Faith and Protection: The Construction of Hope by Parents of Children with Leukemia and Their Oncologists

PETER SALMON,^a JONATHAN HILL,^c JOANNE WARD,^c KATJA GRAVENHORST,^b TIM EDEN,^d BRIDGET YOUNG^a

^aDivision of Clinical Psychology and ^bDivision of Primary Care, University of Liverpool, Liverpool, U.K.; ^cChild Psychiatry Research Group and ^dAcademic Unit of Paediatric and Adolescent Oncology, University of Manchester, Manchester, U.K.; ^eIntermediate Care, Wrexham County Borough Council, Wrexham, U.K.

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ABSTRACT

Background. Oncologists are criticized for fostering unrealistic hope in patients and families, but criticisms reflect a perspective that is oversimplified and “expert” guidance that is ambiguous or impractical. Our aim was to understand how pediatric oncologists manage parents’ hope in practice and to evaluate how they address parents’ needs.

Methods. Participants were 53 parents and 12 oncologists whom they consulted across six U.K. centers. We audio recorded consultations approximately 1–2, 6, and 12 months after diagnosis. Parents were interviewed after each consultation to elicit their perspectives on the consultation and clinical relationship. Transcripts of consultations and interviews were analyzed qualitatively.

Results. Parents needed hope in order to function effectively in the face of despair, and all wanted the oncologists to help them be hopeful. Most parents focused hope on the short

term. They therefore needed oncologists to be authoritative in taking responsibility for the child’s long-term survival while cushioning parents from information about longer-term uncertainties and being positive in providing information about short-term progress. A few parents who could not fully trust their oncologist were unable to hope.

Conclusion. Oncologists’ pivotal role in sustaining hope was one that parents gave them. Most parents’ “faith” in the oncologist allowed them to set aside, rather than deny, their fears about survival while investing their hopes in short-term milestones. Oncologists’ behavior generally matched parents’ needs, contradicting common criticisms of oncologists. Nevertheless, oncologists need to identify and address the difficulty that some parents have in fully trusting the oncologist and, consequently, being hopeful. *The Oncologist* 2012;17:398–404

INTRODUCTION

Hope is important to patients with life-threatening disease, such as cancer [1], and is advocated as an ethically important goal of cancer care [2–4]. Hope is usually formulated as a state of optimism, arising from appraisal of information about the future [1, 4–8]. According to this view, clinicians influence hope by the information that they provide or withhold about the future.

Nevertheless, hope remains conceptually and clinically problematic. The boundary between reasonable hope and inappropriate denial is confusing [9]. Similarly, the boundary between information that promotes hope and information that is falsely reassuring remains unclear. There is concern that, where information is inaccurate, partial, or

overoptimistic, hope becomes unrealistic to the extent of denial [8]. Clinicians commonly constrain or shape information in cancer consultations to sustain hope [10–14] and are criticized for avoiding explicit information to protect themselves [15–19].

There are two reasons why these criticisms of oncologists may oversimplify their task. First, patients do not passively receive information, but actively *construe* it; therefore, different patients hear the same information hopefully or hopelessly [9]. Secondly, clinicians give information within clinical relationships; the same information can feel hopeless or hopeful depending on the relationship [20]. Therefore, we need to understand information and hope by simultaneously examin-

Correspondence: Peter Salmon, M.Sc., D.Phil., Division of Clinical Psychology, University of Liverpool, Whelan Building, Brownlow Hill, Liverpool L69 3GB, United Kingdom. Telephone: 44-0-151-7945531; Fax: 44-0-151-7945537; email: psalmon@liv.ac.uk Received September 7, 2011; accepted for publication December 16, 2011; first published online in *The Oncologist Express* on February 27, 2012. ©AlphaMed Press 1083-7159/2012/\$20.00/0 <http://dx.doi.org/10.1634/theoncologist.2011-0308>

ing psychological processes in the patient and interpersonal processes in the clinical relationship.

