

# Hope and hoping in the talk of dying cancer patients

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## Abstract

Hope is the subject of increasing research and discussion within the healthcare literature. However, although deemed of vital import to patient welfare, there is little examination of how hope features within patients' speech. This qualitative study presents the discursive properties of hope as it emerged unprompted during semi-structured interviews with 28 patients in the final phase of terminal cancer recruited from the oncology clinic of the Royal Adelaide Hospital, Australia. In the context of discussions about decision-making at the end of a terminal illness, when used as a noun, hope invariably referenced the medical domain—focussing either on the objective probability of medical cure (typically taking the negative form “there is no hope”), or the subjective possession of the patient, needed to fight their disease. Positioning the patient as relatively powerless and subject to external forces, this hope was most commonly associated with absolute solutions, and life-and-death stakes. Hope as a verb emphasised the patient's active engagement in life, identifying what was good and positive for them. It was used to assign responsibility to others, to indicate and establish solidarity or agreement between the speaker and others, effectively strengthening interpersonal ties between individuals. Through hoping, patients established connection with others and with the future. In the context of interactions between patients and clinical staff, we conclude that the use of hope-as-a-verb may have benefits, enabling the patient—even when dying—to focus on the positive, to connect to others, and to continue to engage with life.

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## Introduction

Since the mid-twentieth century, hope has been the subject of much research and discussion within healthcare discourse and practice (Cutcliffe & Herth, 2002; Elliott, 2005). Yet many have concluded that hope research is fragmented, imprecise, and episodic, and that “hope” itself remains problematic (Cutcliffe & Herth, 2002; Kylma &

Vehvilainen-Julkunen, 1997; Lohne, 2001; Stephenson, 1991) with different versions of hope articulated (Elliott, 2005; Elliott & Olver, 2002; Wang, 2000). These differences may be associated with specific research traditions or disciplines. For example, the dominant approach within psychology has been to employ quantitative methodologies within a cognitive behaviourist tradition, to operationalise and measure hope, correlating it with other variables (Cheavens, Michael, & Snyder, 2005; Snyder, Cheavens, & Michael, 2005). Nursing researchers have often favoured a qualitative approach, drawing upon an experiential paradigm

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focused upon meaning, asserting and then attempting to delineate a complexity of hope (Dufault & Martocchio, 1985; Morse & Doberneck, 1995; Stephenson, 1991). Within medicine, hope is commonly equated with the promise, potential, or provision of curative treatments for disease (Beste, 2005), and medical anthropologists, sociologists, and others interested in the social function of hope have concluded that hope may be a powerful rhetorical tool invoked to justify specific healthcare practices (Brown, 1998; Danforth, 1997; Good, Good, Schaffer, & Lind, 1990). Within bioethics, hope is most often discussed in terms of the pros and cons of “false” hope, and located in opposition to “truth-telling” on the part of the physician to the patient (Beste, 2005; Simpson, 2002, 2004). Representing an additional, prevalent construal of hope within medical discourse, this rests upon a conceptualisation of hope as the possession of an individual patient, to be objectively measured and compared with a presumed optimal amount, with interventions typically targeted to reduce discrepancies between optimal and actual levels of hope (Elliott & Olver, 2002; Wang, 2000)—a conceptualisation evident in the clinical practice of medicine, nursing, and psychology.

However, some have claimed that defining and measuring hope risks distancing hope from its everyday context of use, asserting the need to connect hope to the everyday experience of patients (Nekolaichuk, Jevne, & Maguire, 1999; Simpson, 2004). There has been, nonetheless, little examination of how hope operates in situ, of how patients use hope, and to what effect, in speech. An exception is the analysis by Elliott and Olver (2002) of the discursive properties of hope as it emerged spontaneously during interviews with cancer patients. Employing discourse analytical techniques (Potter & Wetherell, 1987), they analysed hope as employed as a noun or verb, demonstrating that these linguistic characteristics were associated with consistent differences in functions and consequences for the patient. Briefly, as a noun, hope was depicted as an object with attendant properties, implicated the medical domain, usually referenced a patient’s death, and the presence or absence of hope was used to justify particular decisions or actions with regard to a patient. By contrast, use of hope as a verb, in introducing the “someone who hopes,” saw hope as determined by an active patient, and most significantly in clinical terms, usually referenced the possibility of some positive outcome.

In this paper we similarly examine the use of *hope*, as spontaneously used in interviews with cancer patients. Unlike Elliott and Olver’s (2002) study, these patients were not just diagnosed with, but dying of cancer, with no possibility of cure—patients often referred to as without hope. Interviews were part of a larger series of studies examining patients’ speech on treatment decision-making at the end of life, specifically the “do not resuscitate” (or DNR) decision, countermanning resuscitation attempts following cardiac arrest. Our aims here are to explore how hope was constructed and shaped discursively for a population of dying patients, and, to examine the implications of their employment of hope, both for patients and for clinical practice.

## Method

The study was approved by the Ethics Committee of the Royal Adelaide Hospital. Participants comprised 28 patients (13 female, 15 male; average age 61) from the Royal Adelaide Hospital oncology clinic. Patients meeting inclusion criteria received an information sheet detailing the project, and were asked by their primary carers (including oncologists and palliative care physicians) if they were willing to participate. Inclusion criteria were that patients were capable of coherent discussion, had stage IV cancer, were assessed by their primary carer as likely to die within 3 months, and critically, were aware of this. They were deemed emotionally stable and unlikely to suffer distress due to the nature of the topic. Follow-up counselling was offered, but no participants used this service. The interviews were conducted by JE, with signed consent obtained prior to commencement. Recruitment ceased when subsequent interviews repeated the content of previous interviews.

