

Hope and Feminist Care Ethics: What Is the Connection?

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Encourager l'espoir des patients est considéré comme un devoir pour les fournisseurs de soins de santé, infirmières et infirmiers compris. Aussi a-t-on proposé différents types d'intervention permettant de répondre à cette obligation. Toutefois, on a consacré moins de temps à examiner ce devoir sous ses aspects moraux et à déterminer un cadre déontologique adéquat pour procéder à cet examen. Étant donné l'importance de l'espoir dans la vie des patients et celle de leurs relations avec les fournisseurs de soins de santé, l'auteure soutient qu'en la matière une approche fondée sur l'éthique féministe est ce qui convient le mieux. L'auteure s'inspire en particulier de l'éthique prônée par Joan Tronto et aborde les quatre aspects qu'elle décrit pour leur lien avec le rôle de l'espoir dans ce domaine. Enfin, l'auteure montre dans cet article qu'il est possible pour les fournisseurs de soins de santé de se soucier de l'espoir, et de l'entretenir. Puis à partir de ce cadre, l'auteure traite de l'orientation future des recherches en sciences infirmières.

Health-care providers — including nurses — are considered to have an obligation to foster hope in their patients. Various interventions for fulfilling this obligation have been suggested. Comparatively little time, however, has been devoted to examining the moral aspects of this duty and to situating this investigation within an appropriate ethical framework. Given the significance of hope in patients' lives, and the significance of their relationships with health-care providers, the author contends that a feminist care ethics approach is best suited for this investigation. In particular, the author draws upon Joan Tronto's ethic of care and discusses the 4 aspects of care she describes as they relate to the role of hope in health care. Ultimately, this paper shows that it is possible for health-care providers to care about and for hope. Based on this framework, future directions for nursing research are discussed.

Introduction

The notion of hope takes on special importance in the health-care context, as pain, uncertainty, and fear frequently accompany illness and injury. Patients look to their health-care providers not only for cures or treatments, but also as sources of comfort. Indeed, nurses have consistently been cited as enablers or supporters of hope by patients across both the age spectrum and the illness continuum (Farran, Herth, & Popovich, 1995, p. 106). Further, it is claimed in the nursing and medical literature that health-care providers have an obligation to promote, instil, and foster hope in their patients (see, e.g., Dufault & Martocchio,

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1985; Kodish, Singer, & Siegler, 1997). A number of health-care interventions for nurturing hope have been described (see, e.g., Herth, 2000; Penrod & Morse, 1997; Roberts, Johnson, & Keely, 1999).

By quickly moving from duty to action, however, we may have skipped over some important ethical terrain. It is worth taking a step back to examine this terrain. I submit that there is more to consider than merely whether a patient is hopeful and the interventions that might be employed to instil hope. In particular, the moral framework most appropriate for analyzing the duty to promote and instil hope must be determined, so that the ethical aspects and issues of attending to patients' hopes can be identified and addressed. I argue that a feminist care ethics framework is most appropriate for this task. I explore the ways in which this framework focuses our attention on relationships of care as they pertain to patients' hopes, and the ways in which it lends itself to future research.

Focusing on Hope

The role that hope plays in the lives of patients and health-care providers should not be ignored or underestimated: hope makes a difference in how people live their lives. Studies suggest, for example, that hope promotes healing (Cousins, 1989; Gottschalk, 1985; Udelman & Udelman, 1985, 1991), facilitates coping (Elliott, Witty, Herrick, & Hoffman, 1991; Herth, 1989), and enhances quality of life (Staats, 1991). Further, a connection has been found between loss of hope and depression and suicide (Abramson et al., 2000; Beck, Steer, Kovacs, & Garrison, 1985; Brown & Harris, 1978). Thus, the significance of hope to people's lives must not be ignored.

Further, one's relationships with others — including health-care providers — can have a great impact on one's ability to have and sustain hope (e.g., Farran et al., 1995; Wong-Wylie & Jevne, 1997). This point is illustrated in a comment by Bonnie Sherr Klein, a woman who is recovering from a stroke and learning how to talk by covering her tracheostomy tube, in which she recalls an incident some 2 months after her stroke:

The speech therapist said that I would never regain normal speech. I could try, and she could help, but we were doomed to failure. The damage had been done, and we had to be "realistic" in our expectations. She was cool and brisk, as if she had just stopped off at the hospital on the way to doing something really important, like preparing to give a dinner party.

