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Hope to hope: Experiences of older people with cancer in diverse settings

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ABSTRACT

Purpose: The purpose of the study was to explore experiences of older people with cancer in ascertaining the attributes of a person-centred approach in sustaining hope and enabling human flourishing. This was a qualitative study comparing patients and professional experiences and perceptions of care across to ward settings.
Methods: Methods involved 10 semi-structured interviews conducted with patients and focus groups (n = 6) and 10 semi-structured interviews with health professionals. Three dissemination focus groups (n = 14) were also carried out with professionals to allow further analysis of the data.
Results: Two main themes were identified, including ‘Emotional adaptations of hope: wants and expectations’ and ‘Hope through belittling their illness’. Findings highlight the way hope is conveyed and the emphasis' accorded to issues such as societal perceptions, knowledge, expectations of care, life stage, relationships, identity, and emotions. Findings also reinforce the importance of maintaining hope, recognising the different ways hope is used, and enabling patients to flourish.
Conclusion: This study highlights how hope is facilitated through the interaction between patients and professionals and that the relational interactive stance. This current study establishes that hope seemed to be temporal, contextual and dynamic in nature, involving an ongoing process. Helping older people with cancer to understand their illness considering the situation of lives and experiences is essential to address expectations and wants.

1. Introduction

Hope has been recognized as an important part of being human and being able to flourish. However there are challenges in providing hope for older people with cancer (Lannie, 2014). The older person commonly presents with a complexity of symptoms and can have multi morbidity which further makes the diagnosis and assessment of needs a challenge (Puts, 2010). Older people are also subject to being cared for in diverse settings so the chance to build up a therapeutic relationship is also lessened as people are seldom in the same ward for acute episodes. Thus the attributes of developing a therapeutic relationship is lessened.

In addition, older people are more likely to be subject to feeling they have little chance of aspiring to their wants and expectations (Kearney and Miller, 2000). Also, due to a lack of clinical assessment of their needs older people are commonly given fewer choices then their younger counterparts (Ellis et al., 2011). Different times in our lives a person can experience great joy and also great suffering and at both of these times we have the potential for human flourishing through finding meaning and purpose to our lives (Gaffney, 2011).

The majority of research on the hope focuses on the factors influencing a person's hope in a general sense (Herth, 1990; Wiles et al., 2008). Research on hope and its significance in cancer and palliative care is scant considering the emphasis in palliative care on person centredness. More research is needed about the factors which engender hope for older people with cancer and palliative care. This paper demonstrates that older persons with cancer can have their wants and expectations met when professionals focus on the personhood of the individual rather than on their diagnosis.

2. Methodology

2.1. Sample and justification of data collection methods

Purposive sampling captures diversity of older people patient and health care professionals’ perceptions. Semi-structured interviews were conducted with older people and focus groups and semi-structured interviews with professionals. Dissemination focus groups were also carried out with professionals to allow further analysis on data. The sample was taken from two wards in a Hospital within a rural area in the North East of Scotland.

In more detail, the sample included the following:

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Focus groups: One focus group was carried out in each of the wards. The sample in the first focus group (specialist) consisted of three registered nurses (all female). All had a course in administration of chemotherapy. One professional was a cancer survivor. The second focus group consisted of three registered nurses; one had a post registration course in cancer care.

The **patient sample** on the specialist ward consisted of three males and two females. The age range was from 70 to 82. They were all in the palliative care stages needing supportive care, apart from one patient who was receiving active treatment. The range of diseases was: hairy cell leukaemia (1), breast cancer with metastases (2), unknown primary with liver metastases (1) and prostate cancer (1). The patient sample in the medical ward consisted of three males and two females. The age range was 75 to 82. They were all in the palliative care stages needing supportive care. The range of diseases was: lung cancer with metastases (2), unknown primary (1), prostate cancer (1) and colorectal cancer (1).

The **professional sample** in the specialist ward consisted of one male and three females. All professionals had a certificate in delivering chemotherapy (not degree level but competency based). The sample in the medical ward consisted of four females. The educational qualifications were: post-registration course on cancer (1), post-registration course on palliative care (2), Diploma in Nursing (4) and a counselling course (1). The two visiting professionals to the two wards included a Clinical Nurse Specialist (CNS) in lung cancer who was undertaking her MSc in advanced cancer care and a Chaplain who had a BSc in Theology.