Interviews lasted between 25 and 75 min and were taped, then transcribed verbatim (by JE) with all names changed to preserve anonymity. Open-ended prompt questions were intended to elicit speech on end-of-life issues, with a primary focus on DNR decision-making, but participants were encouraged to raise and discuss any issue that they considered relevant. Our interest in hope justified the inclusion in the interview protocol of a specific prompt question on hope (e.g., “Can you tell me about hope and hoping”). However, recognising that prompted and spontaneous manifestations of hope might differ markedly, the hope question

was positioned at the end of the interview, and patients' responses to this question will be reported elsewhere (analysis in preparation). Here, we report exclusively on patients' use of hope as it emerged unprompted in their talk on end-of-life decision-making.

The transcribed data were entered into the qualitative computer software package N6 (*Qualitative Solutions and Research*, 2002) to facilitate analysis. The material here presented was identified through the use of a string-pattern-search (using the N6 software) for hop[e|ed|es|less|eful|efully|ing]. This collected all instances of the word *hope* (and derivatives thereof), with surrounding context. Each of these items of speech was initially coded as comprising noun or verb use of hope, and in keeping with discourse analytic techniques, further analysis examined its consistency or diversity of use (Potter & Wetherell, 1987). Accordingly, each excerpt was coded into categories based upon the functions and consequences of particular construals of hope for these patients (see Fig. 1).

We acknowledge that the category "discourse analysis" is heterogeneous, encompassing a plurality of methods (Willig, 1999a). Nevertheless, all examine language as it is used, aiming to deliberately systemise ways of talking in order to understand them better (Parker, 1992). Two distinct strands of discourse analysis have been defined (Willig, 1999a). "Conversational analysis" examines speech within a local context, examining sequential turns of talk in interaction, and what the talk is doing at each moment. "Foucauldian" or "Post-structuralist" Analysis considers language as situated within a wider societal context, noting that patterns of meaning, sometimes known as "discourses," carry

with them particular power relations, enabling and constraining what can be said and done. Although often positioned as antithetical and oppositional, recently some have argued for integration of these two traditions, noting that although participants' talk will always function to achieve some specific action in situ, it will also engage with the specific social, cultural, and historical context, whether that be to reproduce or challenge available discourses (Riley, 2002; Wetherell, 1998; Willig, 1999a). Riley has suggested that a "synthetic" approach, combining analytical techniques, can enable highly productive analyses, allowing examination of the situated nature of meaning-making, relating these to background normative conceptions, and contextualising the talk within the ideological and institutional framework of the broader society (2002, pp. 446–447). Employing such a strategy, we considered each example of hope speech in terms of its function within the immediate conversational context, as well as reflecting upon what might be taken for granted in each excerpt, identifying discourses drawn upon—including the procedures and practices that constitute the wider society, and particularly with reference to healthcare constructions of hope—considering how they constituted and reinforced different outcomes or practices (Lupton, 1994), and particularly for the patient.

Willig (1999b) has also noted that discourse analysis is a useful method for problematising categories used in mainstream psychology, a point that may be extended to include all healthcare research. Adapting her words on trust, our aims were to challenge conceptualisations of hope as "a stable trait or as a set of cognitions residing within the individual's mind;" rather, to view hope "as

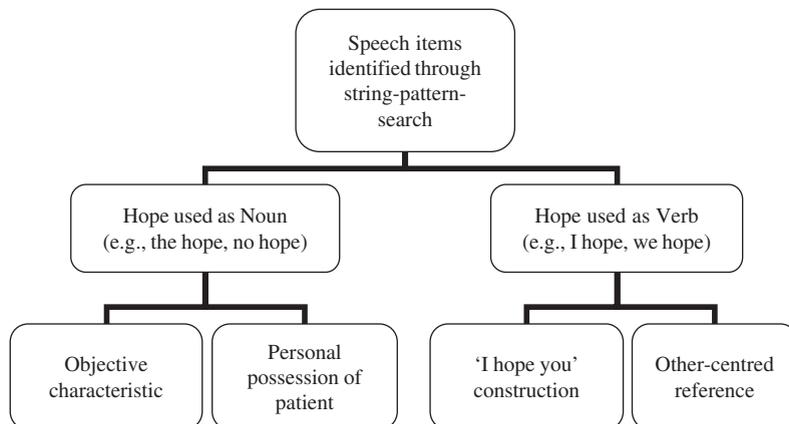


Fig. 1. Example showing how hope was coded within N6. *Note:* The third level had many more categories.

situationally specific, negotiated and purposeful social action,” considering “what social or interpersonal objectives ... [were] achieved through its deployment” (Willig, 1999a, pp. 2–3). As is increasingly common in qualitative research, results and discussion (data and analysis) are presented together to facilitate reader assessment of the credibility of our conclusions (Grbich, 1999).

## Results and discussion

During the interview, in absence of direct prompting, 26 persons collectively used the word hope or a derivative thereof a total of 80 times. Replicating previous findings (Elliott & Olver, 2002), participants’ differential use of noun or verb was associated with markedly different implications for the patient.

### *Hope-as-a-noun*

There were two distinct versions of hope-as-a-noun (HN) within participants’ speech: The first rendered hope an objective attribute of present circumstance, the second as the subjectively held possession of the individual.

#### *Hope: The objective attribute of circumstance*

This version of hope most typically presented in the negative “There is no hope.” As such, it was employed to justify particular actions, such as refraining from resuscitation.

*Tina.* If there’s no, not much hope sort of thing, just let me go. ... Let me go to sleep.

