

---

# Harmonizing hope: A grounded theory study of the experience of hope of registered nurses who provide palliative care in community settings

---

KELLY PENZ, PH.D., R.N.<sup>1</sup> AND WENDY DUGGLEBY, PH.D., R.N. A.O.C.N.<sup>2</sup>

<sup>1</sup>College of Nursing, Southern Saskatchewan Campus, University of Saskatchewan, Saskatchewan, Canada

<sup>2</sup>Aging and Quality of Life, Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada

(RECEIVED May 3, 2010; ACCEPTED September 17, 2010)

## ABSTRACT

*Objective:* The purpose of this study was to explore the hope experience of registered nurses (RNs) who provide palliative care services in community settings. The specific aims of the study were to (1) describe their hope experience, (2) develop a reflexive understanding of the processes of their hope, and (3) construct a substantive theory of hope of palliative care RNs.

*Methods:* Using constructivist grounded theory methodology, purposeful theoretical sampling was used to enroll 14 practicing community palliative care RNs in the study. Twenty-seven open-ended telephone interviews were conducted and nine daily journal entries on hope were copied. Interviews and journals were transcribed verbatim and analyzed using Charmaz's grounded theory approach.

*Results:* Participants described their hope as a positive state of being involving a perseverant and realistic understanding of future possibilities. Their hope sustained and motivated them, and helped them to strive to provide high-quality care. The main concern for participants was keeping their hope when faced with work life challenges and contrasting viewpoints (i.e., when their hopes differed from the hopes of others around them). They dealt with this through harmonizing their hope by the processes of "looking both ways," "connecting with others," "seeing the bigger picture," and "trying to make a difference." Their experience of hope was defined within the social context of their work and lives.

*Significance of results:* The results of this study suggest that hope is very important to palliative care RNs, in that it helps them to persevere and sustains them when faced with work life challenges in their practice. This study also highlights the need for continued research in this area as there appears to be a lack of evidence on the meaning of hope for healthcare professionals, and, in particular, understanding hope in the context of palliative and end-of-life care delivery.

**KEYWORDS:** Hope, Palliative care nursing, Nursing work life, Community, Constructivist grounded theory

## INTRODUCTION

An ongoing aim of the healthcare system is to ensure the provision of high quality, palliative and end-of life

care services within community settings (Romanow, 2002; Carstairs, 2005). As a result of a shift toward more community-based palliative care delivery, registered nurses (RNs) who are expected to provide these services have to contend with numerous occupational stressors including dealing with patient suffering, workload constraints, limited peer support, and role strain (Newton & Waters, 2001; Payne, 2001; Wilkes & Beale, 2001; Appelin et al., 2005).

---

Address correspondence and reprint requests to: Kelly Penz, College of Nursing, University of Saskatchewan, Southern Saskatchewan Campus, 4500 Wascana Parkway Regina, SK S4P 3A3, Saskatchewan, Canada. E-mail: kelly.penz@usask.ca

Hope has been defined as a “multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving a future good, which to the hoping person is realistically possible and personally significant” (Dufault & Martocchio, 1985). Research on the concept of hope in health care suggests that hope may be linked to healthcare professionals’ motivation (Kulig, 2001) and active work engagement (Simmons & Nelson, 2001), and may assist them in providing a higher quality of care (Duggleby & Wright, 2007). However, little is known about the concept of hope from the perspective of community practicing palliative care RNs. In order to develop a more comprehensive understanding of the potential role that hope may play in the work lives of RNs who provide palliative and end-of-life care in community settings, further study of their experience of hope is necessary.

## BACKGROUND

When examining the literature on the concept of hope in palliative care, it is evident that hope plays an important role in the lives of some patients, informal caregivers, and family members. Hope has been found to have a positive impact on the coping ability and quality of life of palliative care patients (Post-White et al., 1996; Koopmeiners et al., 1997; Benzein et al., 2001; Duggleby & Wright, 2005; Duggleby et al., 2007) and their family members or informal caregivers (Herth, 1993; Borneman et al., 2002; Holtslander et al., 2005; Holtslander & Duggleby, 2009). Although only a few studies have focused on the hope of healthcare professionals, the available literature suggests that hope also has a positive impact on the work and personal lives of professional caregivers (Sherwin et al., 1992; Kulig, 2001; Simmons & Nelson, 2001; Stephen-Haynes, 2002; Duggleby & Wright, 2007; Feudtner et al., 2007).

Studies exploring hope from the perspective of healthcare professionals suggest that hope is a multidimensional and dynamic entity (Kulig, 2001; Duggleby & Wright, 2007). For healthcare professionals, hope appears to be associated with positive feelings about the future, spirituality, and interpersonal relationships, and may work as a mediator of positive work outcomes (e.g., high-quality care, work engagement, higher personal performance) (Sherwin et al., 1992; Kulig, 2001; Simmons & Nelson, 2001; Stephen-Haynes, 2002; Duggleby & Wright, 2007; Feudtner et al., 2007). In a qualitative study exploring hope from the perspective of eight district nurses, the essence of hope included patient-centered holism, meeting patient needs, developing a partnership and feeling a sense of personal worth, having a future orientation, and spirituality

(Stephen-Haynes, 2002). Similarly, in an interpretive study involving 10 rural public health nurses, hope was experienced as positive and future-oriented, and served as a form of motivation (Kulig, 2001). As well, the participants’ relationships with others, the work that they performed, and the differences that they made in people’s lives, helped reinforce and enhance their hope (Kulig, 2001). In a mixed method study of 113 palliative healthcare providers (e.g., nurses, social workers, physicians, aides etc.), participants described their hope as making a difference and a better future, as well as having a sense of peace, and relating to spirituality (finding meaning and purpose) (Duggleby & Wright, 2007). Hope for the palliative caregivers helped them provide care and comfort, establish positive relationships with patients and their families, and offer hope to those at the end of life (Duggleby & Wright, 2007).

Hope may also act as a potential mediator of positive work outcomes. In a correlational study of 81 rehabilitation RNs, Sherwin and colleagues (1992) found that hope was a predictor of lower levels of burnout, and suggested that the stresses associated with caregiving may be seen as positive challenges for formal caregivers. When exploring eustress in 158 hospital nurses, Simmons and Nelson (2001) found that even though intensive care unit (ICU) nurses had the highest levels of death and dying in their work setting, they also had the highest levels of hope. The authors suggested that the hopeful behaviors of the ICU nurses represented active engagement in their work environment. In a study involving 410 pediatric palliative care RNs, the nurses’ level of hope was significantly associated with both their self-reported comfort and their perceived competence in providing palliative care. The researchers stressed that there may be a link between hopeful thinking and enhanced personal performance of palliative care RNs, which may be pivotal in confronting the challenges they face when dealing with life-threatening illness (Feudtner et al., 2007).