The professional sample in three **dissemination focus groups** consisted of permanent members and visiting staff members. The first dissemination group consisted of three staff nurses. One had experience of the medical ward. All had a competency certificate in chemotherapy. One participant had already been interviewed. The second dissemination group consisted of two staff nurses, an occupational therapist, a dietitian and a pharmacist. One participant had already undertaken a semi-structured interview. The dietitian was assigned to the specialist and medical ward. The third dissemination group consisted of three females and one male: an occupational therapist, a pharmacist, an education facilitator (cancer and palliative care) and a staff nurse. One staff nurse had already been interviewed and had attended a focus group.

The total sample consisted of the following:

- Patients (10)
- Registered nurses (18)
- Occupational therapists (2)
- Dietitian (1)
- Nursing practice education facilitator in cancer and palliative care (1)
- Pharmacists (2)
- CNS (1)
- Chaplain (1)

3. Choice of methods

3.1. Focus groups with health professionals

Focus groups were helpful exploring group qualities and opinions on how this affects the care, e.g. role, clinical opinions, focus of care. Also to identify particular education and experiences that enhance or conflict with care or psychosocial support for patients, e.g. cancer care education. Also to understand how people perceive the care of the older patient from group role perspectives, setting, referrals. Focus groups would enable issues which participants may not discuss in an interview, e.g. emotion management, how to manage moral and ethical issues in stopping treatment.

Table 1
How data is analysed and reflected upon.

Proximal care One particular aspect of care delivery: proximal care, was drawn to my attention. During an interview on the specialist ward (*place*) and reflecting on Staff Nurse Jones (*actor*) stating 'You just make the time … [more time to] sit down and ask what they really want' made me realise that to be engaged in emotion management, nurses had to be not only physically present with the patient but also to listen to their concerns. Giving time to patients to present their experiences may help them connect with their past experiences (*event*). Thinking about the value of the attributes of the ward settings enables my understanding. I appreciate the different ways older patients (*goals*) with cancer experience care in the context of the ward settings. This seems to help validate their experience and strengthen the therapeutic relationship.

3.2. Semi-structured interviews with health professionals

Semi –structured interview with professionals were chosen to:

- Explore individual qualities and opinions and evaluate how this affects the care, e.g. role, clinical opinions, focus of care.
- Explore issues which participants may not discuss in a focus group setting, e.g. emotion management.

3.3. Semi-structured interviews with older persons

Due to the vulnerability of the older people interviews were thought as best rather than focus groups (ethical opinion). Interviews with patients enabled;

- Exploration individual views and opinions regarding their care, e.g. treatment choice, their age, whether care was supportive or active.
- Discover what they want from their experience of care, what helped or what inhibited their care needs, e.g. power issues, paternalism, therapeutic relationships.
- Search for individual qualities and opinions and assess how this affects the care, e.g. individual care issues, stage of disease.

There were five stages to the data generation. Firstly, issues from the gaps in the literature review formed the prompts for the focus groups and semi-structured interviews. Secondly, focus groups were carried out with professionals in each of the wards. Thirdly, professional and patient (twenty) interviews were carried out on each of the wards. Fourthly, three dissemination focus groups further informed ongoing data analysis. All these stages were not considered in isolation, but seen as an iterative process.

4. Ethical considerations

The process of ensuring the study had ethical approval was to proceed through the Fife and Forth Valley Research Ethics Committee. Ethical approval was granted 08/S0501/33.

Data were analysed using constant comparison, analytic induction while ensuring theoretical sensitivity guided by Ritchie and Spencer's (1994) thematic framework analysis. Analysis was seen as dynamic and open to change, as theory and explanations developed. A systematic rigorous approach was guided by analytic induction and theoretical sensitivity. Ritchie and Spencer's (1994) framework was used as this places emphasis on using explanations and exceptions to an analytical advantage. The five stages are: familiarization of the themes within the data, identifying a thematic framework, indexing, charting, mapping and interpretation. Framework involved:

- Coding data into categories so that items with shared characteristics are placed together.

Table 2
Focus of care and fostering hope.