*Nina.* I said [to my doctor] if he’d thought there might be a slender chance, he’s to do what he thinks best, but if he thinks there’s not a hope in hell, no, [don’t resuscitate].

The object of (no) hope was typically left unstated by these participants, suggesting that the meaning of hope is here taken-for-granted, constituting a shared cultural assumption (Bruner, 1990). It seems likely that this hope reflects a dominant medical construal of hope as equivalent to the possibility of available treatments to ensure cure or remission (Beste, 2005; Elliott, 2005). Correspondingly, “no hope” means no such treatments are available, and death is imminent and irreversible. Grammatically, the phrase “There is no hope” functions to construe hope as an objectively verifiable attribute of the

situation, the presence or absence of which is simply relayed by the medical practitioner. In terms of the relative agency accorded to the patient and the clinician in this context, HN minimises that of the former and increases that of the latter (albeit acknowledging that the clinician can be also deemed to be somewhat passive, construed as merely conveying that there is or is not hope, rather than being held responsible for discovering the critical treatments). Thus, the patient is located as subject to the situation, and actions or outcomes deemed appropriate according to various biological parameters, as determined by the expert clinician. Conferring upon medical science the ability and prerogative to determine the existence and legitimacy of hope in the guise of discovering new evermore potent treatments, this constitutes the most common representation of hope within the medical literature (Elliott, 2005). It is a powerful rhetorical tool in establishing the status and legitimacy of medical scientific endeavour, one that sees hope as fundamentally intertwined with the aspirational values of science (Brown, 1998).

Sometimes this “no hope” version was used to justify the practice of euthanasia.

*Oliver.* Well, I suppose that if there’s absolutely no hope and the person can sense themselves, then, [euthanasia is] fair enough.

*Opal.* I’m all in favour of [euthanasia] if it’s done the right way. ... I think in a case where there is absolutely no hope at the end of the road, then I can’t see the point of it just going on and on....

When so construed, this hope has life and death implications for the patient: Presence of hope means life, absence means death. This has significant consequences in terms of how we think about those patients with or without hope: Patients themselves are construed solely in terms of biological features (how sick they are) that in turn inexorably equates to a presence or absence of (an objective) hope. Thus, the significance of other specific individual characteristics of each patient that may reside in alternative depictions of persons (e.g., those that foreground emotional, psychological, or interpersonal constructs) is relatively diminished. This strategy works to render a potentially complex and contentious issue (here, euthanasia) rather more simple and unproblematic, as a particular outcome is seen to inhere in the characteristics of the situation itself, requiring no further consideration (see Potter, 1996, pp. 115–116).

This aspect of HN (focussing on biological to the exclusion of any other interpretation of individuals), appears evident in Xavier's speech endorsing the practice of euthanising humans, wherein the human individual without hope is compared to a dog or a cat. What is significant in terms of justifying the outcome is established as independent of whatever characteristics may be deemed to distinguish humans from animals.

*Xavier.* What if your cat or your dog was in this position, would you keep prolonging it, or would you want it to go quickly and quietly when it had no hope, and it was in pain? And the answer would be that it would have to go, really.

Here, the response of euthanasia is presented as a reasonable and routine (even trivial) response to the circumstances of no hope, with no culpability attributed to those responsible for it. Equating animals and humans also works to minimise the significance of any agency that might reside within the individual (patient) under consideration, as it is presented as acceptable that others make the assessment as to what course of action is appropriate.

However, another consequence of the "no hope equals death" argument is that the assertion of the smallest "amount" of hope (again construing it as objectively assessable) may serve to rebut the conclusion that death is inevitable, an argument called upon by Ruth.

*Ruth.* I saw an oncologist whose attitude unfortunately all the way along was very much, "you're terminal and there's nothing we can do." ... There was never any hope offered. Of any kind, and I mean, let's face it, if you have a one-percent chance, then there's hope, and while I wouldn't want it to be overblown or overdone, neither can you say that there's none. ... [He] was very fond of using words like "terminal" at a stage when I was not ready to use them.

Ruth established a link between hope and the probability of successful treatment that would delay or prevent her death; her oncologist's failure to "offer" hope, however small, was negatively construed as inappropriate and insensitive to her needs. Such terminology serves to re-present the active role of the medical profession in this hope—Ruth is merely the potential recipient of this offered "gift" with limited capacity to affect the outcome. Nonetheless, within a culture where fear of death is the norm, the implication that it is inevitable and

imminent is likely to be negatively perceived (Charmaz, 1980). Drawing upon this equivalence of "no hope" and death, Ruth argued that even a "one-percent chance" of hope means "there's hope" and therefore death cannot be presumed to be inevitably imminent. Moreover, as even small "amounts" have vital import in relation to life or death, Ruth's argument works to further endorse the value of hope. This understanding then formed the basis for her criticism of her oncologist ("using words like terminal"), with the inference that the clinician conveying judgements about the inevitability of death should be responsive to a patient's readiness to receive them. This contributes towards something of a dilemma for clinicians who, although endorsing the need for patients to be informed of their prognosis, may yet be hesitant to unequivocally assert that there is no chance that the patient may be well, to unambiguously predict patients' death (Christakis, 1999; Gordon & Daugherty, 2003; Olver, 2005). However, this aspect of HN may also function as something of an escape clause available in the above-cited pro-euthanasia statements: determining that there is "no hope"—indeed, that there is "absolutely no hope"—may be open to contestation.

#### *Hope: The subjective possession of the patient*

The second version of HN saw hope as the subjectively held possession of the patient, as varying in amounts, and associated with particular features of patient well-being. In this context, many participants considered that a discussion about the DNR decision would negatively affect patients' hope, and that this constituted justification for avoiding such discussions.