When examining healthcare professionals’ conceptualizations of hope, it becomes evident that hope is complex and may also be characterized by contrasting viewpoints. In a few studies, healthcare professionals’ perceptions of hope seemed to be associated with recovery from illness or, lack of disease progression and remission (Carter et al., 1998; Gelling et al., 2002). In a quantitative study of 317 community health professionals’ (e.g., nurses, general practitioners, social workers) responses to multiple sclerosis and motor neuron disease, providers were significantly less likely to convey hope when their patients’ prognoses were poor and when they knew progression toward severe disability or death was

inevitable (Carter et al., 1998). The authors suggested that the participants perceived that hope was static and that they associated hope with the absence of disease or lack of disease progression (Carter et al., 1998). In a qualitative study exploring 17 nurses' experiences of hope in an ICU, participants were concerned about the role of hope in a highly technological environment and felt that using the word "hope" in an area with a high incidence of death may not be appropriate. The results of this study imply that some of the nurse participants may have defined the concept of hope in relation to recovery, and may not have felt that hope was realistic in situations where death was likely (Gelling et al., 2002).

When examining research studies on healthcare professionals' hope, the majority do not include palliative care RNs. The nature of care delivery for palliative care RNs is highly demanding, with numerous occupational stressors being present in their work environments (Payne, 2001; Wilkes & Beale, 2001; Appelin et al., 2005; Arnaert et al., 2009). It is possible that their experience of hope may be similar to that of nurses working with rehabilitation patients, or similar to the experiences of district nurses, and public health nurses. However, the unique aspects of their work, such as dealing with persons at the end of life, having limited resources, working in isolation, and collaborating with others at a distance, indicates the need to study their distinctive experiences of hope. Duggleby and Wright (2007) found that in their sample of 113 palliative healthcare providers from a variety of professional backgrounds, nurses had lower hope scores when compared to the remainder of the palliative care professionals. The results of this study suggest that palliative care nurses' hope may be different as a reflection of their unique experiences, which warrants further study of hope in this population. Using constructivist grounded theory methodology, the purpose of this study was to explore the hope experience of RNs who provide palliative care services in community settings. The specific aims of the study were to 1) describe their hope experience, 2) develop a reflexive understanding of the processes of their hope, and 3) construct a substantive theory of hope of palliative care RNs.

## METHOD

### Design

Based on the present state of knowledge on the concept of hope from the perspective of palliative care RNs and on the dynamic and complex nature of hope itself, a constructivist grounded theory approach (Charmaz, 2006) was used to achieve the specific aims of this study. This approach seeks to

develop a reflexive and theoretical understanding of a studied phenomenon, while attending to the social context in which the research process is occurring (Charmaz, 2006). The use of constructivist grounded theory also encourages data collection from more than one source, such as formal interviewing techniques and analysis of diaries or journals (Charmaz, 2000). This study was approved by an institutional behavioral ethics review board before it was initiated.

### Sample and Recruitment

Purposeful theoretical sampling (Patton, 2002; Charmaz, 2006) was used to recruit RNs who provide palliative care services in community settings in a western Canadian province. Three recruitment collaborators (professionals who had knowledge of community practicing RNs) were asked via telephone and letter to identify potential participants based on the following criteria: (1) RNs who are currently providing direct palliative and end-of-life care services in community settings, (2) RNs who are currently employed in the province from a variety of geographic areas, (3) RNs who are experienced in palliative nursing practice from the perspective of recruitment collaborators, (4) RNs who are practicing in rural and/or urban settings, and (5) RNs who show a willingness to participate in the study. Participants were also recruited through an information display at a provincial hospice and palliative care conference for healthcare professionals. Telephone contact was made with interested participants and a research package was sent to them including a letter, information brochure, consent form, demographic form, journal and instructions, potential interview questions, and postage paid envelopes for the return of study materials. Once the signed consent forms and the completed demographic forms were received from the participants, the first interview times and dates were set.

### Data Collection

The data collection for this study occurred from May 2008 to July 2009 and included a demographic form, open-ended telephone interviews, participants' journal entries over a 1 to 2 week period, interview notes, and the primary researcher's written memos. Because of the geographical distribution of study participants across a western Canadian province, the open-ended interviews were conducted via telephone. Telephone interviews ensured a broad geographical sampling of participants (Wilson & Edwards, 2005), and increased time effectiveness (Wilson et al., 1998) and the development of less stressful and positive relationships between

researchers and participants (Musselwhite et al., 2007). A total of 27 interviews were conducted with 14 participants. All participants save one, were interviewed twice in order to clarify and elaborate on the first interviews. The single participant, who was interviewed once, was a clinical expert in the area of community palliative nursing practice, and provided an in-depth confirmatory interview toward the completion of data collection. Interviews ranged from 45 to 75 minutes in duration.

An interview guide was used during the interviews, and was adapted as the study progressed by adding areas to explore, which helped to clarify and define the gaps in the emerging theory (Charmaz, 2004). The nature of interview questions focused on how they define hope and what hope means to them, how hope influences their care of palliative care patients, and the positive and negative influences on their hope. Participants were also asked to participate in directed journaling for 5–10 minutes per day, for a 1 to 2 week period. They were given specific instructions about what to write in their daily journal (i.e., what gave them hope today, what took away from their hope today), with journals being completed by nine participants. The journal entries provided an additional form of data, thereby enriching the interview data (Charmaz, 2006) and facilitating the researchers' understanding of the participants' hope experiences. Interview notes were taken during the course of, and following each telephone interview to enrich the interview data. The notes were descriptive and included basic information such as the setting the participant was in, and anything not evident in the written transcripts of the interviews (e.g., change in voice intonation, emotional responses). Written memos were also compiled throughout data collection and analysis and helped to capture the researchers' thoughts and lead to new ideas and directions to pursue.

As the study progressed, theoretical sampling was used to refine the data, which involved collecting more focused data to define the gaps in the analysis and discover the variations between categories (Charmaz, 2004, 2006). As analysis continued, this included asking further questions of earlier participants, as well as, sampling those practicing in both urban cores and small rural settings, where access to resources may have differed; those in leadership positions and front line nurses or "field nurses"; and those from health regions in which palliative services were well established and those from regions that were in flux or where changes to palliative care delivery were occurring. In two cases, participants were not sure if they really had a lot of hope. Some aspects of what two separate participants shared seemed to challenge the emerging theory and the

two participants were therefore considered to be contrast cases (Charmaz, 2006). The insights of the contrast cases were included in the theory to further develop its range of variation. Data collection continued until saturation was reached (i.e., until no new properties of the developing theoretical categories emerged during interviewing and analysis) (Charmaz, 2006).

### Data Analysis

The telephone interviews and journal entries were transcribed verbatim, and were checked for accuracy by the primary researcher who had conducted the interviews. Consistent with grounded theory methods, data collection and analysis of the study data occurred simultaneously, with interview and journal data being integrated for analysis as one document. The open-ended data were managed using Non-numerical Unstructured Data Indexing, Searching, and Theorizing (NUD\*IST-6), and the demographic data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 14. Three phases of coding were used, which included initial, focused, and theoretical coding. Initial coding was used to look at the actions in each segment of data (incident-by-incident), and assisted in developing the social processes of palliative care RNs' hope. Focused coding was used to integrate and sort the most salient categories from the data, and lead to further adaptation of the interview guide and analytical techniques for subsequent data collection. Finally, theoretical coding was used to explore the relationships between the developing categories and helped move the process in a theoretical direction. Table 1 provides an example of the coding process. Throughout the research process, relevant literature was integrated into the analysis in order to compare where the theory fit in relation to the literature.