In the present study, we examined hope in consultations between pediatric oncologists and parents of children with acute lymphoblastic leukemia (ALL), which accounts for one third of childhood cancers [21]. These consultations sharply focus the importance of hope; although long-term survival has improved dramatically from ~20% in 1970, 20%–25% of children still die as a result of the disease or complications [22]. Oncologists cannot guarantee saving the child's life, and cannot generally predict long-term survival confidently until 5–10 years after treatment [23]. Against this uncertain background, parents have to keep motivated to support children through treatment that is demanding in duration (typically 2 years), toxicity, and requirements on parents (e.g., administering cytotoxic drugs at home). Parents of children with cancer report that sensitive communication by clinicians can reconcile realism with hope [24, 25]. Therefore, we reasoned that a detailed study of such communication might teach us something about *how* they achieve this reconciliation. Our objective was to understand how pediatric oncologists manage parents' hope in routine consultations. We approached this objective interpersonally, by observing how hope arose in interactions with parents, and psychologically, by exploring parents' own perspectives.

PARTICIPANTS AND METHODS

Design

As part of a longitudinal qualitative study, the Relationships Between Parents and Practitioners Regarding Children with Leukaemia (RAPPORT) study, oncologists audio recorded their consultations with parents 1–2, 6, and 12 months after diagnosis (phases 1, 2, and 3, respectively), and parents were subsequently interviewed by a researcher.

Participants

After ethical approval (Ref. 06/MRE08/18), we sought consent to participation from parents of children aged 1–12 years being treated for ALL at specialist U.K. centers. We excluded families in which children had serious medical complications, where practitioners judged parents to be too distressed for informed consent, or where children were cared for by an oncologist who wished not to participate.

Procedure

A clinical practitioner sought parents' permission for a researcher to contact them about the study; the researcher then provided written information and sought written consent. The next consultation was digitally audio recorded by the oncologist, and the researcher interviewed parents as soon as possible after this. Interviews, also digitally audio recorded, were conducted by one of two researchers (J.W., K.G.), with each family being interviewed across phases by the same researcher. Interviews were conversational, using a topic guide. After asking parents about their family and employment context (or, for phases 2 and 3, about any changes since the previous interview), the interviewer prompted them to describe: their expectations and experience of the recorded consultation, their current and recent relationships with the oncologist

and other staff, and their own fears and hopes since diagnosis (or, for phases 2 and 3, since the previous interview). Recordings were transcribed and anonymized.

Analysis

Consultation and interview data were nested within "cases." Following a method described previously [26], we analyzed within cases (examining consultation and interviews together for each family in turn) and across cases (focusing separately on consultations and interviews across all families). We focused on phase 1 data, incorporating phase 2 and phase 3 data to test and develop the findings. The analysis was inductive, following a constant comparative approach, whereby we developed and refined broad analytic categories to describe the content of specific speech turns or exchanges and also the meaning or function of speech in the context of what was being said—or not said—across the consultation or interview as a whole (the final categories structure the Results, below). Several authors read each transcript, with other authors reading selected transcripts and all authors contributing to developing the analysis through regular discussion. Findings were periodically referred to the RAPPORT Steering Group, which included practitioners and parents. Procedural measures to ensure the quality of the analysis included respondent validation by discussing the emerging analysis with later participants and with participants at phase 3, attending to "outlier" cases [27] that deviated from the general pattern, and scrutinizing the analysis according to its catalytic validity—that is, potential to influence practice and research [28].

To evidence our interpretations, we present illustrative quotations and indicate the anonymized center (A–F) and mother (M), father (F), child (K), or consultant (C). Quotations are from phase 1 unless indicated otherwise. The ellipsis (. . .) signifies omitted speech. Square brackets mark explanatory text.

RESULTS

Sample

Nine specialist pediatric centers in different regions of the U.K. were formally approached to participate and six enrolled. Of the three remaining centers, two declined and one was not pursued because the target number of centers had been reached. Of 15 consultants at the study sites with overall responsibility for patients with ALL, 12 audio recorded consultations (one declined to participate; the other two did not identify suitable patients). Three nonconsultant grade oncologists also audio recorded consultations. Of 71 families admitted to the study sites when the RAPPORT study was open during phase 1, we approached all those who were eligible ($n = 53$), of whom four subsequently withdrew. From the 35 remaining families, 53 parents (31 mothers, 22 fathers) participated. According to the Townsend Deprivation Index [29], the sample was socioeconomically diverse, with eight families from the most deprived fifth of areas in the U.K. and ten from the most affluent fifth. However, all families except one were white British. Children were aged 1–12 years (median, 4 years) at diagnosis. Table 1 provides details of the consultations and interviews.

