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The hope paradox in advance care planning communication and decision making in oncology nursing practice

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Abstract: Advance care planning (ACP) is a core component of high-quality oncology nursing, yet its implementation is frequently challenged by a persistent communicative tension known as the “hope paradox.” Patients and families often express hope oriented toward cure or recovery, while clinicians must simultaneously facilitate realistic discussions about future care preferences and potential clinical decline. This narrative review examines how oncology nurses navigate this paradox in ACP communication, positioning hope not as a barrier to decision making but as a dynamic psychological resource that can be ethically aligned with realism. Drawing on psycho oncology theory, person centred care models, and palliative care literature, the review conceptualises hope as multidimensional and evolving, encompassing not only cure oriented goals but also relational, existential, and comfort-based aspirations. We propose a nursing focused “hope coordination” framework in which nurses act as facilitators who elicit patient values, integrate emotional and informational support, and guide shared decision making without extinguishing hope. Evidence based communication strategies are synthesized, including values focused questioning, acknowledgment of concurrent hope and uncertainty, and iterative ACP discussions embedded within routine care. The review further highlights implications for oncology nursing education, system level documentation, and outcome evaluation. Reframing ACP as an extension of hope centred care may enhance patient understanding, ethical decision making, and perceived quality of communication in oncology practice.

Keywords: advance care planning; decision making; hope; oncology nursing; patient centred care; psycho oncology; shared decision making; values-based communication

1. Introduction

Advances in cancer diagnosis and treatment have transformed many malignancies into chronic or life-limiting conditions characterized by prolonged trajectories, recurrent decision points, and increasing psychosocial complexity. Alongside these advances, the importance of integrating psychosocial and ethical dimensions into oncology care has been increasingly emphasized [1,2]. Among these dimensions, hope occupies a central yet contested position in cancer nursing practice. Hope sustains patients’ motivation, emotional resilience, and sense of meaning, but it also presents challenges when illness progresses and future-oriented decisions must be discussed [3]. Clinicians often wrestle with how to maintain patients’ hope within the framework of realistic discussions about prognosis and care options, creating what has been described as the “hope paradox”.

Advance Care Planning (ACP) has emerged as a crucial component of high-quality oncology and palliative care. ACP aims to support individuals in clarifying their values, goals, and preferences for future medical care, particularly in situations

where decisional capacity may be compromised [4,5]. Evidence suggests that effective ACP is associated with improved goal-concordant care, reduced unnecessary aggressive interventions, and better experiences for patients and families [6]. Despite these benefits, ACP remains underutilized or delayed in oncology settings, often initiated late in the disease trajectory or avoided altogether [6]. This delay often reflects deeper systemic issues, including the belief that discussions about future care planning undermine patients' hope [7].

A major barrier to ACP implementation in oncology is the persistent belief that discussions about future care planning undermine patients' hope [7]. Clinicians frequently report concern that introducing ACP may signal treatment failure, loss of optimism, or impending death [8]. Patients and families may interpret ACP as a form of abandonment or withdrawal of care, particularly when hope is narrowly understood as hope for cure or survival [2]. This perceived conflict between maintaining hope and engaging in realistic planning constitutes what may be described as a "hope paradox" in oncology care. The hope paradox reflects a deeper conceptual and communicative problem rather than an inherent incompatibility between hope and realism. Research across nursing, psycho-oncology, and communication science demonstrates that hope is not a singular or static construct. Patients with cancer often hold multiple, coexisting hopes that evolve over time, encompassing not only cure but also comfort, dignity, relational closeness, meaning, and control [2,3]. When clinical communication fails to recognize this plurality, ACP discussions may inadvertently threaten patients' identity-affirming sources of hope, even when clinicians intend to act in patients' best interests [9].

Oncology nurses are uniquely positioned at the centre of this paradox. Through sustained bedside presence, continuity of care, and close engagement with patients and families, nurses routinely navigate emotional, ethical, and relational complexities that extend beyond biomedical decision-making [2]. Nurses are often the first to recognize shifts in patients' understanding, emotional readiness, and expressions of hope, and they frequently act as intermediaries between patients, families, and the broader medical team [10]. Yet, despite this central role, nursing contributions to hope-sensitive ACP communication remain under-theorized and inconsistently integrated into formal ACP frameworks [11]. Existing ACP literature has largely focused on physician-led communication models, legal documentation, or system-level implementation outcomes [6]. While valuable, these approaches may not sufficiently capture the relational and emotional labour inherent in ACP conversations, particularly those mediated by nurses. Moreover, traditional evaluations of ACP success often prioritize document completion or discrete medical decisions, overlooking experiential outcomes such as feeling understood, emotionally supported, or able to sustain meaningful hope [6,12].