*Tom.* I might live for another 12 years, and to live that way, knowing that I've just talked about a lot of end-of-the-road things, you know, it wouldn't go over well for me, because that way I believe that I've given up a bit of hope, and fight and that, you know.

Tom depicted hope positively as a vital resource in his "fight," accessing a dominant theme in western culture. Patients with cancer are typically depicted as engaged in a fight against their disease, and ultimately in a fight against death, with hope regularly implicated in this (Charmaz, 1980; Christakis, 1999; Good et al., 1990). Tom's reference to a "bit" of hope also works to establish that hope be quantified (thus reinforcing its status as a "thing"),

and to endow hope with considerable potency. Even small amounts of hope—whether construed as objective (see Ruth) or subjective (see Tom)—are deemed to play a significant role in the patient's fight against their disease.

Practically, Tom's assertion that talking about end-of-road things (namely, the DNR decision) meant giving up hope enabled him to justify not talking about them and to positively construe avoidance of the DNR discussion as continuing the fight. Precisely because patients can be held responsible for giving up the fight, and for reduced levels of hope (Brown, 1998; Stacey, 1997), they can justify refusal to participate in such discussions. Insisting that patients consider and speak about "end-of-the-road things" (e.g., the DNR decision) may be problematic: It may be interpreted as requiring them to acknowledge the inevitability of their own demise, thereby giving up hope—contradicting the cultural injunction that they actively resist death, with hope deemed vital to maintain this resistance.

Wendy similarly held that DNR discussion might "take away" hope, and represented hope as a vital resource.

*Wendy.* You wouldn't ask [patients about the DNR decision] straight after diagnosis. ... [At that time] you need some hope to help you get through just the treatment, and if you've discussed [the DNR decision] ... it might take away some of that hope. And I don't think they need that. ... [I]f you haven't got any hope, there's not much point in even going there for the treatment. ... That's because you need that hope to keep you coming back. If you had no hope then you wouldn't come for your treatment, you'd virtually give up.

In this instance, hope appeared to constitute not only a resource, but also some form of motivator for continuing treatment: If you have hope, then you undertake treatment. Although oncologists (Good et al., 1990; Gordon & Daugherty, 2003) and patients (Hagerty et al., 2005) alike deem hope to be consequential upon treatment provided, Wendy implied that hope may also be a reason for treatment. As the justification for (and thus reason for undertaking) most treatment following diagnosis of cancer rests in some probability that it will successfully intervene in the disease, the patient's hope (or this version of it) is established as dependent upon their reception of medical informa-

tion. Without hope that treatment will be successful, patients can have no reason to undertake it—they would "give up." With that hope, treatment is acceptable. This aspect of hope, functioning to encourage patient participation in or compliance with a medical regimen, constitutes a major reason for the medical interest in hope (Brown, 1998; Good, et al., 1990).

As with the objective, the subjectively held patient hope was rarely defined, again suggesting a taken-for-granted cultural assumption about it. We suggest that it refers to the patient's belief that some thing, action, or entity (usually medical authority) will be successful in preventing or significantly delaying their death. Overstating it somewhat, in this version of HN, the patient's hope represents their belief in a cure, not surprisingly given the overwhelming focus on cure within medical discourse (Ballard, Green, McCaa, & Logsdon, 1997; Beste, 2005; Poncar, 1994). The construal of this subjectively held hope is so similar to the definition of objective hope (referencing availability of treatment to cure or remit disease) that we suggest that these two versions of HN are two sides of the same coin—a supposition that would account for the interdependence of these two version noted by Elliott and Olver (2002, pp. 186–187): Both centre upon cure, and in doing so, both identify the medical profession as primarily responsible for, and capable of providing this; thus both locate agency outside of the patient themselves—a point argued theoretically by others (Beste, 2005; Hegarty, 2001).

#### *Hope-as-a-verb*

As a verb, hope introduces the "hoper," and implies a "doing," an active occupation of the hoper. This works to establish and confirm agency, rather than passivity. Rather than construing individuals (patients) as being *subject to* the vagaries of an implacable reality of impending death (implied in the "no hope" version of HN), hope-as-a-verb (HV) functions to enable participants to represent themselves as *the subject*, and to affirm their presence and participation in life's activities.

#### *Hoping: The imagined positive future*

One of the most common ways that participants used HV was in the context of a future identified as desirable (in the sense of being desired). This was

often, but not always, established through contrast. Some patients spoke of a negative potential future outcome and hoped to avoid it, some of a present unwanted circumstance they hoped would change for the better.

*Wendy.* Well, I hope [that I won't return to hospital]. I haven't made any more appointments. I'm just going to do them as need be ....

*Una.* I get my pains at unfortunately odd hours of the morning, but hopefully we'll find a blend of drugs that I can go home without this little box [morphine syringe driver] that's attached to me.

Hope-as-a-verb appears to allow for acknowledgement that both the positive and the negative are possible in the future, but to orient towards the former. This aspect of hope appears conceptually similar to features noted by Morse and Doberneck (1995), who included not only “the envisioning of alternatives and the setting of goals,” but also “a bracing for negative outcomes” as components of hope. They and others (Halpin, 2003; Simpson, 2004) highlight that hope connotes both positive and negative possibilities. This may perhaps allay the fears of those who consider that hoping for some future outcome that may be deemed unlikely represents a denial of the possibility that it might not occur (Herth, 1991; Poncar, 1994).

This use of hope also appears to facilitate the envisaging of a possible future with positive aspects to it, in which patients are construed as active and not completely subjugated to medical circumstance. Nunn (2005) has similarly asserted that hope commonly references an envisaging of self, in a future that is good in some (but not necessarily all) respects. Similarly, Stephenson (1991) described hope as including anticipation, a positive future orientation, and what is meaningful to the hoper.