I was devastated. How could I be me if I couldn't speak? Who the hell did she think she was? Who taught her it was her job to make me "realistic," to dash my so-called false hopes? (Klein, 1998, p. 146)

The speech therapist's dismissal of her efforts as "doomed to failure" does not convey a sense of caring about, or even acknowledgement of, Bonnie's hopes and fears with respect to her recovery. It is clear that, because of her dependence on the speech therapist for support, Bonnie resents the way in which her hope is challenged — and potentially destroyed — by this person. Given the nature of the relationship between patients and health-care providers — with the patient having less power, less control, and less information about his or her condition (Sherwin, 1992) — patients are dependent upon and vulnerable to what health-care providers say and do in terms of both their ability to hope and what they can hope for. Therefore, exploring the moral dimensions of this relationship with respect to hope seems particularly important. A recurring theme emerges from stories like Bonnie's, about hope being supported or destroyed by a health-care provider: patients want health-care providers to acknowledge and address their suffering, problems, victories, defeats, and recovery in a caring manner.

Given the significance of hope in people's lives and the significance of people's need for support, *how* should health-care providers fulfil their moral duty to attend to the emotion of hope in their relationships with patients? From a philosophical perspective, the first step is to choose an ethical framework for situating the analysis and/or providing a basis for the assessment of moral decisions. I shall now explore the suitability of the traditional or standard ethical approaches for addressing these aspects of hope in health care.

Choosing an Ethical Framework

One could consider using the standard or traditional ethical theories for this investigation. Indeed, any of a variety of ethical theories and approaches, such as Kantianism or consequentialism, could be used in identifying and addressing problematic assumptions or practices with respect to hope in health care. However, not all ethical theories are equally suited to the same types of moral work. What this investigation requires is a normative framework that is able to sort through and deal with the ethics of relationships. In particular, the framework must be able to provide insight into how best to structure, conduct, and evaluate relationships between unequal partners. As Sherwin (1999) argues, some ethical theories may have more appeal than others in a particular case, because "each sort of theory helps to make clear certain dimen-

sions of the subject that may be inaccessible when using other approaches" (pp. 202–203).

Traditional ethical discussions, if they do address the question of hope in health care, tend to focus on the dilemma of telling the truth versus preserving a patient's hope and the difficulty of dealing with patients who have "false" hopes (see, e.g., Brody, 1981; Kodish & Post, 1995; Ruddick, 1999). And yet in Bonnie's case there is much more that can and should be said about the patient's hope of regaining her ability to speak. To limit the analysis to whether this hope is false and should be destroyed is to ignore a number of other ethical features of the situation. For example, it is not clear what the grounds for judging hope are, whether Bonnie's hopes do need to be changed, and even whether the therapist's own hopes (or lack thereof) for Bonnie's recovery need to be examined. One might also critique both the therapist's approach to destroying hope and the manner in which she tries to make Bonnie hope for something realistic. There is little doubt that the relationship between Bonnie and the therapist is damaged by the way in which this discussion about hope occurs.

One of the difficulties with using the standard ethical approaches to examine hope is the paradigm that underlies theories like deontology and consequentialism, despite their differences. This paradigm assumes that the best moral decisions are those that are made from a disinterested and disengaged point of view, on the basis of certain universal or codifiable principles (for more discussion, see Walker, 1998). In addition, these theories have tended to abstract away from the particularities of each individual, to identify a generic feature of all individuals, such that one can determine who is worthy of consideration when making moral decisions.

The upshot of this paradigm for circumscribing the moral terrain is that traditional theories, in focusing on what determines whether a person deserves moral consideration, are not able to "make clear" the different relationships and contexts within which people live and work. By assuming that individuals are equal and that "each counts for one" (as claimed by basic utilitarian theory), these theories tend to overlook the ways in which people are interdependent and how such interdependence should be factored into our moral decisions. Thus, while the standard approaches to ethics do help to "make clear" certain features of the moral terrain (such as the consequences of actions), we will need a framework based on a different paradigm. In other words, investigation of the role of hope in health care requires a moral theory that is designed for exploring relationships and interdependencies.

What is needed, then, is an ethical theory whose starting point is the relationships between persons who occupy different roles or positions. Care ethics recognizes the particularity of individuals as well as the relationships of care between individuals. It creates a space within which our emotions, as part of our moral life, can be attended to. This framework can also help us to see how our moral decisions both affect and are affected by our emotions and our connections to others, whether personal or professional. Care ethics requires us to look at the ways in which patients and health-care providers interact — primarily not out of concern for rights, autonomy, or truth-telling (although these can play a role in patient care as well as patient hope), but out of concern for the ways in which care is given and received.

