p.125)
[1291] (Ibid., 2006b, pp.125-130) See (Renz, 2016, pp.117-144)
[1292] (Hester, 2001, p.17)
[1293] (Ibid., pp.17, 68)

I am not suggesting that community cures uncertainty any more than action does. Not everyone has access to a healing community—isolation in suffering is a tremendous problem in palliative care.[1294] Some communities can be pathological, a source of uncertainty, or contribute to the suffering of uncertainty.[1295] I point towards action and community as ways to palliate uncertainty, but, as we know all too well from palliative care, sometimes the best attempts to palliate and alleviate suffering can worsen suffering. We must return to the pragmatic demand to act without guarantee.

In a similar vein, Greenhalgh, in her chapter in *Clinical Uncertainty in Primary Care: The Challenge of Collaborative Engagements*, observes that individuals from diverse countries and academic traditions independently converge on the view that uncertainty is best addressed through "collaborative and collegial approaches" and that these approaches are not presented as definitive "fixes" for uncertainty. She writes,

> I am confident that committed participation in any one of these [collaborative] approaches will help clinicians in their struggle to do the best for their patients despite the inherent uncertainty of primary care practice. And I am also convinced that no matter how long such groups go on meeting or how much any specific approach is refined, there will never be a fix for those problems and situations that most trouble us. The most we can do with those is muddle through while we continue to reflect in supportive environments.[1296]

From a pragmatist point of view, this is not a pessimistic reading but a compassionate one. As stated eloquently by philosopher Harvey Cormier in *The Truth is What Works: William James, Pragmatism, and the Seed of Death,*

[1294] (Lederman, 2024; Love & Liversage, 2014; Nelson, Wright, Peeler, Brockie, & Davidson, 2021)
[1295] (Brown & Walter, 2014; Dowd & Salama, 2024; Greenhalgh, 2013)
[1296] (Greenhalgh, 2013, pp.18-19)

> James wants to give us, not a license to say or believe just anything at all, but a license to be *human*—where that is not a matter of containing the eternal biological, spiritual, or rational essence of humanity but is instead more like a matter of being, as the cliché has it, *only human*…Human beings are the beings who peer into the dim future, try furiously to achieve goals, and sometimes cause more chaos and misery than relieve. They do make mistakes and sometimes make things worse; but they also, from time to time, hit upon bright things to think or say that actually seem to make things better. These absurd creatures store these thoughts, these helpful "truths," in their memories and libraries.[1297]

Reflecting on the practice of medicine, I wish to expand these "helpful truths" from being stored in memories and libraries to being actively lived in communities and held in relationships with one another.

In an interview with Kaag, Jonathan Beasley (representing the Harvard Divinity School) asked the following question: "James sought to understand his own trial and tribulations, his suffering, suicidal thoughts, and health troubles. What makes James's teachings and questions of struggle so relevant today?" Kaag replied,

> I think we often try to approach trouble—psychological, personal, political, physical—as a doctor would approach a patient, with cool scientific methods and working things out as objectively as possible. There is nothing particularly wrong with this, and James would have admired this resolve. He wrote *Principles of Psychology* at least in part as a way to address, empirically, psychological conditions. This being said, the empirical was always balanced with the personal, ethical, existential (maybe even spiritual) disposition of a man who was willing to simply sit with the trouble and acknowledge its gravity. When my students read James, they often say they are listening to a "friend" or a "counsellor"...[1298]

In some ways, James models a good physician—his empirical, scientific approach is "balanced with the personal, personal, ethical, existential (maybe even spiritual)." Like a good physician,

[1297] (Cormier, 2000, p.xiv)
[1298] (Kaag, 2023)

he provides helpful counsel for our condition, but he also sits with us in uncertainty that cannot be resolved, "acknowledg[ing] its gravity." As we hold uncertainty together in community, James is one who holds that uncertainty with us.

In *TTT&S,* James talks about being a model worth imitating. He writes that imitation is a deep psychological drive of human beings. "Invention, using the term most broadly, and imitation, are the two legs, so to call them, on which the human race historically has walked."[1299] Man has always been an "imitative animal *par excellence.*"[1300] When asked what to do about the weakened American character, James appeals to the psychology of imitation. "Become the imitable thing," he exhorts, "if you should individually achieve calmness and harmony in your own person, you may depend upon it that a wave of imitation will spread from you, as surely as the circles spread outward when a stone is dropped into a lake."[1301]

In some ways, we model for our patients how to hold uncertainty.[1302] If we, as health professionals, are rushing to cover up uncertainty, what does this communicate to our patients about how they should respond to medical uncertainty when they encounter it next? It can be empowering for our patients when we model how to hold the uncertainty, without denying it, without panicking about it, standing calmly, and acting decisively not because there is no uncertainty but in the midst of it. Osler speaks of the importance of *aequanimitas.*[1303] It takes courage to say, "I don't know," but doing so shows our patients that they also can say "I don't know" and that sometimes it is okay not to know. Acknowledgement of uncertainty is an