Even when participants referred to their death, hope functioned to identify the positive option and thus what outcomes patients valued for the future—below, a relatively easy (short, natural, comfortable) death. If death is inevitable (as it is for all, but rather more imminently for these individuals), HV may allow patients to express and arguably to anticipate ways in which it might be acceptable.

*Vera.* Let nature take its course. ... Yeah, and hopefully that's the way it will be.

*Wendy.* [Doctors] have already said that there's not much more that they can do. I just hope that

they understand what I want, and yeah, just keep me comfortable, and just understand my needs ....

Implicit in the use of hope here is recognition that attaining the desired outcome is not a foregone conclusion, and that the capacity of the hoper to achieve it is limited. Hope thus refers to a future which is beyond the speaker's control and unknown (Crapanzo, 2003; Simpson, 2004). It is one, nonetheless, in which certain outcomes are deemed more or less likely (by virtue of being spoken about or implied by contrast), and more or less preferable (denoted by their positive or negative relationship to hope and thus to the hoper).

#### *Hoping: The interpersonal implications*

Crapanzo has noted that hope has “important interlocutory dimensions,” evincing a “culturally determined communicative etiquette” (2003, p. 16). Such interlocutory use is evident in Xavier's account of his interaction with his doctor following his terminal diagnosis.

*Xavier.* [I said to the doctor] I hope that you're not going to try and prolong things, when they shouldn't be prolonged ....

In using hope, Xavier could identify what he wanted, and acknowledge that attaining this was not completely under his control. In the context where patient autonomy is theoretically primary, but doctors are the ones who act to realise this, hope functioned to oblige doctors, as individuals independent of their professional role, to consider Xavier's wishes. In conveying “I hope you don't do this” rather than “Do not do this,” Xavier introduced two agents (“I” the speaker, and “you” the listener), locating them in an interpersonal relationship wherein the actions of “you” will affect “I,” and where some action is preferred by “I.” Xavier thus effectively utilised hope to warn doctors that the described actions would disregard what he wants, thus negatively construing such actions. For his doctor to prolong things was identified as wrong, not only because they would thereby violate some prohibition (evident in the use of the imperative “shouldn't be prolonged”—with “prolonged” signifying exceeding an appropriate limit), but, more compellingly, because they would be knowingly countermanding Xavier's desire. Thus, although the ultimate outcome was undeniably important, it was

placed in the context of an interpersonal relationship between two persons, establishing it, and hope, as having moral and interpersonal connotations.

Thus HV functioned in Xavier's speech to acknowledge and enact the structural relationship between doctor and patient, simultaneously placing moral obligation upon the doctor to positively respond to the patient. An individual's use of HV in interpersonal exchanges may consequently act to increase the probability that their desired outcome is achieved, establishing and enacting both patient agency and interpersonal ties with others. Others have asserted the existence and merits of relational or affiliative aspects of hope (Dufault & Martocchio, 1985; Farran, Herth, & Popovich, 1995; Herth, 1991) and Beste (2005) has argued that a "relational" hope could provide a useful counterpoint to constructions of hope that see it as an individual attribute with emphasis on cure—alternatives that seem to parallel these participants' employment of HV and HN.

Similarly, the agentic aspect of hope has been discussed and delineated by others (e.g., Nowotny, 1989; Snyder et al., 2005). What this discursive analysis adds is clarification of how this is performed in situ, showing how hope functions in speech to establish and enact agency. Certainly, the positioning of the hoper as actively engaged in their life may be particularly pertinent for patients in the terminal phase of an illness.

As a further example of enacted agency, Zack used HV in the context of relating his part in his ongoing and developing relationships with significant others.

*Zack.* Julie is just another friend. And I've got, well, hopefully, I've asked this friend of mine, Rebecca, ... if she would marry me ... and she's agreed to.

Many aspects of hope may be discerned in Zack's speech: "Hopefully" functions to signal what is valued, and—given that the future, including Zack's presence within it and Rebecca's future behaviour, remains unrealised—to acknowledge the uncertainty of attainment of this. Notwithstanding the uncertainty, what is depicted, what is valued, is a future that not only featured Zack, but in which he is linked (indeed, married) to another person. Thus Zack established himself as connected to a future time, and some other person. In doing so, he affirms his own worth, and the worth of the other implicated in that hope. Zack was undeniably dying,

and accordingly his future plan to undertake married life with another might be deemed unrealistic. We would argue, however, that used thus, the "reality" of attaining what is hoped for (the object of hope) is irrelevant, as hope functions to value both the desired object, and the one desiring it. To hear and acknowledge this hope is to value Zack and his connections with others (see also Simpson, 2002, 2004).

In referring to future outcomes, hope may enable patients to see themselves as present in the future, and as valued in some way. For some patients, the object of hope was some outcome in a future where they were physically absent—after their death.

*Sean.* I want to try and [make sure] ... that [my family] all get on well together, and share everything together, like they do now. ... And I love to see it, and I hope it continues it, you know.

This HV references an ongoing effect of the hoper Sean's actions before death, implying an enduring legacy. Others have asserted the value of such a perception, allowing emphasis on what is meaningful to the patient, and providing an alternative focus to cure (Beste, 2005; Duggleby & Wright, 2004). Here, the future depicted represents Sean as having value even after his death, affirming his positive effect upon others. This establishes his agency, his active participation in life. But there are several further consequences of this construal of hope.