Using a Feminist Care Ethics Framework

While all theories of care ethics examine relationships of care, the most appropriate for an analysis of hope in health care is feminist care ethics. The advantage of a feminist care ethics over other care ethics theories is the opportunity it offers to specifically address power imbalances in caring relationships. Many feminists ask who has what power, who has particular resources and who does not, and who makes decisions and for what reasons. These questions encourage us to consider the various relationships within which people are embedded, and the choices they are sometimes forced to make as a result of these relationships. The questions raised by a feminist perspective are directly relevant to the role of hope in health care, especially in combination with a care perspective. Since health-care providers have, on balance, more power than patients, we need to ensure that we do not increase the power imbalance by taking something away from patients. In the case under discussion, what should not be taken away is patients' ability to discover and sustain hope. From the perspective of feminist care ethics, one can also consider the ways in which, for example, cutbacks and policy decisions affect the ability of health professionals to provide care, including their ability to meet patients' hope needs.

In *Moral Boundaries: A Political Argument for an Ethic of Care*, Joan Tronto (1993) makes a sustained critique of the traditional care ethics debate and highlights the political context within which both this debate and caring activities occur. She is careful to attend to the ways in which power relations affect our understanding of what care is, what the practices of care are and should be, and who is and should be providing care. The result is a well-developed and well-defended feminist theory of care ethics. By breaking care or caring activities down into

four aspects, and noting the contextual elements that affect each aspect, Tronto's approach represents an advancement over other care ethics theories, for two reasons: (1) it is explicit about the importance of recognizing and understanding the other person's needs and responding appropriately (this is discussed below), and (2) its political basis enables Tronto to address criticisms of other care ethics theories for paying insufficient attention to the social and economic contexts in which caring relationships exist (see Carse & Nelson, 1996; Houston, 1993). In other words, Tronto's ethic of care will help an investigation into hope and its role in health care to reveal and comment on the ways in which current forms of care distort and trivialize expressions of hope, and may lead to improved caring about and for this emotion.

But what does it mean to "care" and to "care about patients and their ability to hope"? How should health-care providers go about offering this kind of care? Tronto's four aspects of care are: caring about, taking care of, care-giving, and care-receiving (1993, pp. 106–108, 127–136). Each of these distinct yet interrelated facets of care is relevant for understanding the ethical issues connected with hope and the role of hope in the lives of patients and health-care providers. I will now review these four aspects of care, paying particular attention to how each one highlights different features of hope that are relevant for its appropriate (ethical) acknowledgement and its role in health care. Due to space constraints, this analysis will focus on patients and their hopes as recipients of health care.

Caring About

Caring about is recognizing that a need for care exists and that something should be done to meet this need. Yet whose needs are being recognized, and what these needs are taken to be, can be shaped in various ways — for example, by the society in which we live and by our position/role in that society. With respect to determining a patient's hope needs, the health-care provider may not know what the patient's values and goals are nor what resources are available to support the patient's hopes (which can, in turn, affect what is hoped for).

This aspect of care therefore requires attentiveness on the part of those who are in a position to offer care. In other words, the health-care provider has a moral responsibility to consider what needs others might have and to acknowledge those needs. As Bonnie's experience illustrates, if the need for hope and the need for the patient to have his or her hopes respectfully addressed are not taken seriously by the

health-care provider, much emotional damage can be done to the patient and, in turn, the relationship between the patient and the health-care provider can be affected. Determining what should be done with respect to the “hope needs” of patients ought to be guided by the other three aspects of care.

Taking Care Of

In *taking care of*, the individual who has determined that there is a need takes responsibility for meeting this need: by deciding that something can be done, considering the various options, and choosing to act. By extension, then, *taking care of* requires that care-givers accept the implications of their decisions about which action(s) to pursue given any apparent constraints or limitations. *Taking care of* boils down to finding an appropriate way to provide care such as by bringing together whatever resources are necessary to make care happen. Proper attention to the needs of others will give some guidance as to what types of actions may be best and can thereby inform this aspect of care. *Taking care of* that fails to consider various treatment alternatives or various assumptions about care can result in an inappropriate action for meeting a patient’s hope needs.