[1299] (James, 2008ar, p.39)
[1300] (Ibid., p.38)
[1301] (Ibid., p.126)
[1302] (Dowd & Salama, 2024, p.1)
[1303] (Osler, 1922)

honesty that runs deeper than just the physician-patient relationship. It is an honesty to ourselves about the uncertain nature of medicine and even the nature of being human.[1304]

Physicians may model living with uncertainty for patients, but the converse is also true; patients may model living with uncertainty to us. Mannix writes,

> We in palliative care have the unmatched privilege of working with people who allow us to see their lives in all their depth, sadness, and beauty. People who until then appeared to be ordinary, reveal to us their infinite strength, wisdom and courage. They also let us in to lay bare their weaknesses and shortcomings and hold up a mirror to our shared frailty.[1305]

Few model the courage to live with uncertainty as well as our patients do. Earlier, I emphasized James' compassion for human weakness. In *VRE,* "Energies of Man," "The Moral Philosopher and the Moral Life," and elsewhere, he testified to extremes of human courage. A recurring theme in his work is that of the inflow of strength, energy, and courage from reservoirs that are untapped in daily life—a "second wind," which James attributes to relationships (often of a spiritual nature) within and with others beyond ourselves.[1306] This phenomenon is likewise observed in end-of-life care.[1307] Mannix, speaking of her patients, continues,

> …They seek to transcend the difficulties that beset them, and to consider a bigger picture. This impulse allows extraordinary acts of courage and devotion, of humility and compassion, supported and validated by their personal spiritual constructs. It is perhaps that spiritual dimension of humanness that reveals us at our very best, even (or perhaps especially) here at the edge of life.[1308]

[1304] (Dempsey & Mulder, 2023a)
[1305] (Mannix, 2018, p.230)
[1306] (James, 2008h, p.133; 2008ah, p.147)
[1307] (Renz, 2015, 2016)
[1308] (Mannix, 2018, p.292)

Living with a serious illness means living with uncertainty.[1309] Palliative care physicians have the immense privilege of witnessing those who live with uncertainty do so meaningfully and fully. James posits that those who suffer have a privileged epistemic position and that death is a significant point that can reveal deep truths about life in general.[1310] As Chochinov writes, "Palliative care has taught me that dying patients often reveal insights that apply across the entirety of human experience."[1311] Quoting Tolstoy, James writes in *TTT&S*,

> The more we live by our intellect, the less we understand the meaning of life. We see only a cruel jest in suffering and death, whereas these people live, suffer, and draw near to death with tranquility, and oftener than not with joy…There are enormous multitudes of them happy with the most perfect happiness, although deprived of what for us is the sole good of life. Those who understand life's meaning, and know how to live and die thus, are to be counted not by twos, threes, tens, but by hundreds, thousands, millions. They labor quietly, endure privations and pains, live and die, and throughout everything see the good without seeing the vanity. I had to love these people. The more I entered into their life, the more I loved them; and the more it became possible for me to live, too.[1312]

It is one thing to acknowledge intellectually that uncertainty is the human condition, but sometimes one has to experience something before one really knows it. Physicians, if they have not experienced the depths of uncertainty themselves, experience it vicariously through their patients. In a conversation with Mannix, she explained to me that acknowledging that we do not have control and understanding that things are uncertain can feel like a loss to start with, but over time, it can become freeing. After describing her personal experience of uncertainty, she said, "The reality of uncertainty is striking to me; even after the situation was 'resolved,' I still didn't know what was going to happen. But if I am honest, I didn't know what was going to happen before, either. I'm not actually in a different place."[1313]

[1309] (Karlsson et al., 2014, p.8)
[1310] (Sutton, 2023, p.157)
[1311] (Chochinov, 2023a, p.1) cites (Breitbart & Chochinov, 2022)
[1312] (James, 2008ar, p.157)
[1313] Personal records, conversation with Mannix

When James the medical student saw the epileptic patient, he saw the uncertainty and insecurity that underlies the surface of all of life, and he realized "that shape I am."[1314] How do we approach a patient for whom uncertainty is their life? With humility and the recognition that uncertainty is our life too. Sharing uncertainty with our patients involves, in part, the humility to learn from those on the edge. We do not just help patients to hold their uncertainty; our patients help show us how to hold ours.

Conclusion

To conclude, I echo Saunders' words: living with uncertainty in end-of-life care is not just individual work but work that is shared, shared within the relationships of the various members of the staff, spiritual, medical, and lay; and as far as we can, with the patient themselves. Where this is so, uncertainty can be palliated, but there is no guarantee.

In Chapter 5, I have discussed the idea of holding uncertainty together by drawing on the relational aspects of James' philosophy. I have suggested that a tension in James' philosophy, between acting courageously and surrendering the ability to act and relying on relationships with others, can be useful for navigating a similarly experienced tension in palliative care. I have explored relationality in the literature on the management of uncertainty in medicine and provided the story of "Bill United" as an example of how uncertainty can be held with a patient, in families, among health professionals, and with communities beyond healthcare. I now offer some concluding reflections.