Types of hope-fostering interventions – medical ward	Types of hope-fostering interventions – specialist ward
'Reflecting on life which is there.'	'Treatment being massive.'
'Just listening to them.'	'They know they can always get treatment here.'
'Giving them a help with a bed bath is comforting.'	'They are all "in the same boat."'
'Relieving their breathlessness through getting them some "fresh air."'	'They see patients worse off than themselves.'
'They don't want to go to the hospice and would rather stay here.'	'They tell us things they don't tell their family.'
	'We know the cancer journey well.'

- Integrating categories and their properties.
- Reaching theoretical saturation.
- Writing a theory and revising as ongoing analysis occured (Seale, 2004, p. 242).

5. Findings

Two themes from the diverse data set are discussed. The particular codes that are discussed are the following;

Emotional adaptations of hope: wants and expectations
Hope through belittling their illness

The findings are from the focus groups and interviews with older people and health care professionals. Findings highlighted commonalities and also different emphasis' accorded to issues such as societal perceptions, knowledge, expectations of care, life stage, relationships, identity, and emotions. An example of how data is analysed and reflected upon using Spradley's (1980) framework is shown in Table 1.

The three main findings unfolding are firstly that patients often express wants in relation to their social and clinical needs at end of life, while professionals tended not to discuss expectations. Secondly, findings indicate that 'hope work' was undertaken by patients to maintain resilience and to protect others. Thirdly, it appeared that patients were helpless and resilient at the same time 'given all they had gone through' and 'having seen it all before'. However, challenges for professionals were in recognising their life context and their wants for end of life. 'Wants' is a term which signifies the unknown and that there is a low chance of it coming to realisation (Wiles et al., 2008). Hope-fostering strategies are categorised across the two wards, demonstrating clinical and social attributes of hope. This is listed in Table 2 below:

5.1. Emotional adaptations of hope: wants and expectations

Acceptance was commonly linked to being older for patients, meaning that patients may have been hiding their true feelings in favour of acquiescence. However, there was also a process of normalisation that related to their past lives which acknowledged what they had previously experienced. Acceptance and normalisation were ways for them to manage their own hope by looking at the social constructs of being old and drawing on their past life experience.

Acceptance of illness related to most patients who had reached the end stages of their illness. Patients understood that they were in the palliative care stages but felt that the social construct of being older was also a reason to accept their illness. The social construct of age thus influences responses to the clinical manifestation of their illness, as exemplified by a quotation from Mary's interview. When asked 'How are you coping with your illness?' she replied:

> No problems whatsoever. I've had a good life. That's what I say to my daughters, I say, 'I've had a great life. I would never change my life.' I've had a great life. I'm very lucky that way. (Mary, breast cancer, specialist ward)

Archie shows acceptance through comparing to others:

> I am getting on now, not like that we lassie there she is young. I've had a good life (Archie, lung cancer, medical ward)

Mary shows a positive slant, but in the following, Colin shows the more negative perspective:

> She just said, 'You've got leukaemia' and I just said, 'Well, if that's it, that's it.' That's how we were told, that was it; there is nothing to it. I mean, I suppose I could get [cancer as a] younger person; it would be different altogether I would say if you were younger. But with me going through my wife and that and getting told that, I just kind of accepted it and that was it. (Colin, leukaemia, specialist ward)

In the second quote, Colin is accepting of his illness in two ways. Firstly he relates to the potential for negation or contesting of hope by professionals. Secondly, through embracing implicit ageism, augmented with his past experience of caring for his wife who died of cancer, he accepts that there are no options. The intersection of past experience and the social construction of age are explicitly linked in all patients' accounts. However, there are varying forms of resilience to one's illness. Graham appears more positive than Colin. Graham acknowledges age, but feels that older people have to adapt, to live and be positive:

> It depends on their ages. It would be different to each with different ages, well maybe, not but to adapt to it. You've got to adapt to what you have got. If you start getting yourself down, it is the worst thing you could ever do, because there is still may be no cure, but if you don't adapt to that it is going to be worse. You have got to try and live with it. Live with what you've got. (Graham, liver disease, specialist ward)

Thus, invoking their inner strength with the societal expectations of being older appeared to foster a sense of coping for patients. Graham repeated the words 'live with it,' which was particularly vivid. Some participants looked to their past illnesses and treatment as ways of showing resilience:

> I had the operation for the prostate and I went for radiotherapy and that and they come back to me and said, 'We think we have cured it and everything'. I said, 'Oh, well but what's this one now?' The difference is that there is no cure for this one. So you accept it, that's the difference. (Colin, prostate cancer, specialist ward)

Colin had cardiac disease and leukaemia, and now has prostate cancer. His wife had died from cancer on the same ward. His hope is not related to desire, but rather acceptance of the absence of hope. This person is an exception in the study, as he previously had leukaemia and now has prostate cancer. He also knows the ward, having visited his wife, so he was familiar with some staff members. Acceptance, comparison to others and past experience appears to be linked in how 'hope work' is processed.