There is therefore a critical need for a nursing-focused conceptual framework that reconciles hope with ACP, rather than positioning them as opposing forces. Reframing ACP as a hope-consistent nursing practice one that supports the transformation and coordination of hope rather than its negation offers a promising pathway for addressing this gap. Such a reframing aligns with contemporary person-centred, palliative, and narrative approaches to care, which emphasize meaning-making, relational continuity, and ethical responsiveness to patient's lived

experiences [1]. The purpose of this narrative review is to examine the conceptual, ethical, and communicative dimensions of the hope paradox in oncology nursing and to propose a nursing-centred framework that positions ACP as an extension of hope-focused care. Specifically, this review aims to:

- 1) Synthesize theoretical and empirical understandings of hope as a multidimensional and dynamic construct in oncology care;
- 2) Examine how misunderstandings of hope contribute to resistance toward ACP;
- 3) Analyse ethical and emotional tensions experienced by nurses in hope-related communication;
- 4) Propose the role of the nurse as a “hope coordinator” within ACP processes;
- 5) Summarize evidence-based nursing communication strategies that align hope with realistic decision-making; and
- 6) Reconsider how ACP success should be evaluated beyond document-centric metrics.

By integrating nursing theory, psycho-oncology research, and communication science, this review seeks to contribute a coherent conceptual narrative that supports oncology nurses in navigating one of the most challenging aspects of cancer care. Rather than asking whether ACP threatens hope, this review reframes the question: How can oncology nursing practice coordinate hope in ways that honour both emotional meaning and ethical realism across the cancer trajectory?

2. Conceptualising hope in oncology care

Hope in oncology nursing is a multidimensional, dynamic construct rather than a unidirectional expectation of cure as tabulated in **Table 1**. Classical nursing theory distinguishes between generalized hope and particularized hope, allowing patients to sustain meaning even when specific outcomes are uncertain [13] This framework clarifies that the loss of one hoped-for outcome does not equate to the loss of hope itself.

Table 1. Multidimensional conceptualizations of hope relevant to oncology nursing practice and advance care planning.

Author	Population/context	Conceptualisation of hope	Key dimensions identified	Relevance to ACP communication
[13]	Theoretical nursing framework	Hope as a dynamic life force oriented toward achievable future good	Generalized vs. particularized hope; affective, cognitive, relational dimensions	Demonstrates that hope can shift goals without being extinguished
[14]	Chronically ill and terminal patients	Hope as a multidimensional, non-time bound construct	Temporality and future; positive readiness; interconnectedness	Supports reframing ACP as compatible with hope
[15]	Palliative cancer patients	Hope as lived experience grounded in meaning and relationships	Reconciliation, meaning making, relational hope	Aligns ACP with dignity and relational goals
[13]	Cancer patients	Hope as mediator of psychological distress and quality of life	Emotional resilience; coping orientation	Suggests ACP may preserve psychological wellbeing
[16]	Psycho oncology perspective	Hope as coping resource under stress	Meaning focused coping; acceptance	Explains coexistence of hope and realism
[13]	Cancer patients with bone metastases	Empirically supported unidimensional but content diverse hope	Inner strength; life value; future orientation	Supports measuring hope beyond cure orientation

Empirical nursing research has operationalized hope as consisting of future orientation, positive expectancy, and interconnectedness with self and others, as articulated by Herth [14]. Furthermore, validation studies have established that hope can coexist with illness progression and symptom burden, especially when both relational and existential dimensions are supported, thereby underscoring the multifaceted nature of hope in clinical contexts [17–19]. Contemporary theoretical syntheses view hope not merely as an individual psychological state but as a relational and adaptive process situated within social contexts and caregiving relationships. This broader understanding is critical in oncology, where patients often acknowledge poor prognoses while still nurturing meaningful hopes linked to comfort, dignity, and relationships [18,19]. This dynamic emphasizes the existence of a “hope paradox,” wherein patients can express both realistic concerns about their health and an enduring hope that draws on these relational dimensions [19,20]. Misinterpretations frequently emerge when clinical teams conflate hope exclusively with cure-oriented goals. Such reductionism risks oversimplifying the complexity of hope, misleading healthcare providers into believing that realistic discussions can threaten a patient’s psychological well-being [19,21]. In fact, research contradicts these concerns by illustrating that discussions around advance care planning (ACP) contribute positively to patient well-being illustrated in **Figure 1**.