[1314] (James, 2008av, pp.160-161)

6

CONCLUSION

"There is no conclusion. What has concluded, that we might conclude in regard to it?"

James, "A Pluralistic Mystic"[1315]

Final Reflections

In James' philosophy of science, the edge is a place of significance. He holds that "the great field for scientific discoveries" is the uncertain—the "unclassified residuum," the "dust-cloud of exceptional observations," floating outside "the accredited and orderly facts of every science."[1316] James states, "Anyone will renovate his science who will steadily look after the irregular phenomena. And when the science is renewed, its new formulas often have more of the voice of the exceptions in them than of what were supposed to be the rules."[1317] The phenomena on the edge, which do not seem to "fit" in the idealized conceptual sciences, are often the source of the most profound insights.[1318]

In James' philosophy of religion, the edge is likewise a place of significance. From this relational fringe buds energies, action and deepest communication with the nature of things. Mystical experience, James suggests, is a "widening of attention" open to what is traditionally

[1315] (James, 2008af, pp.189-190)
[1316] (James, 2008n, pp.247-249) See (James, 2008av; 2008aw, pp.222-223)
[1317] (James, 2008n, p.248)
[1318] (Sutton, 2023, p.100)

excluded from awareness, "revealing objects that always stood there to be known."[1319] New focus, new possibilities, enter the field of vision from the fringe.

The edge in James' philosophy is a place of uncertainty but also a place of growth. He uses the image of a tree, slowly growing by its rings[1320] and describes the edge as a "zone of formative processes, the dynamic belt of quivering uncertainty, the line where past and future meet," in other words, a threshold of transition and novelty.

Palliative care is situated on the edge of healthcare, attending to those who cannot be cured, who themselves dwell on the threshold between life and death. Those in palliative care "work with human nature *in extremis*."[1321] In practice, palliative care is on the fringe of medicine, often consulted as a last resort when it is deemed that "nothing can be done." In a medical culture of rampant autonomy, palliative care emphasizes relationship, team and community; in a culture of biomedical reductionism, palliative care witnesses to total-pain managed by interdisciplinary team and the support of the community to provide holistic, bio-psycho-social-spiritual care; in a culture driven to "cure" and "fix," palliative care focuses on the alleviation of suffering and helping people to live fully with conditions that may or may not be cured.

These values are not new or unique to palliative care alone. This specialty, however, is unique in that these values are codified into the center of its philosophy and ethos of practice. In some ways, like James' pragmatism, palliative care is "a new name for old ways of thinking."[1322] Some claim that palliative care should be a model for medicine on the whole and that its

[1319] (James, 2008aq, p.159)
[1320] (James, 2008l; 2008o, pp.192-193)
[1321] (Ruetenik, 2005, p.244)
[1322] (Clark, 2007; James, 2008ai, p.5)

philosophy ought to inform other specialties of care.[1323] Written in bold on the first page of the NCHPC guidelines is "Palliative care principles and practices can be delivered by any clinician caring for the seriously ill, and in any setting,"[1324] and the NCHPC encourages all clinicians to acquire core palliative care skills and awareness of its philosophy.

In developing Values-Based-Medicine, Fulford drew on the values-rich domain of psychiatry as a source for better understanding values-complex interactions in other specialties of medicine.[1325] In a similar way, the uncertainty-rich domain of palliative care offers a valuable resource for shaping how uncertainty is understood and addressed across the broader landscape of medical practice. As mentioned above, James likened that which is on the edge to the outer rings of a tree, where growth takes place. Perhaps this specialty on the edge might become a place of growth for medical practice on the whole.

Addressing over a thousand palliative care practitioners, I closed the keynote addresses at both the McGill International Palliative Care Congress and the UK Palliative Care Congress by suggesting the following,

> A key point in James' philosophy is that how people deal with uncertainty is largely a matter of personality and temperament. Here is the thing I want to point out, though. By and large, the person who is drawn to care for people at the end of life tends to be the type who doesn't have an incurable urge to fix, who is okay leaving things unresolved, who can sit with the tension of unknowns, and who can find joy in being alongside people in their darkest moments.
>
> I'm naming what you already do. You already are experts on living with uncertainty. We know that uncertainty is ok.