Living with illness and coping was also identified in patients' accounts, as they looked to other identities rather than being the 'cancer patient.' These were Mary's closing words in her interview in response to being asked what advice she would give someone in the same position as herself:

> Anyway, that's the advice I would give. I think it is the advice that

> folk have thought about. I think of Jane Tomlinson, that woman who did all the cycling, well, obviously she didn't preach the word as such but she showed that if you had a goal and an aim then you got on with it and you had something worthwhile to aim for, and didn't lie down to, you're going to die in 6 months. So help yourself. There you go. (Mary, breast cancer with metastatic disease, specialist ward)

Mary had a proactive approach to her illness. Despite having a disseminated disease, she presented herself as a strong individual and liked to ensure she had something to aim for as she liked to go to the Probus Club regularly. It is interesting that she appealed to a goal relating to her personhood rather than a wish related to her health care needs. The complexities involved in conveying hope is further complicated in the situation where patients are receiving treatment due to chronological age.

> You certainly get older people that are pushing for the next treatment option. I have had a lot of those. And sometimes you are thinking to yourself, ‘You are 85 now and you are asking for this new drug that might extend people's lives by a few years, but the trials done have been up to the age of 65.’ (Staff Nurse Formage, specialist ward, dissemination focus group)

The quotation above highlights the interface between the clinical and individual construct of illness. Some patients were resilient and used the words ‘You have to fight it,’ while others wanted to give up hope. When patients were doing this, they were also acknowledging that the palliative stages of their illness were leading towards the end of their life.

I said to Jeannie, I'm ready to go. I cannot go on like this. I am not liking the tiredness and pain. It's relentless. Unless there is a miracle but I doubt it. (John, Liver mets, medical ward).

The experience of symptoms influences the way patients either foster or lose hope, as identified. Older people therefore had many clinical aspects to their illness, which influenced their quality of life. Older patients with cancer often had to deal with psychosocial aspects of their illness such as supporting others. Thus, ‘hope work’ was not just for themselves but for other family members.

Patients had the potential to discuss their fears and emotions with professionals, which they would not have done with family members. However, opportunities were thwarted as expectations were not always spoken about. The ward was commonly a place where patients were also told of the progression of their illness.

5.2. Hope through belittling their illness

Some patients used certain words as ways of belittling their cancer, such as saying ‘Cancer is small’ or through living with the sense of the unknown with regard to their cancer. This belittling appeared to be a mechanism for maintaining positivity. The temporal aspects of hope appeared to be augmented with the belittling meanings they attached to words:

> After I had the treatment, when it had shrunk to that and was *very, very small*, that was the greatest moment of the lot and then I asked, yesterday morning, about the breathing. ‘Oh you are going to have that all the time.’ And I thought ‘Oh well.’ But *I don't know* what is showing up in the bone scan *I don't know* what is showing on that at all. (Jinty, breast cancer, specialist ward)

The quotation above demonstrates how hope was an ever-changing concept as the meaning attached to their illness shifted for patients, through interaction or acquisition of knowledge from different sources. It is interesting to note the change from ‘greatest moment’ to ‘Oh well,’ then to the repetition of ‘I don't know.’ It seems that we are hearing through her words how she is managing to cope with the lack of information. The quotation below is another example of this belittling strategy, which also conveys the process of patients protecting their own feelings by internalising their thoughts, which can promote a sense of positivity.