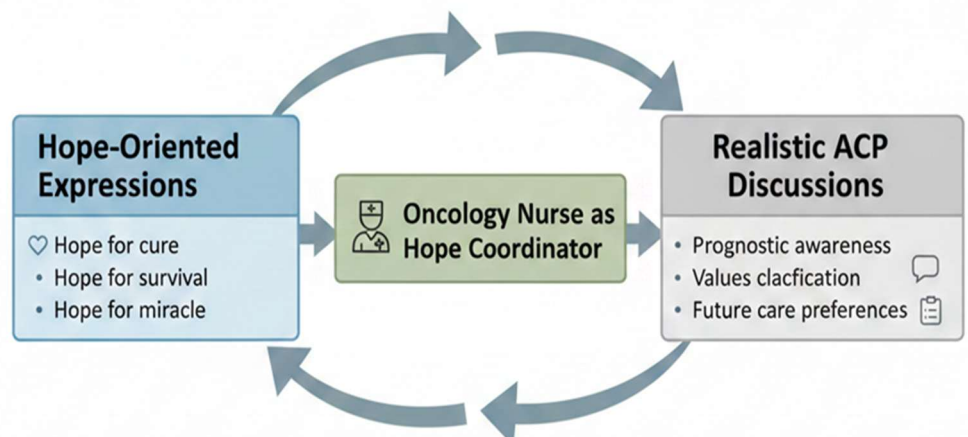


Figure 1. Conceptual framework illustrating the apparent tension between curative hope and advance care planning (ACP), and the reframing of ACP as an extension of hope-centred nursing care rather than its negation.

Advance Care Planning (ACP) has evolved to be widely defined as a process that assists individuals in articulating their values, life goals, and preferences for future medical care, rather than functioning as a singular decision-making act. This transformation reframes ACP as anticipatory, supportive, and adaptable across various illness trajectories [19,20]. Longitudinal studies of patients with advanced cancer corroborate this view, revealing that end-of-life discussions typically do not correlate with increased depression or anxiety; rather, patients engaging in ACP report better understanding of their illness and receive care more aligned with comfort-oriented goals [18,20,21]. The manner in which clinicians approach ACP conversations is critical. Evidence indicates that the timing and framing of these discussions significantly affect patient perceptions, determining whether they are

viewed as threatening or supportive. When ACP discussions are rooted in values and meaning, patients are more inclined to participate actively without feeling that their hope is compromised [19,20]. This highlights the importance of trust and collaborative communication during such sensitive interactions, indicating that effective ACP can enhance rather than diminish hope in patients with life-limiting illnesses [19,20,22].

3. Advance care planning and the “hope paradox”

Advance Care Planning (ACP) is increasingly recognized as a vital process in healthcare that helps individuals articulate their values, goals, and preferences regarding medical care, particularly in the context of serious illness. This process-oriented definition emphasizes the importance of ongoing communication and adaptability in ACP practices rather than reducing it to a mere set of decisions or documentation. Such a framework allows for more personalized and context-sensitive interactions between patients and healthcare providers. Longitudinal studies have shown that discussions about end-of-life care do not correlate with increased anxiety or depression in advanced cancer patients. Research by Wright [23] and colleagues highlights that engaging in end-of-life discussions can lead to improved understanding of the illness and more coherence between patient care and comfort-oriented goals. This evidence counters the prevalent myth that discussing ACP and end-of-life issues detracts from patient hope or well-being.

Multiple studies suggest that ACP discussions, when framed appropriately, can enhance patient engagement without diminishing their outlook on treatment. A systematic review by Bernacki and Block [24] illustrates how the timing and context of these conversations significantly influence patient perceptions. When these discussions incorporate patients' values and meanings, they are often seen as supportive rather than threatening [25]. Effective communication is paramount in ensuring that ACP discussions are productive and patient-centred [26]. Research has shown that without proper training, healthcare providers may struggle to navigate these sensitive conversations. Seymour et al. [26] emphasize the role of nurses in providing such critical discussions and highlight the necessity of communication skills training to empower healthcare professionals in this domain [26]. Numerous communication frameworks exist that suggest practical strategies for navigating sensitive subject matter in ACP. Arch et al. [27] advocate for integrated approaches that encourage healthcare providers to focus on collaborative decision-making, emphasizing the need for patients to feel that their voices are heard and valued during the ACP process. This participatory approach aligns with findings that show improved patient outcomes when discussions are collaborative and transparent [28].