To ensure that the theory had fit, relevance, and modifiability, trustworthiness of the data was sought through credibility, originality, resonance, and usefulness (Charmaz, 2006). Credibility was established by using the participants' language in the analysis, and by keeping the raw data, written memos, and interview notes, which provided an audit trail for the study. Originality was ensured through theoretical sampling and using constant comparative methods of data analysis, as well as referring to the literature related to the social processes that emerged. Resonance and usefulness were also addressed by confirming the theoretical processes with the participants when possible, and by providing descriptions of the theory that were grounded in the data.

**Table 1.** Example of coding process "Harmonizing Hope"

Transcripts	Incidents	Categories	Concepts
What the clients' or families' hope is, would usually trump mine, because I have to do what's best for them.	Considering the hopes of others first.		
I don't know if a resolution is the thing but, I guess sometimes I almost feel like a mediator to try and deal with everyone's emotions.	Trying to resolve differences. Mediating the emotions of others.	Creating a sense of harmony.	
Because we didn't agree with what they did. . . I guess what they thought, they were doing a good thing, in their eyes.	Having different hopes. Seeing from the other perspective.		Harmonizing hope.
It was really hard for me but yet I've drawn from that. . . Even though I don't agree with her philosophy on a personal basis.	Learning from differences. Agreeing to disagree.	Harmonizing different hopes.	
I mean everybody has to deal with it in their own way.	Accepting different ways of coping.		

## RESULTS

### Sample

A total of 14 RNs who provide palliative care in community settings were interviewed for this study, with nine submitting daily journals on hope. All participants were female and reported working in the community and/or home care, in both rural and urban settings. Five also reported providing care in hospital and long-term care, as well as in the community. There was a vast geographical distribution of participants across the province studied, and the study included participants from six separate health regions. Participants ranged in age from 37 to 58 with a mean age of 49.1 years, and had worked in the area of palliative care an average of 11.3 years (range 1–25). There was a mixture of religious/spiritual preferences of participants including: none, Agnostic, Protestant, Lutheran, Roman Catholic, United Church, and Seventh Day Adventist. Table 2 describes additional characteristics of the participants.

### Social Context of Hope for Palliative Care RNs

The studied experience is embedded within the larger social context of the participants' worlds (Charmaz, 2006). The social context, or conditions under which the study took place, was interconnected with the emerging theory that is presented in this article. The emerging theory and specific findings of this study were interpreted and understood within this context.

The main aspects of the social context for the participants in this study consisted of their rewarding and challenging work life experiences and the im-

pact these experiences had on them both personally and professionally. As is shown in Figure 1, the jagged edges of the social context of this study are shown in green as surrounding the process of harmonizing hope, representing both the ups and downs in the participants' lives, and the work life challenges and rewards that influenced their experiences of hope. The main themes of these experiences included: "who I am," "resigning myself to the system," "feeling valued/respected," and "managing grief and loss." In general, the participants described their significant experiences, which gave meaning to their work, and helped them to explain the positive and negative impact of their experiences on themselves and those around them. The participants stressed the importance of knowing themselves personally/professionally, and having a sense of their professional identities as palliative caregivers. There were also challenging aspects of their work lives that made them feel resigned to the system never changing and, at times, made some question why they stayed in the nursing profession. These included a lack of resources, dispelling myths, difficult family dynamics, lack of support, overwhelming workloads, staff shortages, and gaps that they saw in care. The rewarding aspects of their work lives helped participants to feel valued and respected as professionals, and contributed to feelings of resiliency. These experiences included having a professional presence in the community and a personal connection in the home, working autonomously, and having collegial relationships. Finally, participants sometimes felt overwhelmed by concomitant and successive losses they were facing, and that they were continually managing grief and loss.

**Table 2.** *Characteristics of participants*

Characteristic	Number
Age	
37–47	6
48–57	6
>57	2
Ethnicity	
Caucasian	14
Health Region of Employment	
Kelsey Trail	2
Saskatoon Health Region	6
Sun Country	2
Sunrise	1
Prince Albert Parkland	1
Regina Qu'Appelle	2
Work Setting	
Community	9
Community, Hospital & Long-term Care	5
Location of Practice	
Rural	6
Urban	6
Urban & Rural	2
Nursing Position	
Home Care Nurse/Field Nurse	7
Palliative Care Coordinator	4
Case Manager/Assessor/Consultant	3
Religious Preference	
Protestant	7
Catholic	4
No Preference/Agnostic/Other	3
Marital Status	
Married/Common-law	12
Divorced	2
Years Licensed as RN	
11–20	2
21–30	9
31–40	3
Years Worked in Palliative Nursing	
1–10	8
11–20	4
21–25	2
Hours of Contact with Palliative Clients Per Week	
<1–10	7
11–20	3
21–40	4
Nursing Education	
Diploma	11
Baccalaureate or Ph.D.	3
Additional Education	
Baccalaureate in another field	1
CHPCN Certification <sup>a</sup>	4
Other (Gerontological Nursing, Northern Clinical Nursing)	2

<sup>a</sup>CHPCN (Canadian Hospice Palliative Care Nursing) Certification

### Definition of Hope for Palliative Care RNs

Palliative care RNs found that the concept of hope was complex and, at times, difficult to put into words. One participant said “[Hope] is sort of an abstract

term, but it is a definite necessity in your life. Hope is essential in that, if you don't have it, then life is very bleak, you don't have a reason to live for.” Palliative care RNs defined their hope as a positive or optimistic “state of being” involving a perseverant and realistic understanding of future possibilities. One participant described “. . .so personally, hope means, not doom and gloom and not that we're going backwards, but that we are progressing and things are looking like they're moving forward.” Another said “. . .being realistic is part of hope for me. I can be, I can still be hopeful and be realistic personally.” For them, hope involved action and striving for something, hope was a choice, it is constantly changing or dynamic, and even though what they hoped for might not be attainable or the outcomes might be uncertain. One said “. . .I don't think hope is something that you can take for granted. I think it's something, it's an activity that you have to work at. And that you have to be an active participant in.”

Hope invigorated and sustained the participants. It acted as a motivator, gave meaning and purpose to their lives, and helped them to focus on a positive future. Most importantly, their hope and how they defined it was interconnected within the context of their practice and interrelated to the hopes of their clients and others around them. To be able to give hope to their clients and others around them, they felt that they themselves also had to have hope and work in a hopeful way. One participant described this as “I guess simply if you don't have hope, it's really hard to continue on and like if you're dealing with other people that have very little or no hope, it's difficult to give them any if you don't have any yourself. [That kind of interconnected hopes of your hopes with your clients' and vice versa?] Yes, both are influenced by each other. As such their own hope helped them provide high quality care and strive forward day-to-day in their lives.”