[1323] (Charlton, 1992, 1995; Gawande, 2014; Murtagh, 2014; Quill & Abernethy, 2013; Van Zuilekom, Metselaar, Godrie, Onwuteaka-Philipsen, & Van Os-Medendorp, 2024)
[1324] (NCHPC, 2018, p.i)
[1325] (Fulford, 2012)

> And we know from our patients that even in uncertainty, life can be lived fully, meaningfully, and joyfully.
>
> We can help lead the way in transforming how uncertainty is approached in medicine on the whole. Together, we can palliate uncertainty, alleviating the suffering of it and helping people live fully with it.[1326]

James opens *Pragmatism* by summarizing the history of philosophy in terms of two temperaments and their responses to questions of uncertainty.[1327] In medicine, likewise, individual patients and physicians vary in their abilities to tolerate uncertainty, and responses to uncertainty are deeply influenced by personality and temperament.[1328] Schneider et al. show that how GPs communicate and respond to diagnostic uncertainty is associated with personality.[1329] Jach, Hodson, Edwards, and others have mapped orientations towards uncertainty to the "big five personality traits."[1330] Zi-ting Han et al. show that there is a relationship between coping styles and response to uncertainty among stroke patients.[1331] These represent only a small selection of studies that identify links between responses to uncertainty and temperament.[1332]

Different specialties in medicine have distinct cultures of practice and draw physicians of different temperaments.[1333] In this dissertation, I have focused on palliative care and what its culture, tradition, and ethos of practice might contribute to the management of uncertainty in medicine. Each medical specialty, with its distinctive cultural practices and values, has something to contribute. In "The Importance of Individuals," James argues that differences

[1326] (Dempsey, 2024b; Dempsey & Mulder, 2023a)
[1327] (James, 2008ai, pp.11-14)
[1328] (Frenkel-Brunswik, 1949; Ghosh, 2004; Koerner & Dugas, 2008)
[1329] (Schneider et al., 2014)
[1330] (Edwards, Weary, & Reich, 1998; Hodson & Sorrentino, 1999; Jach & Smillie, 2019)
[1331] (Z. Han, Zhang, Wang, Zhu, & Wang, 2021)
[1332] (Boelen & Carleton, 2012; Borkovec, Robinson, Pruzinsky, & DePree, 1983; Hillen, Gutheil, Strout, Smets, & Han, 2017; Ladouceur, Talbot, & Dugas, 1997; Robichaud, Koerner, & Dugas, 2019; Shihata, McEvoy, Mullan, & Carleton, 2016)
[1333] (Borracci, Ciambrone, & Arribalzaga, 2021; Morales et al., 2021)

between individual temperaments (and even their clashes) each play their part in meliorism. He writes that the dynamic "zone of individual differences" is "the zone of formative processes," in line with the analogy used earlier, "the soft layer beneath the bark of the tree in which all the year's growth is going on."[1334] James explains that there are many different specimens of mind, and each type is, necessarily, "partly perceptive and partly blind."[1335] There are many specimens of medical minds too, and we need each other, with our different attentions, to cover one another's blind spots. Each specialty, with its own temperaments, contributes its part to dealing with uncertainty in medicine, and this too is part of the holding of uncertainty together with humility.

Restating Research Aim & Summary

This dissertation addresses the need for a paradigm in medicine that helps patients and healthcare providers to live with uncertainty, which cannot be "cured." Through engagement with James' pragmatism as an attitude of orientation, which turns attention from uncertainty towards action, I urge healthcare providers to address the suffering uncertainty causes. The practice of Palliating Uncertainty shifts attention away from futile quests for certainty and towards meaningful action, enabling individuals to live—and even flourish—amidst uncertainty.

James' pragmatism challenges medicine to normalize uncertainty and to acknowledge it honestly and humbly. In a pragmatic approach to uncertainty, efforts are focused on palliating the effects of uncertainty in a plurality of ways. I argue that turning attention to action does not "cure: uncertainty but rather palliates it—that is, it cloaks uncertainty not merely in the

[1334] (James, 2008o, pp.192-193)
[1335] (James, 2008a, p.60)

sense of concealing or hiding it, but in the richer sense of covering, comforting, and alleviating the suffering it causes, allowing one to continue living a life shaped by their values and sense of meaning. James provides a paradigm in which uncertainty is to be accepted and lived with courageously. He acknowledges, however, that response to uncertainty is largely a matter of temperament and that a person cannot be asked to be courageous all the time. In James' pragmatism (and especially in the spiritual/religious elements of his thought), uncertainty is not carried alone but held together in community. The approach Palliating Uncertainty likewise holds uncertainty in relationships with our patients, each other, and communities beyond healthcare.

Contributions and Implications of Research

This application of James' philosophy to palliative care is original. By bringing James' thought into dialogue with palliative care, I have developed a novel framework for addressing the challenges of uncertainty in medicine. In doing so, I have critically examined prevailing attitudes and approaches to uncertainty within medical practice. Through this work, I have made meaningful contributions to the fields of medical practice, science and religion, theology, and Jamesian scholarship.

Regarding medical practice, my primary objective is to inspire a cultural shift that reshapes how we approach and manage uncertainty. I challenged the "Michigan Answers" "culture of certainty" and questioned its assumptions about uncertainty in Chapter 1. I reframed uncertainty as an experience to be palliated through a change in attention and showed how this might play out in practice through the cases of Part II. I offered a way of living with uncertainty through what James describes as a religious/spiritual disposition, humble before that which cannot be known, yet acting courageously, and attuned to relationships. With the story of "Bill

United," I showed how uncertainty is held in a community and made a case that offering relational support is a way of taking action in uncertainty. This relationality (which emerges from James' religion/spirituality) provides a way in which we, together, can live meaningfully in the uncertainty of end-of-life care.