The “hope paradox” associated with ACP further complicates how healthcare providers engage patients in these conversations. Rather than being inherent to ACP, this paradox often results from communication practices that fail to acknowledge that patients' hopes can be multifaceted and evolving over time. Studies have shown that when healthcare providers emphasize flexibility and adaptability in medical decision-making, patients feel more empowered and hopeful regarding their choices. This perspective is echoed by Hanson et al.[29], who argue that enhancing

communication quality can significantly improve family-rated measures of decision-making and overall satisfaction in nuanced care settings [29]. In conclusion, Advance Care Planning serves as a critical process for promoting well-being and proactive decision-making among patients with serious illnesses. The empirical evidence from various studies demonstrates that effective communication, when intertwined with values-based discussions, can alleviate concerns related to ACP and ultimately guide patients toward care that aligns with their personal goals. As healthcare systems evolve, the integration of communication training and frameworks that prioritize patient involvement in decision-making will play an essential role in maximizing the benefits of ACP.

4. Ethical dilemmas, moral distress, and keeping hope

Ethical analyses summarised in **Table 2** consistently identify tension between truth-telling and hope preservation as a central challenge in oncology communication [27]. Clinicians often fear that prognostic disclosure will extinguish hope, leading to delayed or softened communication.

Table 2. Ethical dilemmas related to hope and advance care planning in oncology settings.

Author	Clinical context	Ethical tension identified	Impact on patients or families	Implications for nursing practice
[27]	Paediatric oncology	Truth telling vs maintaining hope	Families fear loss of hope with prognostic disclosure	Need for staged and relational communication
[24]	Serious illness care	Late ACP due to clinician discomfort	Reduced goal concordant care	Nurses can initiate values-based dialogue
[23]	Advanced cancer	Prognostic awareness vs emotional protection	Discordance between care and patient values	Supports early, hope sensitive ACP
[30]	Nursing ethics	Moral distress when hope is perceived as threatened	Nurse burnout; communication avoidance	Reframing ACP as hope supportive reduces distress
[16]	Paediatric end of life care	Maintaining hope while acknowledging dying	Families seek hope beyond survival	Validates non cure oriented hope
[31]	Paediatric haematology oncology	Ethical conflict between beneficence and honesty	Moral residue among clinicians	Supports ethical training in hope coordination

However, empirical studies in paediatric and adult oncology show that honest disclosure can coexist with sustained hope, particularly when delivered with empathy and relational continuity [16,27]. Families receiving clearer information report greater trust and less decisional regret. Moral distress arises when clinicians, especially nurses, are required to support aggressive treatment perceived as misaligned with patient interests or values [31]. This distress is amplified by repeated exposure to situations where hope is framed unrealistically, contributing to burnout and emotional exhaustion. Qualitative evidence describes “keeping hope” as emotional labour performed by clinicians balancing realism, compassion, and family expectations under conditions of uncertainty [16]. These findings compiled in **Figure 2**, which support reframing hope not as an ethical obstacle, but as a relational phenomenon requiring skilled coordination rather than suppression.

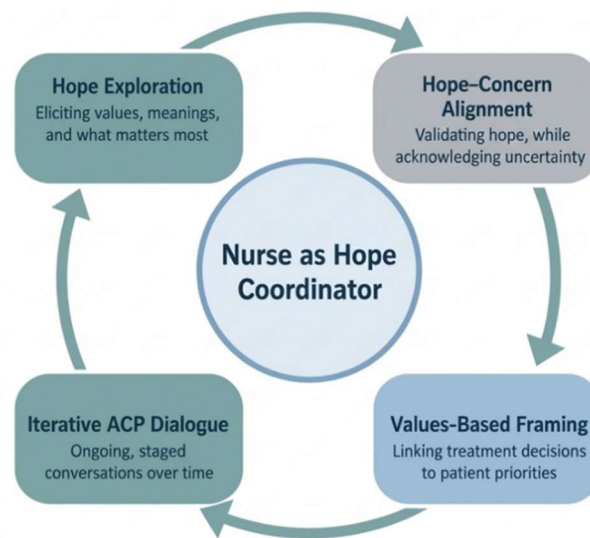


Figure 2. Structured communication strategies used by nurses to acknowledge hope while introducing advance care planning in oncology settings.

5. Nursing as hope coordinator: A conceptual model

Relational nursing theory emphasizes the active role patients play in making sense of their experiences, particularly in contexts of illness and suffering. Parse [32] articulates how this theory positions patients as dynamic participants whose interpretations of their situations evolve over time. In this framework, nursing presence is not merely about physical proximity, but also about enabling patients to articulate their hopes and aspirations without rushing them into premature conclusions about their care trajectory. By fostering an open environment, nurses can support patients in navigating the complexities of their evolving hopes within the uncertain landscape of serious illness. Narrative medicine complements this approach by highlighting the clinician's responsibility to engage with patients' stories, acknowledging their suffering, uncertainties, and aspirations [33]. The concept of narrative competence equips nurses with the skills to discern the deeper symbolic meanings and existential nuances of hope that often escape traditional biomedical discussions. This competence is crucial in palliative care settings, where understanding the holistic context of patients' experiences greatly enhances the quality of care.