> … I have got it [cancer] in the two lungs now, but I don't know the progress in that yet, but they seem to be a wee bit bad. (Jinty, breast cancer, specialist ward)

> I am waiting on the Doctor but I never know the truth as they say wait and see, wait and see. I just want to know (Jim, colon cancer, medical ward)

The process of living with uncertainty was common for patients because they did not know the results of tests. Most of the patients in the study were awaiting the decision of either stopping treatment, being told of future treatment or maintaining continued symptom management. In this quote below, Jinty is weighing up the potential outcome of having treatment and living longer against the side effects of the treatment:

> I had chemo at the hospital, my fingernails got it, my feet got it, my hair got it, and if I get through this, if I've to go through this thing again I am going to lose my hair again. I'm lucky I've got two wigs, but what point is there wearing them if I am not going to be here? I'll have to wait and see what the verdict is … I'll have to wait and see what is going to happen, wait and see what the verdict is going to be. We will wait and see what happens. If I have to go through more radium and lose my hair again is it all worth it? Is it all worth it if I am not going to be here? (Jinty, breast cancer, specialist ward)

Jinty uses the phrase ‘wait and see’ many times to emphasise the prolonging of the verdict before deciding what exactly she hopes for. This fluid articulation of hope enabled patients to speak of the future as they lived with a sense of the unknown. There was perhaps a positive slant to uncertainty in one way, but in another way it is not helpful in making a plan and does not allow for clear expectations; thus hope becomes a ‘want’ rather than being grounded in reality. Some patients talked about the desire to attend to specific aspects of their life that were important to them, such as doing the garden or seeing their grandchildren. This attention to modest future goals was something referred to by most patients. These goals appeared to be realistic and were perceived as important to them. Thus, the importance of realising clinical and social expectations is particularly important for older patients with cancer so that they can plan for their families, as well as for themselves. While patients identified their own goals, they also looked to fellow patients' to make sense of and enable them to manage their situation in the greater context of the ward.

6. Discussion

The care environment is a place where patients can re-focus themselves, reflect on their illness and express their hopes for the future, which they may not be able to do with their family. Therefore the environment provides a context for processing, dealing and coping with their hopes. This concept can be applied in the sense that hope was not always an expectation that was achieved, but a conceptual want which often prevented despair.

The focus of care, notion of sameness and trajectory of illness appeared to influence the hope-fostering strategies.

The hope-fostering strategies in the medical ward were based on giving encouragement for ‘small wins’ within symptom management, while in the specialist ward ‘generalised hope’ could be monopolised through the expectation of probable treatment.

There were competing challenges for some patients in trying to ensure that both their social and clinical needs were heard by professionals. Hope-sustaining strategies were gaining information from professionals, looking back at experiences and comparing to others. These strategies were temporal but seemed helpful for patients to maintain their wants while living with uncertainty. The experience of being with other people is noted as a helpful distraction in other studies (Duggleby and Wright, 2004; Benzein et al., 2000; Benzein et al., 2001). The positive impact of comparing their own life situation with that of others has also been discussed in another study of older people with cancer (Thomé et al., 2004a, b).

There were important differences in the ways in which hope was 'processed' by patients and professionals, and this characterises their varying identities of hope: social, clinical: expectation, want: generalised or particularised. These aspects of hope were influenced by factors such as the type of disease (each having different patterns), the frequency of admissions which governed care provision and interactions with different staff. Insights from the caring environment highlighted that these fundamental factors determine how care is delivered in each of the wards. Hope was seen as a temporal concept that changed over time.

The temporal nature of hope is acknowledged in several papers (Lohne and Severinsson, 2004, 2006; Smith and Sparkes, 2005). Hope for recovery in these studies provided a powerful mechanism for patients to cope with some devastating impacts on health, such as spinal cord injury (Lohne and Severinsson, 2004, 2006; Smith and Sparkes, 2005) and AIDS (Ezzy, 2000). Some studies explain hope as shifting from one style to another (Ezzy, 2000; Lohne and Severinsson, 2004, 2006) or as processes of ups and downs (Lohne and Severinsson, 2004, 2006; Verhaeghe et al., 2007). Verhaeghe et al. made sense of the data from a clinical perspective, as patients in the study were comatose, and so physical changes were magnified. However in this current study, due to the context of being older and having cancer, hope was not such a 'peak or trough' pattern but rather a slow and deep decline oscillating between hope and hopelessness. Age as a social construct reinforced patients to normalise and accept their illness by perceiving that 'they have had a good life'. 'Acceptance' is defined as: The act of receiving what is offered, with approbation, satisfaction, or acquiescence (Wiles et al., 2008).