First, as what is hoped for entails a positive future for Sean's family, hope affirms their value. At the same time, in establishing that the hoper Sean has an interest in this positive future for his family, it values and reinforces the interpersonal ties between both parties. Finally, to the extent that family might be aware of the hoped-for futures for themselves, there may be some moral obligations upon them to work to achieve it. This again positions the hoper as having an active presence in life, even if not their own.

There are additional consequences of using hope-as-a-verb. Because it construes the future outcome as uncertain, it can enable the speaker to disavow responsibility for whether or not the preferred outcome is realised. Thus, the speaker can imply support for an outcome without claiming responsibility for it. For example, Zack's use of "hopefully" indicated the preferred outcome (marrying Rebecca), but established that not everything was under

his control; Sean indicated the preferred state of family harmony, but established that he cannot dictate that. Thus, if the stipulated outcome is not realised, the speaker cannot be held responsible.

It was this aspect of hope that was exploited in the following excerpt. This followed on a request from a patient that JE, the interviewer, pass on their critical views about doctors, presumably to those doctors.

*Interviewer.* Thank you, it's been really lovely talking to you and getting your thoughts, and I hope I can pass these things on.

The use of hope here enabled JE to endorse the value of the patient's request, whilst establishing that realising this might depend upon factors beyond her control. Thus, she established that any failure to attain the preferred outcome was not attributable to her, proactively absolving her of any blame.

In a like manner, the use of HV in the following extracts also enabled the speakers to confirm their previously stated desire for (and thus allegiance to) a future outcome, but in establishing the limits of their control, to temper the extent to which they might be held responsible for achieving this.

*Xavier.* I think I will know [when I'm close to death]. I hope I'll know, but there are a lot of people who don't want to know.

*Sean.* I'm going to put myself through a test, and I'm going to try and do better than what I can do now. And if I succeed in that, then I think I'll get over it. I hope.

This use of "I hope" HV (following on the use of "I think") functions both as an acknowledgement of a level of uncertainty of outcome, and to position the speaker as aware of this. This in turn serves to deflect the potential interpretations of their speech that they are being unrealistic or unreasonable in predicting a future outcome. Hope here works to moderate modality, that is, the degree of commitment of the speaker to the truth or necessity of the utterance (Fairclough, 2001, p. 242). In effect, Xavier and Sean "toned down" the strength of their previous assertions: that they "think" something will occur became that they "hope" it will occur, signifying a lessened commitment to the actuality (whether or not it will occur) of outcome.

However, HV also carries with it something about the relationship of the speaker to the given outcome. "I hope something will happen" implies

an active desiring on the part of the speaker for, and thus commitment (in a difference sense) to the outcome that is not implicit in the "I think" version. Thus HV enabled these participants simultaneously to assert their commitment to the preferred outcome, and to acknowledge their own limitations in achieving this. Put another way, HV serves to increase the speaker's commitment to the outcome itself (via an implicit valuing of the object of HV), but to decrease their commitment to the fact that the outcome will occur (via an implicit acknowledgment of uncertainty in HV).

The final use of HV here examined incorporates many of the features mentioned above. At the end of the interview JE would thank interviewees for their participation at which point ten (over one-third) responded with "hope," prompting responses from her that were remarkably similar. Some typical examples:

*Kate.* I hope I've helped a little bit.

*Interviewer.* I'm sure you have, I'm sure you have.

*Oliver.* I hope it's been a help.

*Interviewer.* It certainly has.

When using this construction of hope, all interviewees positioned themselves as the hoper, and thus as desiring some particular outcome—that their participation would have (or had had) benefit—in the form of help. As this was a stated aim of the interview, this use of hope enabled them to assert this outcome as a good, and consequently to align themselves with the aim of the research, and by extension, with the researchers. We suggest that this use of HV signals goodwill on the part of the speaker towards the listener, and thus can be employed to denote solidarity between parties. It thereby works to strengthen the interpersonal connection between them. Indeed, the regularity of JE's response, taking the form of a reassurance further attests to the utility of hope in facilitating goodwill, solidarity, and interpersonal connection.

In this guise, it appears plausible that HV constitutes part of an adjacency pair: To hope to another requires that they not only respond, but respond appropriately (see Potter, 1996, pp. 58–61). This is evident in the sole negative case formulation appearing in this context.

*Otis.* I hope I haven't been too boring.

*Interviewer.* Not at all.

Table 1  
Differences between noun and verb versions of hope in dying cancer patients' speech

Hope as noun	Hope as verb
Limited to medical domain	Not limited to medical domain
Typically “No hope”	Typically “I hope”
Negative future	Positive future
Absolutes	Possibilities
Construes the patient as <i>subject to</i>	Construes the patient as <i>the subject</i>
Limits the patient's agency	Endows the patient with agency
Construes the patient in biological terms	Construes the patient in psychological, moral, and interpersonal terms
Focus on death	Focus on life

This is an instance of potential self-deprecation on the part of the speaker, with a particular response called for on the part of the other, namely, rebuttal, as indeed was enacted by the interviewer. Within these couplets, hope enabled the hoper to affirm their own value and agency in interaction. Finally, appearing so regularly at the end of the interview, hope may also function as part of a social ritual to satisfactorily end the conversation, signalling a mutual valuing of the encounter and of parties within it, as well as both indicating and enacting a positive interpersonal transaction. Although others have stressed the social and communal aspect of hope (Crapanzo, 2003; Halpin, 2003; Marcel, 1978), we have here demonstrated how hope actively enacts, establishes, and maintains interpersonal ties between individuals.