Incorporating insights from palliative and person-centred care models, it is essential that advance care planning (ACP) is informed by the lived values of patients rather than solely by clinical milestones related to their diagnoses [24,34]. ACP can thus be seen as a continuation of hope-consistent care instead of its negation. Research by Kodba-Čeh et al. [22] supports the notion that engaging patients in discussions about their end-of-life preferences can foster a sense of hope, contrary to the misconception that such discussions primarily evoke fear and anxiety. Further investigations reveal that structured ACP processes do not adversely affect a patient's psychological well-being, reinforcing the idea that proactive planning enhances rather than diminishes hope during critical health transitions [35,36].

Building on these concepts, it becomes evident that nurses play a vital role as

“hope coordinators.” They facilitate ongoing dialogues that align patients’ evolving hopes with clinical realities and future care planning. Davison and Simpson [37] emphasize the challenges inherent in this process, noting the constant threat that unaddressed fears about the future pose to patients’ hope. By recognizing and addressing such fears, nurses can create a more conducive environment for hope to flourish. Ultimately, integrating these theories and practices into nursing not only validates patients’ identities as active meaning-makers but also reinforces the role of nurses in promoting holistic care that respects and responds to patients’ individual narratives and values. This collective understanding positions the nursing profession as a cornerstone in fostering hope within the ACP process and beyond.

6. Communication strategies for coordinating hope and realism

Evidence from serious illness communication research in **Table 3** demonstrates that parallel acknowledgment of hope and uncertainty preserves trust and emotional safety [38]. Patients respond more positively when clinicians validate hope while gently introducing contingency planning.

Table 3. Common ethical challenges encountered in hope-related advance care planning and corresponding nursing responses.

Strategy	Description	Supporting evidence	Clinical value
Hope exploration questions	Open questions to elicit what matters most	[14,15]	Broadens hope beyond cure
Hope and concern juxtaposition	Validating hope while introducing planning	[23,24]	Reduces resistance to ACP
Values based framing	Discussing care priorities instead of death	[10,39]	Enhances patient centeredness
Narrative listening	Eliciting illness stories	[32,33]	Builds relational trust
Iterative ACP conversations	Ongoing rather than one time discussion	[38,40]	Preserves hope continuity
Documentation of values	Recording patient values in care plans	[41]	Supports care consistency

Values-based communication tools are essential in advance care planning (ACP), as they prioritize the preferences and values of patients, rather than merely focusing on prognostic information. This patient-centred approach facilitates more meaningful and less distressing discussions regarding end-of-life care, which significantly enhances the overall ACP experience. Research by Epstein et al. emphasizes that using questions designed to elicit patient values is crucial for effective communication within outpatient oncology settings [10]. This methodological framework helps in fostering deeper connections, thereby reducing patient resistance to ACP discussions and promoting a sense of adaptive hope even in difficult medical contexts [42]. In oncology settings, evidence suggests that iterative, staged conversations yield better outcomes than single, comprehensive ACP discussions. These staged conversations, particularly when conducted by healthcare professionals who have established relational continuity with patients, are found to be less distressing for patients. For instance, Cohen et al. [20] highlight that palliative care interventions led by oncology nurses result in improved ACP uptake, affirming the role of structured communication in fostering patient engagement and compliance [4]. The staged approach allows for continuous reflection and adjustment

of care plans that align with evolving patient values, thus enhancing the quality of care provided.

Furthermore, effective documentation systems that capture not only treatment limitations but also patient values significantly contribute to continuity of care. The systematic review by Bush et al. [43] underscores the importance of integrating patient wishes and preferences into electronic health records (EHRs), which can facilitate ongoing communication across healthcare settings [43]. This integration ensures that the treatment provided aligns closely with the patient's expressed goals, thereby enhancing their experience and satisfaction with the care they receive [44]. By continuously updating care plans based on ongoing conversations, healthcare providers can uphold a more hopeful narrative for patients, even when facing end-of-life challenges [45]. Incorporating values-based communication tools within ACP is paramount for effective patient engagement, particularly in oncology contexts. By prioritizing patients' values through structured, iterative conversations and robust documentation systems, healthcare providers can ensure a collaborative approach that diminishes distress, supports adaptive hope, and aligns care with patients' ultimate wishes. This comprehensive strategy not only enhances the patient experience but also adheres to best practices in providing quality healthcare.