This last point is illustrated by a study of American oncologists’ understanding of and discussions about hope. The oncologists based their hopefulness “primarily in the biomedical dimensions of their work. Caring is conveyed through the treatment process, through offering therapeutic options and holding out hope for the development of new treatments on the cutting edge of medicine and technology” (Good, Good, Schaffer, & Lind, 1990, p. 74). While medical intervention may well be necessary, this form of care will not necessarily meet all of the hope needs of patients and may even distort both oncologists’ and patients’ perceptions of such needs. Toombs (1995) argues that this form of care tends to treat “the psychological, spiritual, social, and cultural aspects of illness” as “peripheral” (p. 12). Indeed, if oncologist-patient discussions are limited to the hope for a cure, then patients’ hopes in terms of quality of life or day-to-day coping with cancer will be left unattended or even overlooked. In other words, *taking care of* entails a re-evaluation of care practices in order to identify those that may unduly limit patient hopes and effectively ignore a patient’s values — especially if these values differ from those of the health-care provider.

Care-Giving

The third aspect of care, *care-giving*, involves “the direct meeting of needs for care” (Tronto, 1993, p. 107). This is perhaps the most obvious part of care, as it is the “doing” of care. Tronto notes that it frequently entails physical work and typically requires contact with the care recipient. In other words, care is primarily a face-to-face activity and involves both the recipient and the provider. However, as Ruddick (1998) points out, the physical demands of care-giving should not overshadow the emotional needs of the patient: “Most recipients of care are only partially ‘dependent’ and are often becoming less so; most of their ‘needs,’ even those [that are] clearly physical, cannot be separated from more elusive emotional requirements...respect, affection, and cheer [and hope]” (p. 11).

This aspect of care extends care-givers’ responsibility to ensuring that care is competently provided. Competence here means the ability and skills to provide care according to need — such as the ability and skills to acknowledge the significance of a patient’s hope. With respect to hope, for example, competent care recognizes the vulnerability that is often associated with hope and responds to it by ensuring that discussions with patients about the possibility for hope take this vulnerability into account. It may influence when and how information is shared with patients and extends to day-to-day conversations with patients. This is not to suggest that patients should be lied to in order to preserve their hope, but attention ought to be paid to not only what information should be divulged in a discussion with a patient but also the discussion itself. In Bonnie’s case, hope care ignores this feature of hope and therefore is not competently given. Telling Bonnie that efforts to regain her ability to speak are doomed to failure does little to address her hope needs. In addition, the therapist gives Bonnie the impression that she is on her way to somewhere more important, which clearly adds to Bonnie’s sense that neither she nor her hope to regain her speech are worthy of consideration.

Care-Receiving

Care-receiving, Tronto’s fourth aspect, is the involvement of the person whose need for care has been identified. Only by including the care recipient can it be determined whether the need has been accurately framed and whether the actions taken are appropriate (Tronto, 1993, p. 108). The moral responsibility Tronto ascribes to this aspect of care is responsiveness on the part of care-receivers. Although Tronto does not fully explain this, responsiveness is understood to cut across the other

three aspects of care; in other words, care-receiving should not be limited to or thought of solely as the end-point of care (everything has been done; now let's see how the person responds). Care-receiving should be integral to defining and redefining needs and to choosing appropriate actions, and it can occur concurrently with care-giving. The care-giver must be aware of and attend to the care-receiver's responses to each aspect of care. Tronto establishes a "feedback loop" of responsiveness (care-receivers) and attentiveness (care-givers) as a part of what makes "good" care.

The importance of feedback from patients is illustrated by the debate on how best to deal with "false" hopes. To assume that a patient's hope should be changed because it is not likely to be met is to miss much of the point about how to care for patients. As Bonnie's story suggests, actually fulfilling a hope may not be what is most important to the patient. What may be most important is for others — including health-care providers — to actually hear what the patient's hopes and fears are and try to understand what the experience of illness or injury is like. Stephen Schmidt, a person with Crohn's disease, writes in an open letter to health-care providers:

When you come into my room...support my hope that tomorrow there may be new medicines[,] that today you care deeply[,] that you will do your best. When you come into my hospital room, promise me presence[,] promise me a healing partnership. (Schmidt, 1996)

Since all aspects of care, from identifying needs, to acting on them, to evaluating the response, are subject to scrutiny using Tronto's theory, better judgements should be made about how to provide ethically appropriate and defensible care with respect to hope.