## Conclusion

Regarding generalisability from this study, we acknowledge that the selection procedure, subsequent sample group, and interview focus may have led to the predominance of particular constructions of hope. Nonetheless, because hope was unprompted, it emerged in the context of a number of different questions, with analysis supporting and extending previous analysis (Elliott & Olver, 2002) showing differential use of hope in cancer patients who were not currently dying. Our further analysis of responses to the direct question about hope will enable comparison of considered and spontaneous manifestations of hope in this dying population. We suggest that it might be instructive to employ similar discourse analytical techniques to examine hope within speech of healthcare workers, (including physicians, nurses, and psychologists) and to investigate manifestations of hope speech in interactions between these and patients, exploring

similarities and differences in their use of hope, specifically attending to potentials for miscommunication between parties.

We have argued for the significance of patients' differential employment of hope, specifically as noun or verb (see Table 1). These two versions of hope have some conceptual similarities to the two discourses of hope delineated by Little and Sayers (2004), respectively, a discourse “of life and death” and “of meaning in life.” Beste (2005) has made similar distinctions between hope for a cure or remission, and hope that focuses on meaning in life: Where the former sees hope as narrowly defined and overly medicalised, the latter allows for a multi-faceted construal of hope that allows patients to autonomously determine what is meaningful to them. Others have similarly asserted the value to patients of a hope that exceeds that determined by medical professionals, one that endures beyond the biological decline associated with terminal illness (Olver, 2005). This discursive analysis of patient speech demonstrates how these different versions of hope are consistently associated with grammatical characteristics of noun and verb, themselves further, respectively, linked to the envisaging of negative or positive futures for the patient. As such, it provides insight into hope as a social practice, delineating how hope (and hoping) plays out in interpersonal and everyday interaction, perhaps suggesting practical guidance to those wishing to value hope, particularly with regard to patient well-being. Where hope consistently appeared as the negative (as “no hope”), hoping (as “I hope”) appeared to identify the positive, representing an active desiring of a positive future (and thus envisaging this). Hoping positioned patients as potentially influencing outcome, with goals that may be achievable, in contrast to their position as relatively helpless to effect change referenced with HN. Hope-as-a-verb

further affirmed the presence and value of the hoper, connecting them to a good, to a future, and to others. We suggest that the focus upon positive possibilities and their role as agentic inherent in patients' use of HV may have therapeutic benefit for the patient—that hoping works to connect them to life's meaningful activities—to life.

As a related point, we further suggest that HN, with the intrinsic depiction of hope as product, might lend itself to a preoccupation with an individualised hope, a concept noted as inadequate and inaccurate (Crapanzo, 2003; Marcel, 1978), and in regard to patient well-being, even unhelpful and destructive (Beste, 2005). By contrast, hope-as-a-verb (the expression of hoping) in construing hope as a process, tends to foster notions of hope as an interpersonal and relational construct, or a social activity that enables articulation (by the hoper) and affirmation (by others) of what is valued by the hoper, that enacts and establishes connection between all. Hope is too important to leave to or locate within the individual (Crapanzo, 2003; Weingarten, 2000). As a final point, embracing such a notion of hope may work to mitigate, or render irrelevant, professional concern over whether hope is real or unreal, true or false, present or not: Rather than attempting to determine the ontological status of a patient's hope, healthcare professionals might more usefully consider the function and consequences of that hope, viewing professed hope as attempt to articulate, share, and value with others those things that connect the patient to what gives their lives meaning, and ultimately, to life.

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### References

- Ballard, A., Green, T., McCaa, A., & Logsdon, M. C. (1997). A comparison of the level of hope in patients with newly diagnosed and recurrent cancer. *Oncology Nurse Forum*, 24(5), 899–904.
- Beste, J. (2005). Instilling hope and respecting patient autonomy: Reconciling apparently conflicting duties. *Bioethics*, 19(3), 215–231.
- Brown, N. (1998). *Ordering hope: Representations of xenotransplantation—an actor/actant network theory account*. Ph.D. thesis, submitted to the School of Independent Studies 229 (Lancaster University, Lancaster, UK, 1998). Retrieved 28 April 2004, from <<http://www.york.ac.uk/org/satsu/OnLine-Papers/Brown%20-%20Ordering%20Hope.pdf>>.
- Bruner, J. (1990). *Acts of meaning*. Cambridge, MA: Harvard University Press.
- Charmaz, K. (1980). *The social reality of death: Death in contemporary America*. Reading, MA: Addison-Wesley.
- Cheavens, J. S., Michael, S. T., & Snyder, C. R. (2005). The correlates of hope: Psychological and physiological benefits. In J. A. Elliott (Ed.), *Interdisciplinary perspectives on hope* (pp. 119–132). Hauppauge, NY: Nova Science.
- Christakis, N. A. (1999). *Death foretold: Prophecy and prognosis in medical care*. Chicago: University of Chicago Press.
- Crapanzo, V. (2003). Reflections on hope as a category of social and psychological analysis. *Cultural Anthropology*, 18(1), 3–32.
- Cutcliffe, J. R., & Herth, K. A. (2002). The concept of hope in nursing 1: Its origins, background and nature. *British Journal of Nursing*, 11(12), 832–840.
- Danforth, S. (1997). On what basis hope? Modern progress and postmodern possibilities. *Mental Retardation*, 35(2), 93–106.
- Dufault, K., & Martocchio, B. C. (1985). Hope: Its spheres and dimensions. Symposium on compassionate care and the dying experience. *Nursing Clinics of North America*, 20(2), 379–391.
- Duggleby, W., & Wright, K. (2004). Elderly palliative care cancer patients' descriptions of hope-fostering strategies. *International Journal of Palliative Nursing*, 10(7), 352–359.
- Elliott, J. A. (2005). What have we done with hope? A brief history. In J. A. Elliott (Ed.), *Interdisciplinary perspectives on hope* (pp. 3–46). Hauppauge, NY: Nova Science.
- Elliott, J. A., & Olver, I. N. (2002). The discursive properties of 'hope': A qualitative analysis of cancer patients' speech. *Qualitative Health Research*, 12(2), 173–193.
- Fairclough, N. (2001). The discourse of new labour: Critical discourse analysis. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 229–266). London: Sage.
- Farran, C. J., Herth, K. A., & Popovich, J. M. (1995). *Hope and hopelessness: Critical clinical constructs*. London: Sage.
- Good, M. G. D., Good, B. J., Schaffer, C., & Lind, S. E. (1990). American oncology and the discourse on hope. *Culture, Medicine, and Psychiatry*, 14(1), 59–79.
- Gordon, E. J., & Daugherty, C. K. (2003). 'Hitting you over the head': Oncologists' disclosure of prognosis to advanced cancer patients. *Bioethics*, 17(2), 142–168.
- Grbich, C. (1999). *Qualitative research in health: An introduction*. St Leonards, NSW: Allen & Unwin.
- Hagerty, R. G., Butow, P. N., Ellis, P. M., Lobb, E. A., Pendlebury, S. C., Leighl, N., et al. (2005). Communicating with realism and hope: Incurable cancer patients' views on the disclosure of prognosis. *Journal of Clinical Oncology*, 23(6), 1278–1288.
- Halpin, D. (2003). Hope, utopianism and educational renewal, the encyclopedia of informal education. Lasted updated: June 17, 2003. Retrieved 17 January 2005, from <<http://www.infed.org/biblio/hope.htm>>.
- Hegarty, M. (2001). The dynamic of hope: Hoping in the face of death. *Progress in Palliative Care*, 9(2), 42–46.
- Herth, K. (1991). Development and refinement of an instrument to measure hope. *Scholarly Inquiry for Nursing Practice*, 5(1), 39–51.