7. Readiness, activation, and ACP as a dynamic process

Observational studies of advance care planning (ACP) conversations reveal that readiness is not a uniform or static patient characteristic, but is rather topic-specific and fluctuating, as illustrated by research indicating that patients may engage readily with value-based discussions while often avoiding discussions on future deterioration scenarios [46,47]. This phenomenon emphasizes the need for clinicians, particularly nurses, to recognize and adapt to these variable readiness states as they navigate ACP discussions. Patient activation, which encompasses the knowledge, confidence, and skills to manage one's health, has a significant correlation with more profound engagement in ACP processes, particularly regarding contemplation and self-efficacy [48,49]. Research shows that higher levels of patient activation are associated with more meaningful engagement in ACP activities, such as not merely designating a surrogate decision-maker but also facilitating deeper conversations regarding preferred care outcomes [50,51]. The connection between patient activation and engagement highlights the potential for interventions that foster such activation to enhance the ACP process.

These findings align with a process-oriented model of ACP that posits nurses should not wait for an abstract state of "readiness" before initiating discussions but should instead modify the pacing and content of conversations based on emotional cues and expressed interests during discussions [40,52]. This flexible approach supports the maintaining of hope while gently guiding patients into future-oriented dialogues. Research supports that when clinicians address patients' emotional states and adjust the conversation dynamically, it encourages more profound engagement without overwhelming the patient with distressing topics [53,54]. Thus, the promotion of a tailored dialogue strategy stands out as an effective practice in enhancing ACP engagement. Engagement in advance care planning is influenced by

patient activation and the fluctuating nature of readiness that is topic-specific. By adhering to a flexible, process-oriented model, healthcare providers, especially nurses, can better facilitate these crucial discussions, ultimately leading to improved ACP engagement outcomes.

8. Evaluating success in hope-consistent advance care planning: Beyond documentation

Traditional evaluations of Advance Care Planning (ACP) have relied heavily on structural outcomes, such as the completion of advance directives or documentation of treatment preferences. However, evidence from communication science and psycho-oncology suggests that such metrics capture only a narrow fraction of ACP's intended impact. In the context of the hope paradox, success must be reframed to reflect whether communication processes preserve meaning, support emotional well-being, and align care with patient values over time [10,39].

8.1. Limitations of document-centric ACP metrics

Multiple studies demonstrate that ACP documentation alone shows inconsistent associations with patient-centred outcomes, including satisfaction, psychological well-being, and perceived quality of care. Communication research indicates that formal documentation may occur without shared understanding, trust, or emotional alignment between patients, families, and clinicians [39]. From a nursing perspective, reliance on document completion risks reinforcing the misconception that ACP represents closure or loss of hope. Ethical analyses further suggest that document-focused ACP may fail to capture the lived moral experience of patients and surrogates, particularly when decisions are made under emotional burden or uncertainty [55].

8.2. Communication pathways as indicators of ACP quality

Evidence from clinician–patient communication models highlight that communication exerts its therapeutic effect primarily through proximal and intermediate outcomes, rather than direct biomedical endpoints. These include patient trust, shared understanding, emotional regulation, perceived support, and self-efficacy [39]. Applying this framework to ACP evaluation suggests that high-quality, hope-consistent ACP should be assessed through indicators such as patient perception of being heard, concordance between expressed values and care decisions, and emotional safety during difficult conversations [10]. These indicators better reflect whether ACP conversations function as supportive nursing interventions rather than administrative tasks.

8.3. Patient-centered communication as an outcome in itself

Patient-centred communication has been increasingly recognized as both a means and an end in high-quality care. Epstein et al. [10] conceptualise patient-centred communication as encompassing understanding the patient as a person, responding to emotions, and achieving shared understanding elements that carry intrinsic ethical value independent of downstream clinical outcomes. In the context

of ACP, this implies that successful conversations may not immediately result in completed documents or finalized decisions. Instead, success may be reflected in patients' increased comfort discussing uncertainty, willingness to revisit values over time, and strengthened therapeutic relationships with nurses and care teams [39].

8.4. Measuring hope without undermining it

The measurement of hope presents methodological and ethical challenges. Instruments such as the Herth Hope Index conceptualise hope as a multidimensional and dynamic construct, rather than a fixed emotional state [14]. Empirical validation studies in oncology populations demonstrate that hope can coexist with accurate understanding of prognosis, contradicting assumptions that realistic discussions necessarily diminish hope [13]. From a psycho-oncology perspective, hope should therefore be evaluated longitudinally, with attention to how its focus shifts over time from cure-oriented goals toward relational, existential, or comfort-based hopes rather than assessed as present or absent at a single point [13].