Although grounded in the context of palliative care, the insights of this dissertation extend to the broader field of medicine. This work has significant implications and, if put into practice, can be used to help alleviate suffering and improve quality of life for patients, families, and healthcare providers. I have proposed that each medical specialty has a role to play in the collective holding of uncertainty and that future work is needed from other specialties to explore the insights that their unique ethos of practice might offer.

Regarding science and religion, this dissertation breaks new ground. I have investigated a field neglected in science and religion (medicine), and (emphasizing the practical over the epistemological/ontological) sought to apply spiritual/religious insights to a secular context in order to make a difference in practice. I have shown an intersection of science and religion in the context of uncertainty and in the alleviation of suffering. Through James, I have demonstrated a continuous interplay and interweaving of both science and religion and the fruitfulness of such a dialogue, which could be developed further in the context of medical humanities.

Regarding theology, this project has explored how uncertainty creates space for the religious/spiritual and the secular to coexist and engage in productive dialogue. James shows the pragmatic utility of religion/spirituality and its disposition towards the world. He highlights the importance of faith (whether secular or religious) as a crucial part of human experience.

Both medicine and theology grapple with the question of how to live with uncertainty, and each holds resources that can inform and support the other. What can theology learn from the scientifically grounded and embodied experiences of uncertainty in medicine? What can medicine learn from religious traditions in dealing with uncertainty and living with mystery? These are questions I have only begun to explore and more work is necessary, especially from the distinctive perspectives of different religious traditions. What I have shown, however, is the value of uncertainty as a space for this dialogue.

Regarding Jamesian scholarship, I make unique scholarly contributions by framing James' pragmatism as a turn in attention and by exploring his approach to uncertainty through a lens of palliation. I have found a way to creatively apply his philosophy to medicine, but have only begun to scratch the surface. There is much more. I also hope to inspire other James scholars to bring James' insights into other disciplines. Finally, in a spirit continuous with that of James, I have carried forward James' own project of crafting a philosophy for life. Ultimately, living with uncertainty is not solely a challenge faced by medicine but a fundamental part of human experience.

Limitations of this Study

This study has several limitations. Though based on empirical studies, this dissertation is not an empirical study itself; though engaging with James, it is not a hermeneutic project, an analytical defense, nor a study of other pragmatists; though considering management of uncertainty, it is not based on an approaches of decision theory and other probabilistic methods; and though distinctively theological, it is written for a secular context with an audience of medical practitioners in mind. The case-based approach is justified upon Jamesian grounds and medical literature methodology, but it introduces subjectivity. There are many more cases that

I wished to include but space limitations did not permit. Although I focus on the context of palliative care, uncertainty is encountered in every medical specialty, each of which has a unique perspective to contribute. The project would be enriched by more engagement with resources in the contemporary psychology of uncertainty and through further exploration of practical systemic changes that could be recommended for healthcare systems. My conclusion is that communities hold uncertainty, but this idea would be better expressed through a collaborative project than through a single-author dissertation. Also, my argument may be misinterpreted as overly dichotomous. I emphasize that the palliation of uncertainty as described here is not intended to oppose the use of biomedical and technical interventions that are aimed at reducing uncertainty; however, it does oppose the idea that the reduction of uncertainty should always, and unquestioningly, be the most important goal of care. As it stands, this dissertation may be too philosophically technical for medical practitioners, and its academic format is not well-suited to sharing the ideas of uncertainty palliation with busy clinicians. This project, however, does provide an essential foundation for further work.

Future Directions

Part III is titled "Living with Uncertainty" for an important reason. A guiding aim of James' philosophy is not merely to theorize about experience, but to return thought to the immediacy of life itself. James writes in *PU,*

> I am tiring myself and you, I know, by vainly seeking to describe by concepts and words what I say at the same time exceeds either conceptualization or verbalization. The return to life can't come about by talking. It is an *act*…the concepts we talk with are made for purposes of *practice* and not for purposes of insight.[1336]

[1336] (James, 2008ag, p.131)

The approach of Palliating Uncertainty must, likewise, "return to life." In James' words, "it is an act" and made for the "purpose of practice and not for the purpose of insight." It is not the approach itself that will palliate uncertainty, but the living of it in practice.

Living with uncertainty exceeds any "conceptualization, and verbalization" that I have written. Theories and models, including those of this dissertation limit. They are not copies to be confused with reality but tools to navigate it. Taxonomies and tools can distract and lose some aspects of the experiences. As Gavin writes, "For James, something is always left out of conceptualization; 'Ever not quite' trails after along after every attempt. What is left out is, quite simply, action."[1337] In short, Palliating Uncertainty is not simply a conceptual approach—it must be enacted, lived, and practiced.