### Main Concern: Keeping Hope

The main concern for palliative care RNs was “keeping their hope,” even when faced with significant work life challenges, and confounding perspectives between what hope meant to them and the different perspectives that they encountered daily of what hope meant to the others with whom they worked, and to their palliative care clients and families. In particular, the participants were often concerned when they encountered viewpoints about hope that differed from their own. One participant explained “It's almost like they don't realize that that is hope. You know, they're so focused on hope being a cure for whatever disease they have, that they don't look

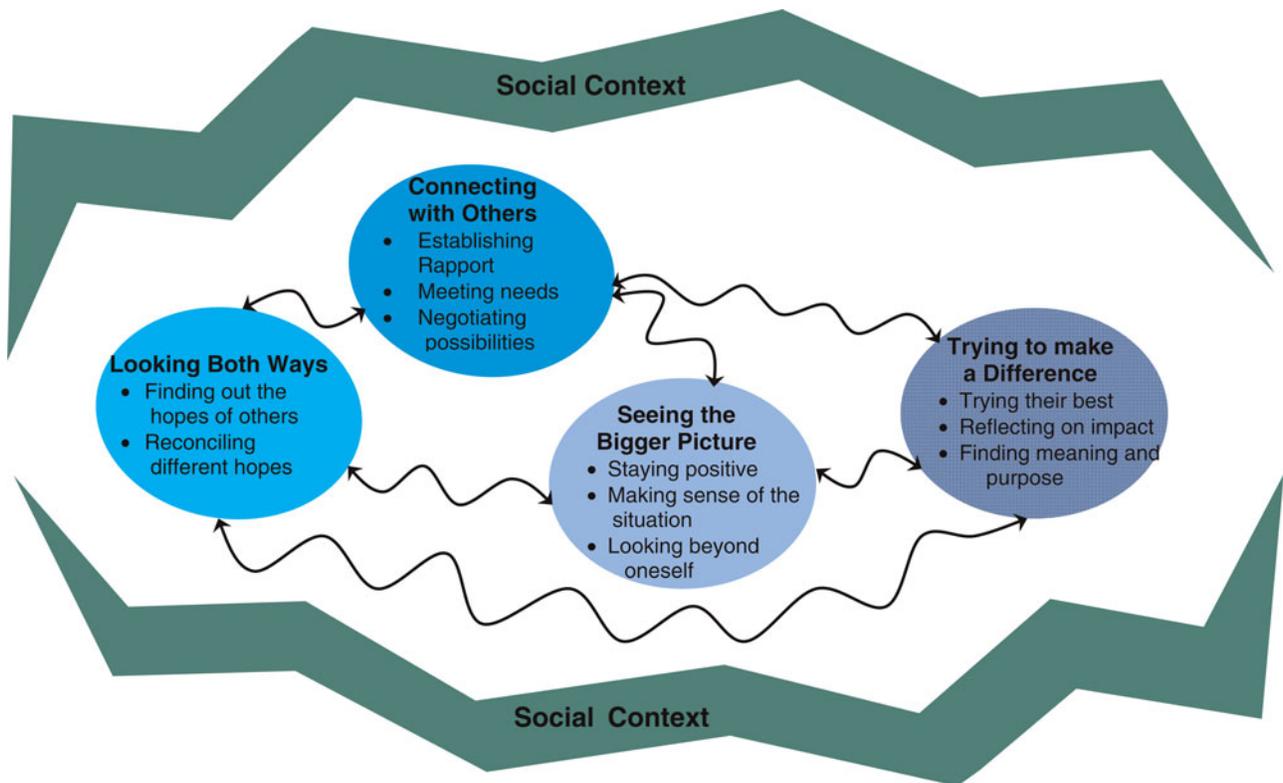


Fig. 1. (Color online) Harmonizing hope.

at it as, ok, well it moves to a different, different area now. And hope can be all these other things too.”

Although the palliative care RNs faced different opinions and challenges on a day-to-day basis, they still felt that it was important that they keep their sense of self, and keep their own hope, but at the same time, also try to keep other’s hopes alive and work to not take hope away from them. A participant said “I think that, my nursing care, I’m very conscious of not trying, trying not to take away hope. To try and keep their hope, keep their hope alive. . . So I think my attitudes on hope, they reflect a lot on my day-to-day work. Because I’m trying to find hope too.” Similar thoughts were shared by another participant, “Well, I guess to be able to have the resources to keep hopeful, that would be my main concern. Like to keep, to be able to keep above the water and keep a hopeful attitude. Keep that positive attitude amongst life’s obstacles, and disappointments and challenges.”

### Basic Social Process: Harmonizing Hope

The palliative care RNs dealt with keeping their hope through the basic social process of “harmonizing hope.” This was an active process of moving forward and striving for a sense of harmony within themselves and with their clients and others in their

work, and in their lives. This process was shared by a participant as she reflected about someone significant in her life “my hope for him is that they’ve found some harmony and, they will journey together and, understand that they are going to change as people and that as we change we need to still be able to be together, and that we need to understand each other and allow each other to grow.” When participants faced confounding perspectives on hope, they did not have a sense that they had to balance their own hopes against the hopes of others. Having a sense of balance would imply that they would have to come to a consensus, or that both sides would have to understand each other equally. Instead this process resembled having a sense of harmony that allowed different perspectives to exist alongside one another. An analogy comes to mind of a choral singing group or choir in which many different voices singing different musical notes, with varied timing, can still blend together and create a certain harmony. One participant said “. . . in our personal lives too. If we think oh, that disappointed us, didn’t meet our expectations, what we hoped for. We have to look at re-defining, re-looking at that and kind of find a new avenue to have hope.”

Figure 1 contains a diagram of harmonizing hope. The theoretical model shows four interconnected sub-processes presented in shades of blue “looking

both ways,” “connecting with others,” “seeing the bigger picture,” and “trying to make a difference.” The wave-like lines and arrows between the sub-processes represent the up and down nature of the participants’ hope experiences and the constant movement back and forth between the processes depending upon the diverse circumstances they were dealing with. As participants worked to harmonize their own hope both in relation to their daily practice with clients and families, and within the broader system of care and society, theoretically, they started with looking both ways and connecting with others, and moved forward to seeing the bigger picture and trying to make a difference. It was necessary that participants went through each of the sub-processes to work toward harmonizing their hope, and as such, they could be found at various points along the way with continuous setbacks and boosts forward. The jagged edges of the social context of harmonizing hope are shown in green as surrounding the process of harmonizing hope, representing both the ups and downs in the participants’ lives, and the work life challenges and rewards that influenced their experiences of hope. Further description of the four main sub-processes follows.