8.5. Toward a nursing-sensitive evaluation framework

Integrating communication science and psycho-oncology perspectives supports the development of nursing-sensitive ACP evaluation frameworks. Such frameworks prioritize relational continuity, emotional safety, patient and family confidence, and alignment between expressed values and delivered care [10,39]. Ethical analyses further support this shift by emphasizing that the moral success of ACP lies not only in outcomes, but in whether the process respects persons, mitigates emotional burden, and supports meaningful participation in decision-making [55].

8.6. Implications for research and practice

Reframing ACP success requires a shift in both research design and clinical culture. Future studies should incorporate mixed-methods approaches that capture experiential, relational, and psychological dimensions of ACP alongside traditional metrics. For oncology nursing practice, success should be defined not by whether ACP conversations are completed, but by whether they sustain dignity, meaning, and adaptive hope throughout the cancer trajectory [13,14].

9. Implications for oncology nursing practice

9.1. Integrating the “hope paradox” across oncology nursing practice

The concept of hope within the context of oncology care represents a dynamic, multidimensional construct that evolves throughout the illness trajectory. Hope is not merely associated with the desire for a cure but can also encompass aspirations for symptom relief, relational continuity, dignity, and meaning [56]. Research suggests that hope can be transformed rather than extinguished when advance care planning (ACP) initiatives are framed to reflect patients' values and goals rather than merely focusing on treatment limitations or end-of-life decisions. When ACP conversations emphasize facilitating patient autonomy rather than dictating choices, they can enrich hope rather than diminish it, indicating that effective communication tailored

to the emotional and informational needs of patients is crucial [57].

This synthesis illuminates the potential for reframing ACP as a “hope-preserving” process compressed in **Figure 3**. Nurses play a pivotal role in aligning patient’s deeply held values with realistic clinical planning. By creating a supportive environment where hope and realistic expectations coexist, oncology nursing practice can develop strategies that incorporate ongoing relational communication, fostering a therapeutic alliance that evolves with the patient’s changing needs [58,59]. Such integration could transform oncology nursing into a practice that not only acknowledges the complexities of hope but serves as a constant source of support as patients navigate their journeys [60].

9.2. Implications for oncology nursing roles and professional identity

Existing literature underscores the critical role of oncology nurses in recognizing variations in patients’ expressions of hope, ambivalence, and distress throughout the care continuum. In contrast to infrequent physician encounters, oncology nurses maintain continuous relationships that enable them to engage in iterative conversations around difficult topics, including ACP [54,61]. These ongoing interactions allow nurses to normalize uncertainty and foster emotional safety, thus enabling patients to express their beliefs and preferences [60].

The vision of nurses as “hope coordinators” offers an innovative perspective on the professional identity of oncology nursing in the field of psycho-oncology. This role emphasizes the importance of skills such as empathic listening, narrative elicitation, and value clarification, which are essential during complex decision-making processes. Notably, nurses do not need to resolve the inherent uncertainties of prognosis; rather, they create a safe space for coexisting hope and fear, bolstering patients’ psychological resilience throughout their cancer experiences [62,63].

9.3. System-level and educational implications

Implementing hope-oriented ACP at the systems level necessitates foundational structural support, including enhanced documentation practices that prioritize capturing patients’ values and preferences over merely completing procedural forms [64]. For instance, electronic health records integrated with narrative fields could promote continuity and coherence across care settings, thereby mitigating the risk of fragmented communication among healthcare providers [65].

From an educational standpoint, oncology nursing training must evolve beyond a mere technical focus on ACP. It is essential to integrate curricula that specialize in emotional processing, managing moral distress, and improving communication during periods of uncertainty [66]. Innovative training methods, such as simulation-based learning and reflective practice, can prepare nurses to engage in ethically complex discussions surrounding hope, truth-telling, and anticipatory guidance tailored to individual patient situations [2,67].