Conclusion

I have used an excerpt from Bonnie's story to illustrate the importance of hope in health care and to support the claim that feminist care ethics is the approach best suited to determining how to morally respond to and acknowledge the significance of hope in people's lives. However, not all of Bonnie's interactions with her health-care providers had a negative effect on her ability to hope. If what I have said about the possibility for care to meet the hope needs of patients is correct, the following account by Bonnie suggests a model of good caring that attends to hope in moral ways:

I still couldn't breathe, eat, pee, sit up, or dance, but surely these would come soon. Meanwhile the nurses did practically everything for me. There was skin care, back care, mouth care, bedpans, massage,

bed baths... The best time was Rick's shift... He'd tell me about his day and what he was doing and what he was going to do next: not profound talk, just talk. (Klein, 1998, p. 117)

Although Bonnie received many forms of care, it is the care that she received from Rick — his conversations with her — that she recalls as the most significant. Rick's care provides a space for Bonnie to identify and articulate her hopes for her recovery. By treating her as a person capable of thinking and of engaging with others (even if in a limited way), Rick fosters in Bonnie a sense of self and what she wants for her life. This example shows that it is possible to care for others in a way that allows for, and even encourages, the development and expression of hope.

Still, determining that Tronto's ethic of care provides a suitable framework for this investigation into hope is only the first step in determining how to attend in moral ways to hope needs. Much more research is needed into current health-care practices with respect to hope. As the above examples demonstrate, frequently hope is not properly considered in interactions with patients and is unduly limited in terms of what count as legitimate reasons for hope. But, as Rick's care of Bonnie suggests, there is reason to *hope* that health-care providers will find ways to morally attend to this emotion as part of the care they offer to patients.

Future Directions for Nursing Research

Since nurses are responsible for the day-to-day care of patients and often have more contact with patients than other health-care providers, they are well positioned to address the hopes and hope needs of patients. Nurses have many opportunities to discover what patients hope for and are well equipped to encourage patients whose hope has been challenged. And yet, given the workload of many nurses and the increasing demands on their time, is it possible for nurses to fulfil their duty to promote hope and their other duties as well? More theoretical and ethical investigation is required to determine whether the duty to promote hope conflicts with or complements other professional duties. Two key questions to address are: Where does, or should, hope fit into the code of ethics for nurses and other health-care providers? Can Tronto's four aspects of care help nurses to identify and resolve the tensions among their various responsibilities? A longitudinal study of how practices of care change over time, in relation to acknowledging and addressing patient hope, would be a valuable tool for monitoring the effects of cutbacks and restructuring.

More research is also required to determine whether current health-care practices destroy patient hope unnecessarily and whether they should be modified to better address hope. For example, patient surveys or interviews about nursing practices that fall under each of Tronto's four aspects of care might reveal the ways in which patients' hope needs are or are not being met. Also, tracking of the care that patients receive could provide insight into the ways in which hope is or is not attended to over the course of a patient's experience. We might then be in a position to address questions such as the following: Is hope attended to over time with a given patient? Is hope addressed only when there is crisis or a sudden change in a patient's health status? Is hope discussed in the terminal phases of a patient's life?

The nursing literature describes a variety of interventions for increasing or instilling hope in selected patient populations. These interventions, however, require more research as to their efficacy and suitability (Farran et al., 1995; Penrod & Morse, 1997). Although Holt (2001) found that the factors cited by patients and families as supportive of hope were for the most part congruent with nursing interventions cited in the literature, more in-situ research on these interventions is required. Herth (2000) recently evaluated a theory-driven nursing intervention program to enhance hope among persons experiencing a first recurrence of cancer. The findings suggest that nursing interventions can foster hope but that further research is needed on how to tailor the intervention(s) to specific patients. As well, some interventions may be more effective at certain times over the course of a patient's illness or recovery. Research into this issue, and into the development of systematic means of measuring the effectiveness of such interventions, might ultimately help nurses to provide care that is more responsive to patients' hope needs.

Also worthy of investigation are nurses' attitudes and beliefs regarding hope and how these relate to and influence their interactions with patients. Whether or not nurses themselves have hope, and what their hopes are, might affect their ability to provide hope care. Given the above-described interconnections between care-givers and care-receivers, this aspect of hope care should not be ignored; in other words, the focus on patient hope should not obscure the hope needs of nurses. The question of whether nurses have hope and are able to develop and sustain hope in their professional practice is vital to broadening the analysis of hope and the ethics of care. Research questions specifically addressing the hopes of nurses might include: How do nurses define hope? What are nurses' key sources of hope/hopelessness? How do nurses deal with situations in which patients' hopes

differ from their own? Does nursing care differ for patients who have hope and those who do not? Simmons, Nelson, and Neal (2001) have done some preliminary work in this direction by comparing the positive and negative work attitudes of home-care and hospital nurses; they found hope to be one of the attitudes that related to job satisfaction and to the need for decreased role ambiguity.

Ultimately, the findings of future research could serve to substantially enhance our ability to create and maintain caring relationships that will better identify and respond to the hope needs of patients, nurses, and other health-care providers.

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