#### *Looking Both Ways*

The first process in harmonizing hope for palliative care RNs was looking both ways. Within this process, they had to consider not only how they defined hope and what hope meant to them as healthcare professionals, but they also had to consider the hopes of their clients/families and others in their lives and work, and how these might have differed from their own interpretation. They accomplished this through (1) discovering the hopes of others, and (2) reconciling different hopes. Having an open-minded attitude and adopting an empathetic approach was key to this process. Even though the participants tried to understand the perspective of others around them, there were times when this was very difficult and/or not possible. In a sense, there was always a give and take between being true to their own hopes and what they believed in the situation, and reconciling that they sometimes had to let go and accept the different hopes of others. They may not have always agreed with the hopes of others, but acknowledging that these hopes existed and accepting where others were at that point in time was very important. One palliative care RN said “because there’s everything out there to there is no hope I’m going to die and there’s nothing left to live for, right to, I can’t even verbalize that I’m not going to be healed. Well I always am open to consider what other people have to say, but then I kind of run it through my own little

maze of belief systems I guess and, you know, basically hang on to what I think is good and kept going. Or else I file [as] it was an interesting perspective. It’s another way of looking at something, not that I necessarily agree with it, but it helps me to understand where they’re coming from.”

#### *Connecting with Others*

Connecting with others was an additional process that contributed to harmonizing the hope of palliative care RNs. This process began at the same time as “looking both ways”, but it was also intertwined with all of the sub-processes as they occurred. Without establishing connections with others in their personal lives and in their work, the participants were not able to continue through the remaining three sub-processes. Relationship building and being engaged or connected to those around them were important for them to feel effective, and gave them hope. The relationships they focused on were mainly in relation to their clients and the clients’ family members; however they also included relationships with other people in their lives such as their work colleagues and their own family and friends. Connecting with others was accomplished through (1) establishing rapport, (2) meeting needs, and (3) negotiating possibilities. Establishing rapport was a process of building trust with those the participants interacted with by listening to their stories and by taking the time to communicate openly. Elements of respect and being client-centered were key to establishing these connections. One participant said, “I mean the more you actually engage someone or spend time or be in tune with the moment, the more they’re going to open up and be, and you’re going to start getting deeper, and deeper. If you’re fully engaged with someone, I find that quite enlightening. I think when someone knows you sincerely care and are interested in them, I think that brings them hope. [And as far as your own hope in relation to that, does that give you hope then as well?]. I feed off of it.”

The palliative care RNs also felt that it was important that they were meeting the basic physical and psychosocial needs of their clients/families and providing the best care possible in order to be able to connect. This was emphasized as important to the hope of one participant, “. . . when I’m connecting and I have the feeling that I’m meeting those needs of my clients. Like that gives me fulfillment and joy and hope for the future and enjoyment of my job.”

Finally, the process of negotiating possibilities may not have been achievable in all situations, but by doing so, the palliative care RNs were able to remain true to themselves and not give up their own

hopes. In this process they strived to foster shared understanding by explaining choices and introducing new ways of thinking, peeling off layers, and making an effort to help others consider more realistic options and possibilities. This was not an effort to make others think like them; however, by entering into this negotiating process, participants felt that this was a way to come closer and that by doing so, their connections could be made stronger. This process was explained by one participant, "well I think it's in the discussion and the listening and the understanding you know, I wouldn't say that's it's really like I force you to think like I'm thinking, I just kind of throw it out there so that they can look at that. It takes time and, and it's I don't know, it's just kind of like the light bulb comes on." All of these actions may not have been accomplished in every situation; however, just the sense that they were striving to make these connections was influential to their hope.

### *Seeing the Bigger Picture*

Seeing the bigger picture was a process that involved being able to move beyond just the acknowledgement of differences and focusing on a more positive and broad understanding of their world, the world of others around them, and their challenging situations. To succeed, the palliative care RNs needed to know what they valued in their lives. There was a sense of putting things into perspective and being in the moment, as well as, looking beyond themselves which helped them see the bigger picture and was part of harmonizing their hope. They were able to accomplish this through (1) trying to stay positive, (2) making sense of the situation, and (3) looking beyond themselves. The palliative care RNs made a conscious choice to try to stay positive even when they were dealing with stressful situations and negative external influences (e.g., loss of autonomy, lack of a team approach). This involved engaging in their own lives and the lives of their clients, and finding their own height of optimism. A participant explained "...to me keeping the positive aspect of hope is important. I think that's how I do a lot of the definition of hope, is through the optimism, being positive and everything in the negative side kind brings it down."

To see the bigger picture, the palliative care RNs also tried to make sense of the varied situations they found themselves within. This included stepping back and considering all angles, which helped them to take things step-by-step and assisted them in defining where to focus their energy. This process is summed up by one participant "but I think what's important in the bigger picture is really knowing

where you, what you believe and where you stand I guess." Finally, having the ability to look beyond themselves, often with a forward-looking perspective that was grounded in the present, was also part of seeing the bigger picture. For the participants, this involved anything from having a vision for the future, to knowing their reasons for being hopeful (e.g., loved ones), and even to relying on a higher power or having a sense of spirituality. This process is summed up by one participant, "dealing with the palliative patients, I find that it makes me very retrospective. I'm thankful for what I do have, and I try to, you know, with my family, my children, make them feel that they are loved and that, they're worthwhile and think they're important in life."

### *Trying to Make a Difference*

In harmonizing their hope, it was important that the palliative care RNs also felt that they were trying to make a difference in the lives of others and in their work. For many, this included the small differences they tried to make on a day-to-day basis with their clients/family members, and for some, this also included striving to make larger scale differences at the community and regional levels of their work (e.g., making palliative nursing more visible, increasing community awareness). This process was accomplished through (1) trying their best, (2) reflecting on their impact, and (3) finding meaning and purpose in their work and lives. Although the differences they made were not always immediately apparent, it was important that they felt they were trying their best with the knowledge they had, and were open to continual learning about themselves and evolving throughout the process. They may have questioned "how they were doing" in terms of their professional role, but it was key that they remain realistic in their expectations of themselves. One participant described this as "...and if I end my day knowing that I did the best that I could with what I had, and what I knew, then it was a good day. That gives me hope." The participants who were considered contrast cases were not feeling as if they were able to make a difference when dealing with numerous challenges in their lives and external work constraints (e.g., lack of autonomy, lack of collegial support, restructuring of care delivery), and therefore were having the most difficulty with this sub-process. One shared her experience by saying, "I am not in a good space. If we don't identify within ourselves that we are either, we've met an impasse or roadblock, we have some inner struggles, I know I can't do good work when I am in that state. I feel helpless."

Reflecting on their impact was an evaluative process part of trying to make a difference, which

included self-reflection, as well as debriefing and receiving feedback from others regarding the tangible outcomes of their work. By talking about their difficult experiences and receiving validation and affirmation from colleagues, clients, and their own families, the palliative care RNs were able to learn from their past experiences and continually move forward. This was explained by one participant, "I mean, she came and spent a lot of time in the office and got me a flower and a thank you card and everything, and then one of the nurses just made the comment about like isn't that really something, I did feel like I made a difference, that's why I'm still doing it after all the years I've been doing it. I really enjoy what I'm doing, I feel like I make a difference, and I really feel I get a lot back from people."