Part of the anaesthetic revelation is that of "life exceeding logic."[1338] For James, problems are "solved livingly;" uncertainty too is "solved" in the living.[1339] Beresford, in his article "Uncertainty and the shaping of medical decisions," closes by telling the tale of the "Archangel" and the "Prole" (the working-class man):

> R.M. Hare invented two characters whom he called the Archangel and the Prole. The Archangel can achieve the crucial perspective and detachment from which his dilemmas simply vanish. The Prole cannot achieve this perspective and sees his moral dilemmas as real and indissoluble. Nussbaum suggests that in politics what we need is more Proles and fewer Archangels; after all, Archangels don't really know how to be human beings. I am suggesting that the same is true in medicine. Here even Archangels would have to face uncertainty but only Proles could understand and act upon it.[1340]

[1337] (Gavin, 1992, p.150)
[1338] (Ibid., p.148)
[1339] (Ibid., p.116)
[1340] (Beresford, 1991, p.11) references (Hare, 1981)

In the parable, the Archangel inhabits the world of idealized concepts. The Prole, the working-class practical person, makes their way through the bog. Hare says that the Archangel can make dilemmas vanish through his "critical perspective and detachment." I suggest that it is not only the Archangel who has the power to make indissoluble dilemmas vanish. The Prole can achieve a practical perspective in which dilemmas (which remain theoretically indissoluble) vanish too. As an agent *involved* in the world, the uncertainty might matter less than other values and the need to act. In medicine, both the Archangel and the Prole face uncertainty. The Prole turns attention towards action and lives with the uncertainty, "solving" it in the living. Hence both Archangels and Proles face uncertainty but only Proles "understand and act upon it."

The word "solves" must be used with a caveat. As Gavin reminds us, "James "wanted philosophy to return to life, but life does not come in neatly disciplinary parcels. Nor does it arrive as a set of issues that can be completely solved."[1341] I prefer to replace the word "solved" with the word "salved," i.e., to use a metaphor from palliative care—that of a wound that is covered and a pain relieved. Uncertainty too is "salved livingly." The uncertainty is not always answered, but life goes on.

My hope is that the approach shared in this dissertation might offer some salve for the pain of uncertainty—that it can help ease the suffering it brings and provide a more compassionate, expansive way of facing uncertainty in medicine as a whole. I choose the preface "I hope," not out of doubt or defensiveness but in acknowledgement of the uncertainty with which we deal. James offered his pluralism as a hypothesis; I similarly offer the approach of this work as a hypothesis to be tested in the living. Like accepting pluralism, acting on the approach of Palliating Uncertainty is a risk, and time will tell in the long run and on the whole whether it

[1341] (Gavin, 2013, p.110)

may help. Where it helps, may it be used; where it does not, let it be cast aside. This is the attitude that James had with regard to his philosophy.[1342]

If uncertainty is not solved by concepts and frameworks and is only solved in the living, then it may seem that this dissertation is inherently constrained by its very nature of dealing in theory instead of action. However, it is important to note that, for all of James' critiques of verbalizations and concepts, his pragmatism breaks down the dualism between theory and action. Thoughts do not just have implications for action (as if there is dualism between thoughts and the world). Concepts are also part of the world and contribute to the stream of experience.[1343] James demonstrates in *PoP* that mental acts are bodily acts, and his pragmatism traces the way in which a thought leads through experience, asking: what difference does this idea make in experience and conduct?[1344] "Pragmatism," JE Boodin writes, "is simply the application of the ordinary method of the scientific testing of a hypothesis to philosophic hypotheses as well…The truth of an idea or plan must be tested by the procedure to which it leads." James' book *Pragmatism* is, itself, such a testing of philosophical ideas. "Where an idea leads" includes the mental sphere of life. In a defense of pragmatism, Boodin continues, "The testing of a doctrine in terms of conduct, or comparing the anticipated consequences with the consequences to which it leads in being carried out, need not always mean material consequences. There is a conduct of the understanding as well as a conduct involving certain perceptual events as its outcome."[1345] Ideas, for James, are both objects in the world and function on the world. Lamberth, writing about James' *PU,* explains that thoughts add to the intimacy of the universe by making that part more harmoniously intimate; they themselves are

[1342] (James, 2008ag, pp.146-149)
[1343] (Gavin, 1992, pp.17-55)
[1344] (James, 2008j, p.81; 2008ak, pp.287-288)
[1345] (Boodin, 1909, p.627)

tossed into the stream.[1346] He explains that philosophical conceptions do not just passively represent the world but actively contribute to it and participate in the creation of the world, shaping the future course of history. After all, it is through the legacy of his ideas that James made (and continues to make) a difference.