Individuals use 'hope work' to protect their families and themselves – hoping they will die a certain way. Perakyla (1991) defines 'hope work' in terms of medical identities. In curative hope work the person is defined as getting better. In palliative care the person is 'feeling better'. In 'dismantling hope' patients are seen as past recovery (Perakyla, 1991, page 407). 'Hope work' was a finding following observation of professionals in three wards (leukaemia, medical and emergency). Findings demonstrated that 'hope work' was more prevalent in the leukaemia ward and medical ward than the emergency ward due to the contextual nature of the wards knowing patients for longer. 'Hope work' was more present between patients and professionals.

Findings from this current study identify 'hope work' as a process that patients use with themselves and for their family. If professionals use hope in a 'generalised way' then it is protecting the person and the professional from the potential of doing or saying the wrong thing. Particularised hope is something that is negotiated between patients and professionals through communication, and also relates to clinical and social aspects, and is temporal.

Hope seemed problematic when professionals and patients had different perspectives of hope during interactions. Professionals mostly tended to link the biomedical approach to hope, while most patients had social and psychosocial hopes. It seemed that there was tension between the organisation and the individuals' 'life worlds'.

It appears there were real possibilities in generating life plan goals through proximal care, yet tensions appeared to arise when professionals tried to do and say the right thing. From a spatial interactive stance, Malone (2003) applied the concept of proximal caring to the nursing profession, describing the person/patient-centred process as being facilitated by 'proximal care'. She emphasised that people contact and the concepts of space and time were factors that enabled communication through direct physical interaction with patients. Processes which improved patients' hopes (desiring an event to occur) were based on professionals communicating and giving the correct information in a meaningful way, being with patients.

Some professionals felt that they did not have the knowledge necessary for telling patients the truth. This deficit in knowledge was due to a lack of either experience or education. These particular professionals were mostly in the medical ward. This is implied in other studies which considered the education of professionals in non-specialist wards in relation to older people with palliative care needs (Roche-fahy and Dowling, 2009; Froggatt, 2000a, 2000b) and cancer (Chouliara et al., 2004b). However, Roche-fahy and Dowling (2009) was the only study which was explicit about hope.

The application of hope as a 'want' or 'expectation' as defined in Wiles et al. (2008) study was helpful, as hope as an expectation gave patients more hope, as was planned. However, most of the sample in this current study lacked control over their illness and therefore seemed to oscillate between a sense of want and hopelessness. A reason for this was professionals' reluctance to discuss the transition to palliative care and patients' expectations of end of life.

In another study (Turner and Stokes, 2006) hope was explored in older patients by comparing an older care setting and an acute medical ward. The literature claims that registered nurses engage in hope facilitation with their patients.

However, these claims are largely inferential, with few studies empirically identifying the extent to which registered nurses use hope interventions with their patients. Whilst participants clearly reported that they engaged in hope facilitation with older patients, there were differences between the reported strategies used by registered nurses in acute and long-term care settings. Further, the strategies reported were not unique to hope promotion and have been variously described in the literature on caring, holistic nursing and therapeutic nursing. These have all been noted as attributes that are essential in fostering hope (Herth, 1990, 2000).

The role of health care professionals in providing hope has been seen as fundamental for patients receiving palliative care (Duggleby, 2000a, 2000b; Duggleby et al., 2010; Duggleby et al., 2007; Herth, 1990, 2000; Duggleby and Wright, 2004). In the current study, hope was a central coping mechanism for all patients – without exception. Hope has been found to be a great psychological vehicle for some patients in previous studies, including those dealing with traumatic comas (Verhaeghe et al., 2007) or spinal injuries (Lohne and Severinsson, 2004).

Most professionals tended not to see hope as a concept that might be important to patients' coping mechanisms, but rather a concept that was used in a 'generalised' way with patients. Using hope in this way enabled some professionals to feel protected when they were uncertain of clinical outcomes with patients. Thus, generalised hope sometimes served as a 'buffer,' protecting professionals from saying the wrong thing. However, generalised hope often led to uncertainty and the potential breaking of trust with patients.