Finally, finding meaning and having a sense of purpose in their work was important in their quest to make a difference. This was an analytical and reflective process that included a broad and holistic understanding of their role as a palliative healthcare professional, and feeling honored to work with individuals at a unique place in their lives. This was captured well by one participant:

this experience has kind of brought me right back to the core of what I've wanted to do for a long time and that's being enabled to be in connection with people in a whole body sense. Because, we're dealing with not only the physical illness and the, psychological and emotional stuff that's going on in their minds, but we're dealing with their families and their spirituality and all of those things. And this is such an amazing circle that I've been on and to come back to this now and look at everything and all my experiences and say, I'd been missing so much in the wholeness of our people. . .that it's, I'm getting back right now tenfold.

## DISCUSSION

The findings of this study present a developing substantive theory of the hope of palliative care RNs. The present developing theory of harmonizing hope provides a process in which palliative care RNs are able to consider the hopes of others, but most importantly, remain true to their own hope. As such, it is more than balancing, as was suggested by Thulesius et al. (2003) who propose that "balancing" is a fundamental process of problem solving between formal caregivers and palliative patients. These authors included maintaining a homeostasis of hope as part of their theory; however, the primary focus was on the caregiver's interpretations of the hopes of others, and not on their own hope.

## Defining Hope

The multidimensional aspects of palliative care RNs' hope were similar to those found in previous research on the concept of hope for healthcare professionals. For rural public health nurses, hope included a positive and forward-looking perspective that was active in nature (Kulig, 2001). For a group of palliative health care professionals, hope was also seen as a better or positive future, and that hope helped them provide high-quality palliative care and comfort to their patients and family members (Duggleby & Wright, 2007). The potential for palliative care RNs' hope to invigorate and sustain them in their practice and to act as a motivator was also implied in studies of healthcare professionals' hope (Kulig, 2001; Stephen-Haynes, 2002; Duggleby & Wright, 2007). What appears to be most important and unique to the palliative care RNs in the present study is the interconnected nature of their hope to the hopes of their clients and others, and to their practice. Their hope and how they defined it seemed to be part of their identities as palliative healthcare professionals, and part of the overall understanding of what they wished to accomplish in their work.

Not only were they concerned with keeping their hope when faced with work life challenges and job constraints, but they also had to deal with confounding perspectives and differing viewpoints than their own. This main concern of keeping their hope was similar to what was found in previous research in which participants were concerned with hanging onto hope (Holtslander et al., 2005), losing hope (Holtslander & Duggleby, 2009), and living with hope (Duggleby & Wright, 2005). However, the processes by which they tried to deal with this by harmonizing their hope were unique to the palliative care RNs and were consistently viewed within the social context of their work lives.

## Looking Both Ways

Having the ability to consider the perspectives of others by "looking both ways" was a main sub-process of harmonizing hope. Here, there was a sense that the palliative care RNs wanted to protect their own interests, but they also emphasized the importance of showing empathy and respect for the interests and hopes of their clients/family members and others. The ability of palliative care RNs to find out or discover the hopes of others and to reconcile differences between what they hoped for in various situations and what others hoped for, was crucial. Duggleby and Wright's (2007) study of the hope of palliative healthcare professionals implied the importance of both professionals and their patients

having a sense of peace or acceptance of the situations they found themselves within. There seem to be similarities between the concept of finding peace in these circumstances and reconciling differences in the present study. However, in the study by Duggleby and Wright (2007), there is more of a focus on the clients' and family members' acceptance, and less on the process by which these other hopes are explored, evaluated, and carefully considered. It is the integrated nature of this sub-process that makes it unique. In order to harmonize their own hope, the palliative care RNs must consider their own way of thinking, as well as the ways of thinking of others in their lives. Again, this sense of harmony is not a balance, as it allows for differences to exist side by side. This is in contrast with Gelling et al.'s (2002) essence of ICU nurses' hope as creating a balance between the hopes of the relatives of their patients and the realistic estimation of the nurses' prognosis. It is possible that the context of working in an ICU with its urgency and technological focus on recovery may have influenced the results of this study, with some nurse participants only associating hope with unrealistic expectations or family members' denial. Additional research is necessary to determine if the discovery of the hopes of others and reconciling the differences in hopes are important aspects of nursing in other contexts and practice settings.

### **Connecting with Others**

Connecting with others was another sub-process of harmonizing hope for palliative care RNs. Although the concept of establishing a connection with patients/clients and their family members is not limited to research on hope and may be at the essence of palliative nursing practice in general, it is important to note that this connection is crucial to the hope experience of community palliative care RNs. In addition, although part of the larger context of their practice, the perception that they were connecting with others was viewed as intertwined with all of the sub-processes of harmonizing hope. In other words, they were not mutually exclusive and all were interconnected and were occurring simultaneously. Establishing rapport was an important part of connecting with others. Similar results have been found in previous research on community palliative care delivery including "getting to know the patient and family" (Luker et al., 2000), forming a relationship of trust (Mok & Chiu, 2004), and being part of a communication web (Dunne et al., 2005). Having enough time to spend with clients in the home and developing a bond of trust were important factors in establishing rapport. Meeting needs

consisted of palliative care RNs providing a complex mixture of physical, mental, emotional, and environmental care for their clients and clients' family members. Previous studies on the hope of healthcare professionals have also linked hope to being able to meet physiological care needs (Stephen-Haynes, 2002) and providing comfort and care through actions such as symptom management (Duggleby & Wright, 2007).

Finally, the process of negotiating possibilities was a unique aspect of connecting with others and harmonizing hope for the palliative care RNs. This process of communication that occurs between the palliative care RNs and their clients has some commonalities to Spiers' (2002) six interpersonal contexts of negotiating care in the home between nurses and patients. For example, the contexts of negotiating knowledge and sensitivity of taboo topics, and the way in which these issues are raised in the home environment (Spiers, 2002), were similar to negotiating possibilities. The key difference found in this study was the importance of the palliative care RNs taking into account the hopes of others as they attempted to negotiate a shared understanding. Further research is required to explore where other aspects of the interpersonal connections made between RNs and those under their care, or those they work with, fit in relation to harmonizing their hope.