The approach of Palliating Uncertainty is, however, to borrow James' phrase, "incomplete until it terminates in action," and has an effect on conduct and experience.[1347] Greenhalgh, reflecting on pragmatism and clinical policy, comes to a similar conclusion. "Pragmatism warns us that these shifts will not be achieved by developing new tools, techniques, conceptual models, criteria for rigor and so on and then putting these into practice."[1348] Similarly inspired, Han closes *UM:FT* as follows,

> In the end, a conceptual framework alone cannot change reality, but it can help us adapt to it. The framework put forth in this book offers no final, universal answers to the question of how individual clinicians or patients should manage the particular uncertainties they experience—only a particular approach to searching for answers. It also provides no way of eliminating the suffering caused by medical uncertainty—only a particular orientation toward this suffering. Whether the framework will ultimately prove useful in spite of these limitations remains to be seen. My hope, however, is that it can be a momentary source of help to clinicians, patients, and others who are struggling with the unknowns of medicine: a steppingstone in an ongoing journey toward uncertainty tolerance.[1349]

My hope is that Palliating Uncertainty may be a "steppingstone" through the bog as well. Pragmatism's ideas offer transformed ways of living, not merely a model to be applied but a hypothesis to be tested, one emerging from experience, entangled in experience, shaping experience, and creating the possibility of new experience.

[1346] (Lamberth, 1997, p.257)
[1347] (James, 2008j, p.81; 2008an)
[1348] (Greenhalgh & Engebretsen, 2022, p.9)
[1349] (Han, 2021, p.141)

James writes in *Pragmatism,* "The pragmatic method, in its dealings with certain concepts, instead of ending with admiring contemplation, plunges forward into the river of experience with them."[1350] He explains that through his theories, all he can do is point. He points to the "mere *that* of life" and leaves it to the life-liver to "fill out the *what* for yourselves." In some ways, James needs us to hold the uncertainty with him.

James' texts are more than philosophical; they are inspirational.[1351] He teaches that "all claims are made in the thick of things."[1352] We act on the truths at hand at a given time and do so without guarantee. The verdict is still out, but still we live on. James' philosophy throws down the gauntlet existentially. Can you live without things making sense? Can you live in the thick of things? Can you live with an incomplete understanding? I say, take hope, you already do. We salve uncertainty in the living, and we salve uncertainty together.

The palliation of uncertainty is not merely an endeavor for individuals but requires broad systemic and cultural changes in medicine—this too is part of holding uncertainty together. I asked in Case 5 how we can build structures to support the palliation of uncertainty. In what follows, I propose several preliminary directions that may serve as starting points for integrating the approach of Palliating Uncertainty into clinical practice.

[1350] (James, 2008ai, p.63)
[1351] (Gavin, 1992, p.188)
[1352] (Kaag, 2020b, p.162)

- Providing education for medical students, as well as opportunities for continuing education for practicing clinicians focused on the principles of Palliating Uncertainty and the development of related skills[1353]
- Integrating the humanities into medical education to foster the cultivation of Palliating Uncertainty and to support a pluralistic approach to engaging with uncertainty[1354]
- Incorporating training in coping mechanisms and resilience-building to support physicians in navigating clinical uncertainty[1355]
- Support and formalize the implementation of Uncertainty Balint Groups as a structured forum for reflecting on and navigating clinical uncertainty within a community context[1356]
- Implement automated prompts within electronic medical records to encourage clinicians to engage patients in conversations about uncertainty and the suffering it causes[1357]
- Enhance the integration of spiritual care in clinical settings to address the existential dimensions of uncertainty[1358]
- Ensure adequate reimbursement and protected time for clinicians to address patients' concerns related to medical uncertainty[1359]
- Address and mitigate systemic pressures for certainty imposed by bureaucratic demands, insurance protocols, and fear of litigation[1360]
- Incorporate the principles of Palliating Uncertainty into the development of medical AI, ensuring that its algorithmic recommendations and clinical prompts reflect this approach

Next Steps

Part of the work of this dissertation has been beginning the process of bringing these ideas into practice. As mentioned in the introduction, I have presented this work as the keynote address at the McGill International Palliative Care Congress, the UK Palliative Care Congress, the Ireland Palliative Care and Psychiatry Conference, as part of the Hospice UK Clinical

[1353] (Han, 2021, pp.111-142; MacLeod, 2024)
[1354] (Lazarus, Gouda-Vossos, Ziebell, & Brand, 2023)
[1355] (Han, 2021, pp.111-142)
[1356] (Roberts, 2012)
[1357] (Perri-Moore et al., 2016)
[1358] (Steinhauser et al., 2017)
[1359] (Etkind et al., 2015)
[1360] (Anderson, 1999; Catino, 2009; Eftekhari et al., 2023; Elaraby et al., 2023; Kakemam, Arab-Zozani, Raeissi, & Albelbeisi, 2022; Rinaldi et al., 2019)

Extension of Community Healthcare Outcomes (ECHO) and various groups at University of Oxford. I have incorporated these ideas in teaching the Oxford medical students in the medical humanities curriculum and have been asked to teach on Palliating Uncertainty at the Oxford Advanced Course for Pain Management for palliative care practitioners. To date, very few of the numerous textbooks on palliative care include uncertainty as an explicit issue to be addressed, and few provide guidance on how to manage it. One of the pragmatic applications of this work has been writing an entry in the Oxford Handbook of Palliative Care on "Palliating Uncertainty," which embodies the movement of these ideas into education and practice. The approach of Palliating Uncertainty is a hypothesis to be tested in real-life practice. With this in mind, the next step in my training is to return to clinical practice and put it into action.