- Kylma, J., & Vehvilainen-Julkunen, K. (1997). Hope in nursing research: A meta-analysis of the ontological and epistemological foundations of research on hope. *Journal of Advanced Nursing*, 25(22), 364–371.
- Little, M., & Sayers, E. J. (2004). While there's life. Hope and the experience of cancer. *Social Science & Medicine*, 59(6), 1329–1337.
- Lohne, V. (2001). Hope in patients with spinal cord injury. *Journal of Neuroscience Nursing*, 33(6), 317–325.
- Lupton, D. (1994). *Medicine as culture: Illness, disease and the body in western societies*. London: Sage.
- Marcel, G. (1978). *Homo viator: Introduction to a metaphysic of hope*. Gloucester, MA: Peter Smith.
- Morse, J. M., & Doberneck, B. (1995). Delineating the concept of hope. *Image—the Journal of Nursing Scholarship*, 27(4), 277–285.
- Nekolaichuk, C. L., Jevne, R. F., & Maguire, T. O. (1999). Structuring the meaning of hope in health and illness. *Social Science & Medicine*, 48, 591–605.
- Nowotny, M. L. (1989). Assessment of hope in patients with cancer: Development of an instrument. *Oncology Nursing Forum*, 16(1), 57–61.
- Nunn, B. V. (2005). Getting clear what hope is. In J. A. Elliott (Ed.), *Interdisciplinary perspectives on hope* (pp. 63–77). Hauppauge, NY: Nova Science.
- Olver, I. N. (2005). Bioethical implications of hope. In J. A. Elliott (Ed.), *Interdisciplinary perspectives on hope* (pp. 241–256). Hauppauge, NY: Nova Science.
- Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London, New York: Routledge.
- Poncar, P. J. (1994). Inspiring hope in the oncology patient. *Journal of Psychosocial Nursing and Mental Health Services*, 32(1), 33–38.
- Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. London: Sage.
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.
- Qualitative Solutions and Research. (2002). QSR NUD\*IST (Version 4) [Windows]. (Qualitative Solutions & Research, Melbourne, 1997).
- Riley, S. C. E. (2002). Constructions of equality and discrimination in professional men's talk. *British Journal of Social Psychology*, 41(3), 443–461.
- Simpson, C. (2002). Hope and feminist care ethics: What is the connection? *Canadian Journal of Nursing Research*, 34(2), 81–94.
- Simpson, C. (2004). When hope makes us vulnerable: A discussion of patient-healthcare provider interactions in the context of hope. *Bioethics*, 18(5), 428–447.
- Snyder, C. R., Cheavens, J. S., & Michael, S. T. (2005). Hope theory: History and elaborated model. In J. A. Elliott (Ed.), *Interdisciplinary perspectives on hope* (pp. 101–118). Hauppauge, NY: Nova Science.
- Stacey, J. (1997). *Teratologies: A cultural study of cancer*. London: Routledge.
- Stephenson, C. (1991). The concept of hope revisited for nursing. *Journal of Advanced Nursing*, 16(12), 1456–1461.
- Wang, C. E. (2000). Developing a concept of hope from a human science perspective. *Nursing Science Quarterly*, 13(3), 248–251.
- Weingarten, K. (2000). Witnessing, wonder, and hope. *Family Process*, 39(4), 389–402.
- Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse Society*, 9(3), 387–412.
- Willig, C. (1999a). Beyond appearances: A critical realist approach to social constructionist work. In D. J. Nightingale, & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp. 37–51). Buckingham, UK: Open University Press.
- Willig, C. (1999b). Introduction: Making a difference. In C. Willig (Ed.), *Applied discourse analysis: Social and psychological interventions* (pp. 1–21). Buckingham, UK: Open University Press.