### **Seeing the Bigger Picture**

Seeing the bigger picture was a sub-process of harmonizing hope for palliative care RNs that has not been found in previous research on healthcare professionals' hope. When examining the literature on hope in palliative care, there are some aspects that are similar to this sub-process. Trying to stay positive was part of seeing the bigger picture, a process that was also important to the hope of older palliative care patients (Duggleby & Wright, 2005), informal caregivers of palliative care patients (Holtslander et al., 2005), and bereaved family caregivers (Holtslander & Duggleby, 2009). Making sense of the situation was a cognitive process in which the palliative care RNs were able to step back and consider all aspects of the circumstances in which they found themselves. Although this process may be present intuitively in previous studies, none have been published that discuss the interplay between this process and hope. The ability of the palliative care RNs to make choices to look beyond themselves was also a factor in seeing the bigger picture. Although other studies on hope have found similar results such as finding hope in spirituality for professionals (Kulig, 2001; Stephen-Haynes, 2002; Duggleby & Wright,

2007), connecting to something bigger for informal palliative caregivers (Holtslander et al., 2005), and looking toward the future for bereaved caregivers (Holtslander & Duggleby, 2009), none emphasized the bigger picture within this process. Future research is necessary to clarify the relationship between hope and seeing the bigger picture for palliative care RNs, and to explore the importance of seeing the bigger picture in other areas of nursing practice.

### **Trying to Make a Difference**

The final sub-process of harmonizing hope for palliative care RNs was trying to make a difference. Again, similar to connecting with others, the RNs' quest to make a difference in patients' lives by looking at the impact they, the RNs, are making, and finding meaning in their work, is not restricted to research on hope or on palliative nursing practice. However, the importance of making this effort through trying their best, reflecting on their impact, and finding meaning and purpose in their work as part of trying to make a difference, have not been grouped in previous research on the hope of healthcare professionals. When examining moral agency in nursing, it is evident that seeing intrinsic value in what they do, and believing that they are making a difference, are key aspects of nurses' professional identity and why they choose to do what they do (Pask, 2003, 2005). For the palliative care RNs. In the present study, trying to make a difference involved taking action by always trying their best, as well as, cognitive reflection of what impact they were making, and what meaning and purpose they achieved through this process. Their ability to harmonize their hope was tied very strongly to this process and if they did not feel that they were trying to make a difference, it was very difficult for them to keep their hope. Although not presented as a broader process, previous research on the hope of healthcare providers has also found the link between hope and making a difference (Duggleby & Wright, 2007), and the differences made in their work as helping to reinforce and enhance their hope (Kulig, 2001). Finding meaning and purpose has been found to be a sub-process of hope for bereaved family caregivers (Holtslander & Duggleby, 2009), suggesting the importance of having meaning in caregiving relationships. Future research would help to clarify whether trying to make a difference is also part of nurses' hope in other palliative care settings and areas of nursing practice.

### **Factors Influencing the Study**

Factors influencing the findings of this study were related to the sample and design. The palliative care

RNs who were recruited and asked to participate in this study were aware of the research topic of hope. Therefore, some may have had a vested interest in this area of research, which may have influenced how they perceived the importance of hope in their work and in their lives. In addition, efforts were made to sample both female and male participants; however, there were no males who showed an interest in participating. As such, it is possible that the findings of this study may not resonate with male RNs who provide palliative care. Future studies confirming this theory and exploring the concept of hope for palliative care providers would benefit from having a more balanced sample of male and female participants, and participants from different cultural and ethnic groups. However the study participants were diverse across a broad geographical area, including RNs with varied ages and years of palliative care experience, and from diverse educational and religious backgrounds and practice positions (e.g., rural and urban, front-line nurses, those in leadership positions). Also, although the telephone interviewing techniques used in this study had many advantages, the primary researcher was unable to take into account any nonverbal communication that may have been occurring and would have added to the richness of the data.

### **Implications for Nursing**

Although contextually situated in the lives of the community practicing palliative care RNs who participated in the study, the findings may have significance for palliative care nurses in other practice settings and for nurses in general. With its exploratory design, this study provides numerous opportunities for future research on the hope of healthcare professionals. Not only does this study suggest that the hope of palliative care RNs may enhance their ability to provide high quality care, but that their hope may also sustain them and act as a buffer in dealing with a lack of resources and other challenges in their work environment. Further research is necessary to continue to explore these links and to further develop an understanding of the processes of hope for healthcare professionals. What fosters or contributes to their hope? What hinders their hope? How can their hope be sustained over time? What actions are required in their practice to look both ways, see the bigger picture, and try to make a difference when large scale changes in palliative care delivery are occurring at the community and regional levels? The potential role that hope may play in the lives and work of palliative care RNs and other professionals cannot be underestimated. As such, the impacts that continued research in this area may

make at the practice level are important to consider. Although the goal of palliative and end-of-life care nursing is the quality of life of clients and their family members, this also requires that the internal resources of the palliative healthcare professionals to provide this care are not overlooked. Future research may focus on the introduction of hope theory into nursing education programs, with a goal of assisting nurses and other healthcare professionals to become more aware of their own hope and its potential benefits in providing care and for dealing with work life challenges.

## CONCLUSIONS

This study presents an exploratory view of the processes of hope for community practicing palliative care RNs. Although the theory presented is in its developmental stages and is defined within the social context of community palliative care nursing, the concepts, processes, and actions outlined provide a foundation for future exploration of healthcare professionals' hope. Although the findings may have some similarities to previous interpretations of healthcare professionals' hope, the processes of "harmonizing hope" make a unique contribution to understanding the potential importance of hope to palliative care RNs and their practice. In conclusion, the findings of this study suggest that hope is very important to palliative care RNs, in that it helps them to persevere and sustains them when faced with work life challenges on a day-to-day basis in practice, and in the broader context of the healthcare system. Being most concerned with keeping their hope when faced with these challenges and the contrasting viewpoints of others around them, the participants found that they were able to do so through a process of harmonizing their hope. Through looking both ways, connecting with others, seeing the bigger picture, and trying to make a difference, the palliative care RNs were not only able to take into account the hopes and concerns of others around them, but also to remain true to themselves and to their objectives as palliative healthcare professionals. This study highlights the need for continued research in this area as there appears to be a lack of evidence on the meaning of hope for healthcare professionals, and in particular, on understanding hope in the context of palliative and end-of-life care delivery. It is important that the psychosocial concerns of formal healthcare providers are not overlooked. The potential role that hope may play in the work and lives of healthcare professionals is essentially uncharted and provides a unique and intriguing focus for further research inquiry.

## ACKNOWLEDGMENTS

This dissertation research was completed by Dr. Kelly Penz at the University of Saskatchewan, College of Nursing. She thanks her supervisor Dr. Wendy Duggleby for expert guidance and continuing support. Kelly Penz also thanks her Ph.D. committee members Dr. Karen Wright, Dr. Donna Goodridge, Dr. Marlene Smadu, and Dr. Jennifer Nicol for their professional insight. The authors also express gratitude to the participants and to the individuals who assisted in the recruitment process for this study including Meredith Wild, Director of Palliative Care, Saskatoon Health Region; Edna Parrott, Director of Home Care, Sunrise Health Region; Jan Cibart, Palliative Care R.N., Regina Qu Appelle Health Region; and Sandy Weseen, Regional Director of Home Care, Kelsey Trail Health Region. This study was funded by a Social Sciences and Humanities Research Council of Canada (SSHRC) Canada Graduate Scholarship-Doctoral.