The Hope Paradox Framework in Advance Care Planning Communication

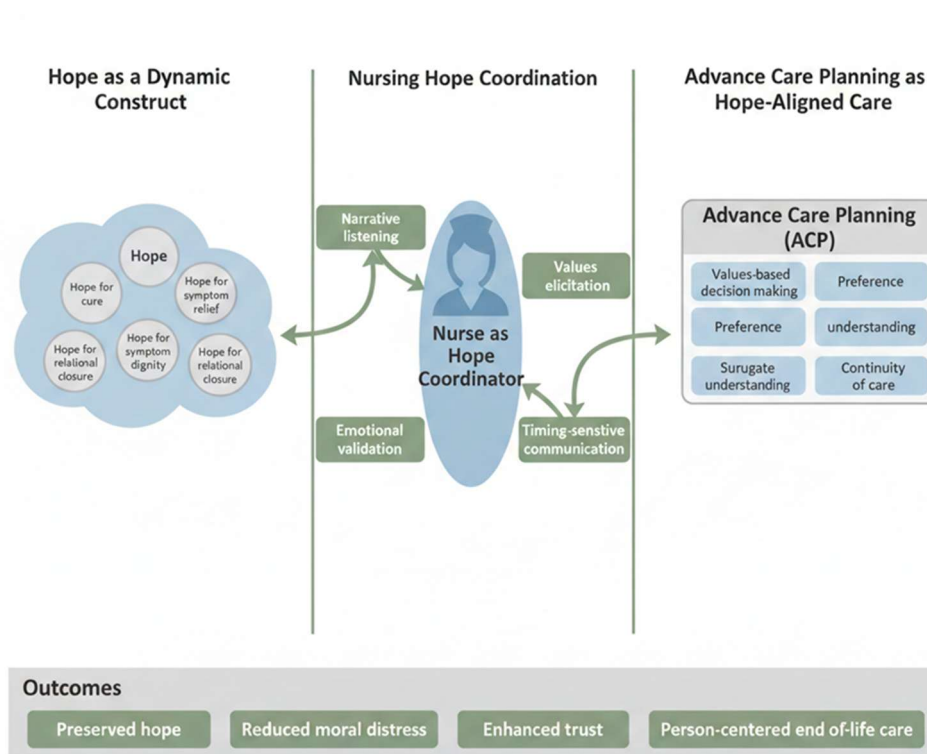


Figure 3. Conceptual framework illustrating how oncology nurses integrate patient-expressed hope with advance care planning through iterative, values-based communication, supporting goal-concordant care without diminishing hope.

9.4. Research gaps and future directions

Despite the rising acknowledgment of hope as a vital psychosocial resource in oncology, several research gaps persist. Current empirical studies tend to measure ACP success primarily through documentation rates rather than focal patient-centred outcomes, such as emotional alignment or perceived understanding [64,65]. Comprehensive future research should incorporate patient-reported and family-reported measures that address these dimensions of care and bearing upon the hope-ACP relationship. Additionally, an overwhelming number of studies concentrate on adult populations within Western healthcare systems. Comparative research across different cultural contexts is, therefore, essential in elucidating how varying cultural norms, family dynamics, and belief systems impact patients' expressions of hope and how this translates into ACP discussions [61,66]. Furthermore, longitudinal qualitative studies could deepen our understanding of how patients' narratives of hope evolve over time in response to nursing communication [56]. Integrating the concept of hope into oncology nursing practice enhances the therapeutic alliance between nurses and patients while facilitating meaningful ACP discussions. Through reimagining their roles, nurses can serve as vital navigators in the patient care experience, fostering not just procedural compliance but a holistic understanding of the cancer journey enriched by hope.

10. Conclusion

Advance care planning conversations in oncology nursing are frequently framed

as moments of loss, closure, or diminished hope. This review challenges that assumption by reframing advance care planning as a relational and communicative practice that can sustain, reshape, and even strengthen hope rather than extinguish it. Through the lens of the hope paradox, it becomes evident that patients and families do not experience hope as a single static construct but as a dynamic and evolving orientation toward meaning, comfort, dignity, and relational connection across the illness trajectory. By integrating perspectives from hope theory, ethical nursing practice, patient centred communication, and advance care planning scholarship, this review proposes that the central task of oncology nurses is not to resolve hope in favour of realism, but to coordinate multiple forms of hope alongside honest discussions of future care. When advance care planning is approached as an extension of hope centred nursing rather than its negation, conversations about preferences, values, and contingencies become opportunities for affirmation rather than confrontation. The hope coordination model articulated in this review positions nurses as relational mediators who actively listen, interpret, and align patient values with clinical realities over time. Such an approach emphasizes narrative engagement, emotional coordination, and iterative dialogue rather than one time documentation. It also highlights the ethical responsibility of nurses to protect patients from false dichotomies between hoping and preparing, optimism and acceptance, or treatment and planning. In reframing advance care planning as a process embedded within ongoing therapeutic relationships, this review underscores the need for systems and training that support nurses in complex communicative roles. While structural and educational challenges remain, the conceptual shift offered here provides a foundation for more humane, ethically grounded, and psychologically supportive oncology care. Ultimately, honouring hope within advance care planning is not about preserving unrealistic expectations, but about recognizing hope as a legitimate and adaptive human response to uncertainty. When nurses are equipped to engage hope with sensitivity and skill, advance care planning can become a space where patients feel understood, respected, and accompanied rather than diminished. This reframing invites a more compassionate integration of realism and hope at the heart of oncology nursing practice.

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