Findings suggest that the factors that helped engender hope for patients were being given information and having choices. Different professionals had various perspectives on their roles and how they facilitated a 'person-centred approach.' Some professionals felt they had a moral duty to speak with patients and inform them of changes in care, while others made changes to their care without telling patients.

Other professionals felt that older patients with care should not be accepting active treatment and that their quality of life should be considered.

In amongst these tensions there was a lack of assessment which might have helped give more options for treatment (Duggleby et al., 2010). The overall purpose of this study was to evaluate the effectiveness of a psychosocial supportive intervention called the "Living with Hope Program" (LWHP) in increasing hope and quality of life for older adult, community-living, terminally ill cancer patients. Using a mixed method design, 60 terminally ill cancer patients over the age of 60 years were randomly assigned to a treatment group and a control group.

Baseline hope (Herth Hope Index [HHI]) and quality-of-life scores (McGill Quality of Life Questionnaire [MQOL]) were collected at the first visit in the patients' homes by trained research assistants. Those in the treatment group received the LWHP, which consisted of viewing an international award-winning video on hope and a choice of one of three hope activities to work on over a one-week period. The control group received standard care. Patients receiving the LWHP had statistically significant higher hope and quality-of-life scores than those in the control group. The Herth Hope Index (HHI) is a 12-item, multi-dimensional index designed to measure a global, non-time oriented sense of hope. It is composed of three dimensions: temporality and future, positive readiness and expectancy, and interconnectedness. The Herth Hope Index is the abbreviated version of the Herth Hope Scale.

Duggleby et al.'s (2010) study is significant, as giving patients small hopes to work on tended to increase expectations. From a professional perspective the tension for professionals as to whether to confront patients with the truth led to false hope for some patients due to the lack of consensus in communication between professionals; however, this was improved through collaborative goal setting.

Kelly (2012) in his editorial paper discusses the challenges of being hospitalised and living with the feeling of disappointment and with uncontrolled symptoms. He talks of the importance of acknowledging and understanding the meaning of life as a precious gift. Kelly reinforces the importance of clarifying and negotiating a more mutual way of making meaningful outcomes from palliative care. Findings from this current study would reinforce these recommendations.

Hope is viewed as a key issue in ensuring quality of life (Herth, 1990; Wiles et al., 2008). In a cancer and palliative care context, it is suggested that hope is 'not based on false optimism or benign reassurance, but is built instead on the belief that better days or moments can come in spite of prognosis.' (Scanlon, 1989, p. 491). Other authors have suggested that, as hope is so 'fragile' in palliative care, it changes from day to day (Gamlin and Kinghorn, 1995).

The fragility of hope can be influenced by our growing awareness of the physical nature of our bodies which generally only becomes obvious when health is deteriorating and vulnerability is a threat to 'self' (Toombs, 2007). Human flourishing adds an important dimension understanding of the nature of human bodies where the potential for human flourishing is possible even as the body is failing (Bishop, 2016).

Staff can enable a sense of hope and human flourishing for the person and for themselves when 'inner strength and inner knowing' about what it means to be a person is embedded in practices (Titchen and Mccormack 2010: 539). This was borne out in three findings of a study undertaken in a number of residential settings for older persons in Ireland (Mccormack et al., 2010).

The work environment is essential to human flourishing for both staff and service users according to Maben (2008) and Mccormack and Titchen (2006). An environment that provides the conditions for everyone to flourish will also enable possibilities for hope (Mccormack et al., 2010; Mccormack et al., 2013). Creating connections for the older person to articulate their deepest fears about their diagnosis can offer opportunities for creating connections, and provide space for the person to modify their outlook and find meaning and hope in their lives as their outlook changes (Gaffney, 2011). From an older person's perspective the pinnacle of human flourishing in wisdom (Chopra Chatterjee et al., 2008).

7. Limitations

It is noted that literature that is used to interpret findings is not specific to older patients. Also this study is a qualitative study and findings are not generalizable but more transferable to other settings.

8. Conclusion

This current study demonstrates that hope appeared to be temporal, contextual and dynamic in nature, involving an iterative process of looking back and looking forward. Helping patients to make sense of their illness in relation to the greater context of lives and experiences of older people is essential to address expectations. The study will be useful for professionals who are facilitating hope with older people with cancer. Changes to the way we think about palliative care and an older person is necessary if is to become a reality.

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