## REFERENCES

- Appelin, G., Broback, G. & Bertero, C. (2005). A comprehensive picture of palliative care at home from the people involved. *European Journal of Oncology Nursing*, 9, 315–324.
- Arnaert, A., Sella, R. & Wainwright, M. (2009). Homecare nurses' attitudes toward palliative care in a rural community in western Quebec. *Journal of Hospice and Palliative Nursing*, 11, 202–208.
- Benzein, E., Norberg, A. & Saveman, B. (2001). The meaning of the lived experience of hope in patients with cancer in palliative home care. *Palliative Medicine*, 15, 117–126.
- Borneman, T., Stahl, C., Ferrell, B.R., et al. (2002). The concept of hope in family caregivers of cancer patients at home. *Journal of Hospice and Palliative Nursing*, 4, 21–33.
- Carstairs, S. (2005). Still not there quality end-of-life care: A progress report. <http://sen.parl.gc.ca/scarstairs/PalliativeCare/Still%20Not%20There%20June%202005.pdf>.
- Carter, H., McKenna, C., MacLeod, R., et al. (1998). Health professionals' responses to multiple sclerosis and motor neurone disease. *Palliative Medicine*, 12, 383–394.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In *Handbook of Qualitative Research*, 2nd ed. N.K. Denzin & Y.S. Lincoln (eds), pp. 509–535. Thousand Oaks, CA: Sage Publishers, Inc.
- Charmaz, K. (2004). Grounded theory. In *Approaches to Qualitative Research: A Reader on Theory and Practice*. S.N. Hesse-Biber & P. Leavy (eds), pp. 496–521. New York: Oxford University Press.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Thousand Oaks, CA: Sage Publishers, Inc.
- Dufault, K. & Martocchio, B.C. (1985). Hope: Its spheres and dimensions. *Nursing Clinics of North America*, 20, 379–391.
- Duggleby, W. & Wright, K. (2005). Transforming hope: How elderly palliative patients live with hope. *Canadian Journal of Nursing Research*, 37, 71–84.

- Duggleby, W. & Wright, K. (2007). The hope of professional caregivers caring for persons at the end of life. *Journal of Hospice & Palliative Nursing*, 9, 42–49.
- Duggleby, W.D., Degner, L., Williams, A., et al. (2007). Living with hope: Initial evaluation of a psychosocial hope intervention for older palliative home care patients. *Journal of Pain & Symptom Management*, 33, 247–257.
- Dunne, K., Sullivan, K. & Kernohan, G. (2005). Palliative care for patients with cancer: District nurses' experiences. *Journal of Advanced Nursing*, 50, 372–380.
- Feudtner, C., Santucci, G., Feinstein, J.A., et al. (2007). Hopeful thinking and level of comfort regarding providing pediatric palliative care: A survey of hospital nurses. *Pediatrics*, 119, e186–e192.
- Gelling, L., Fitzgerald, M. & Blight, I. (2002). Hope in the ICU: A qualitative study exploring nurses' experiences of the concept of hope. *Nursing in Critical Care*, 7, 271–277.
- Herth, K. (1993). Hope in the family caregiver of terminally ill people. *Journal of Advanced Nursing*, 18, 538–548.
- Holtzlander, L. & Duggleby, W. (2009). The hope experience of older bereaved women who cared for a spouse with terminal cancer. *Qualitative Health Research*, 19, 388–400.
- Holtzlander, L.F., Duggleby, W., Williams, A.M., et al. (2005). The experience of hope for informal caregivers of palliative patients. *Journal of Palliative Care*, 21, 285.
- Koopmeiners, L., Post-White, J., Gutknecht, S., et al. (1997). How healthcare professionals contribute to hope in patients with cancer. *Oncology Nursing Forum*, 24, 1507–1513.
- Kulig, J.C. (2001). Hope at the community level according to rural-based public health nurses. *Online Journal of Rural Nursing and Health Care*, 2, 1–19.
- Luker, K.A., Austin, L., Caress, A., et al. (2000). The importance of 'knowing the patient': Community nurses' constructions of quality in providing palliative care. *Journal of Advanced Nursing*, 31, 775–782.
- Mok, E. & Chiu, P.C. (2004). Nurse–patient relationships in palliative care. *Journal of Advanced Nursing*, 48, 475–483.
- Musselwhite, K., Cuff, L., McGregor, L., et al. (2007). The telephone interview is an effective method of data collection in clinical nursing research: A discussion paper. *International Journal of Nursing Studies*, 44, 1064.
- Newton, J. & Waters, V. (2001). Community palliative care clinical nurse specialists' descriptions of stress in their work. *International Journal of Palliative Nursing*, 7, 531–540.
- Pask, E.J. (2003). Moral agency in nursing: Seeing value in the work and believing that I make a difference. *Nursing Ethics*, 10, 165–174.
- Pask, E.J. (2005). Self-sacrifice, self-transcendence and nurses' professional self. *Nursing Philosophy*, 6, 247–254.
- Patton, M.Q. (2002). *Qualitative Research and Evaluation Methods*, 3rd ed. Thousand Oaks, CA: Sage Publications, Inc.
- Payne, N. (2001). Occupational stressors and coping as determinants of burnout in female hospice nurses. *Journal of Advanced Nursing*, 33, 396–405.
- Post-White, J., Ceronsky, C., Kreitzer, M.J., et al. (1996). Hope, spirituality, sense of coherence, and quality of life in patients with cancer. *Oncology Nursing Forum*, 23, 1571–1579.
- Romanow, R.J. (2002). *Building on Values: The Future of Health Care in Canada—Final Report*. Saskatoon: Commission on the Future of Health Care in Canada.
- Sherwin, E.D., Elliott, T.R., Rybarczyk, B.D., et al. (1992). Negotiation the reality of caregiving: Hope, burnout and nursing. *Journal of Social and Clinical Psychology*, 11, 129–139.
- Simmons, B.L. & Nelson, D.L. (2001). Eustress at work: The relationship between hope and health in hospital nurses. *Health Care Management Review*, 26, 7–18.
- Spiers, J.A. (2002). The interpersonal contexts of negotiating care in home care nurse—Patient interactions. *Qualitative Health Research*, 12, 1033–1058.
- Stephen-Haynes, J. (2002). The concept of hope—A phenomenological study. *Journal of Community Nursing*, 16, 28–30.
- Thulesius, H., Hakansson, A. & Petersson, K. (2003). Balancing: A basic process in end-of-life cancer care. *Qualitative Health Research*, 13, 1353–1377.
- Wilkes, L.M. & Beale, B. (2001). Palliative care at home: Stress for nurses in urban and rural New South Wales, Australia. *International Journal of Nursing Practice*, 7, 306–313.
- Wilson, K., Roe, B. & Wright, L. (1998). Telephone of face-to-face interviews? A decision made on the basis of a pilot study. *International Journal of Nursing Studies*, 35, 314–321.
- Wilson, V. & Edwards, L. (2005). Telephone interviewing in educational settings. <http://www.scre.ac.uk/spotlight/spotlight84.html>.