Final Summary

We meet uncertainty not as a problem to be solved, but as a condition to be lived—fraught, felt, and full of possibility. It is not only medicine, but life itself that calls us into the uncertainty: to stay with it honestly and to act within it bravely, to suffer and alleviate its suffering together. James and palliative care remind us that uncertainty is not just to be borne, but to be made meaningful through relationship and ongoing creation of hope and healing. As James would insist, this work is never final, never fixed. Palliation of uncertainty calls us to act. Together, we can help palliate uncertainty, alleviating the suffering of it and helping each other live fully with it.

7

Epilogue

In an 1892 letter to his friend Grace Norton, James recounts a beautiful summer in the "medicinal country" of Switzerland and reflects on life in Florence, Italy—sharing with her the joys of his reading and conversations and news of family and friends. He tells Grace of his sons' English school and of his daughter's dancing, gymnastics, and ballet lessons. Tongue in cheek, James comments, "What an awful trade that of a professor is—paid to talk talk, talk! I have seen artists growing pale and sick whilst I talked to them without being able to stop…It would be an awful universe if everything could be converted into words words words."[1361] As he says in the anaesthetic revelation, "Philosophy must pass from words."[1362]

Words can be useful, but in palliative care we often encounter the plain inadequacy of words. I concluded my presentation at the UK Palliative Care Congress with movement rather than words, and embodied the themes of this dissertation through a dance performed within a spinning metal circle known as a cyr wheel.

I began the dance lying on the ground in the center of the wheel, dressed in a patient's gown. Across the room sat my mentor in palliative care, Dr. Mulder, wearing his physician's white coat. I explained that the space within the wheel represented the uncertainty—the space that I dance within. The wheel itself was the circle of which James speaks, the community that holds

[1361] (James, 2008r, pp.357-358)
[1362] (James, 2008af, p.190)

the uncertainty and that holds me when I, as a patient, feel as though my world is spinning.[1363] Through the movements of the dance, I portrayed a plurality of relationships with this community. As the dance drew to a close, I once again lay on the ground within the wheel. In the silence, Dr Mulder stood from his chair, stepped into the ring, held it with me, and walked alongside me. I concluded: "We can step into the uncertainty with our patients and hold it with them. We do not carry the uncertainty alone but with our patients and with each other, and sometimes in the act we can do something beautiful."[1364]

[Please watch]

https://www.youtube.com/watch?v=nESyRLbYX7M&ab_channel=ArielDempsey

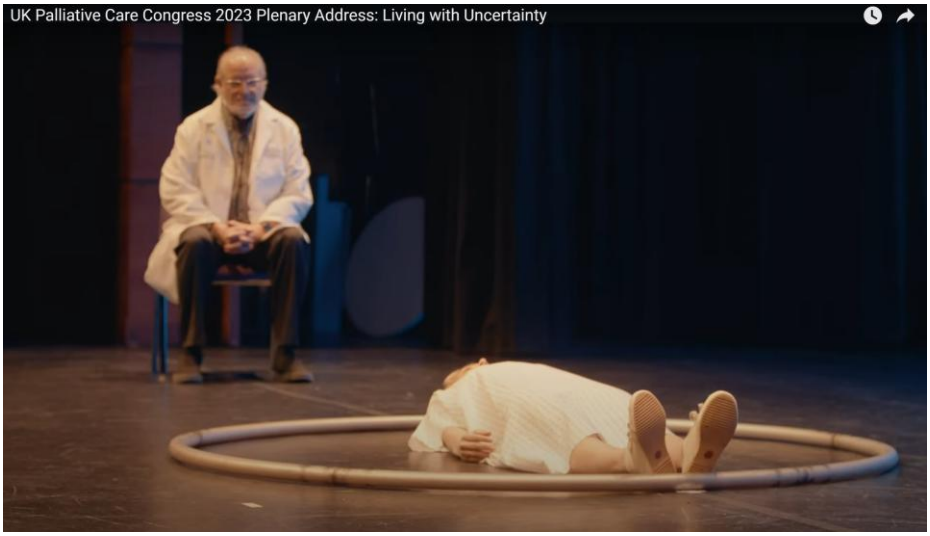

Figure 24) 2023 UK Palliative Care Congress Plenary: "Living with Uncertainty" Cyr Wheel Dance[1365]

[1363] (James, 2008ap, p.116)
[1364] (Dempsey & Mulder, 2023a)
[1365] (Ibid.)

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