Table 1. Details of data collected at each phase

Data	Phase 1	Phase 2	Phase 3
Median (range) weeks consultation recorded after diagnosis	6 (2–13)	27 (20–38)	56 (47–69)
Median (range) duration of consultation recording in minutes	23 (6–70)	16 (4–31)	11 (4–31)
<i>n</i> of families with consultation recording missing	3	2	0
Median (range) weeks interview conducted after recorded consultation	2 (0–11)	2 (1–18)	3 (1–42)
Median (range) duration of interview recording in minutes	98 (28–180)	98 (34–233)	87 (23–184)
<i>n</i> of parent interviews missing	2	2	4
<i>n</i> of parents interviewed at home ^a	43	44	42
<i>n</i> of couples interviewed jointly ^b	2	3	3

^aOther parents were interviewed at hospital, their workplace, or the university.

^bOther parents were interviewed separately.

Summary of Analysis

Consultations contained little emotional talk and virtually no references to hope, and were characterized by short-term and procedural discussions with a strong emphasis from oncologists on what was going well and the immediate clinical management. In interviews, in contrast, parents described intense emotions, the central importance of hope, and the oncologist's critical role in maintaining hope. In presenting our analysis of hope below, we draw on these interview accounts to show why the absence of explicit emotion from consultations and the absence of references to the long-term future were critical in enabling parents to hope. Parents generally limited questioning in consultations to clarification of treatment plans, and only three expressed doubt—in interviews or consultations—in what oncologists told them, and we consider these as “outlier” cases.

Despair

Every parent described the despair associated with fearing that the child might die. Despair encompassed not just emotional distress but also feeling vulnerable and unable to think and act effectively: “you’re absolutely laid open . . . I wondered whether I’d be able to carry on” (A/F5). Even during phase 3, parents’ worst fears remained close to the surface, often erupting spontaneously or when triggered by consultations, tests, or hospital readmission. Parents described struggling continually against these fears, indicated by frequent references to needing to “keep positive.” Invariably, parents linked being positive to being able to act and think effectively in the face of despair. As C/M5 explained: “That’s one of the biggest things, we’ve got to keep positive, although when you’re actually heartbroken, you think the worst . . . You have no choice . . . because if you don’t [cope], you know, what happens to the rest of your family . . . You’ve got to try and keep positive but it’s not really easy . . . because you feel as if you’re in a black hole.”

The Interpersonal Basis of Hope: Faith in the Oncologist

Most parents linked their ability to hope to “having faith in” the oncologist. None described evaluating the oncologist, or deciding whether or how much to trust him or her. Instead, they

said “I just trust him” (D/M7) or “you have to sort of really sort of put your faith into them and just trust” (B/M7). Therefore trust was usually present from first meeting the oncologist (Box 1).

Parents consistently valued oncologists’ explicit positivity (Box 1). When asked how he would advise doctors, one father urged them to “offer crumbs of hope” (A/F5). When, during phase 3 interviews, we sought parents’ views on the positive and often light-hearted tone of most consultations, they invariably approved. When asked whether he would value discussion of longer-term survival, D/F1 explained: “It’s in your mind anyway . . . you don’t need to talk about that . . . you never forget about that . . . every waking minute, it’s there at the back of your mind,” adding “What you want to hear is how she’s doing . . . the stage she’s at in the treatment.” Because of their need for positivity, parents’ information needs were complex (Box 2). They needed oncologists to bias their presentation of information positively, but they also needed to be able to believe that oncologists were truthful.

The Psychological Basis of Hope: Focusing on the Short Term

Parents’ hope invariably entailed a shortened perspective on the future. Instead of hoping for cure, they took comfort from evidence that the illness was not as bad as it might be, and milestones associated with treatment came to define parents’ perspective, so they typically described taking life “day by day” or “a week or a fortnight at a time” (Box 3). D/F9 explained that “I can’t sit there like in a prison cell . . . marking the lines off on the wall and it’s another week gone. It’s not like that, it’s just wherever we are in the treatment . . . ‘Does it look it’s going to be OK?’” Parents struggled to keep this perspective and it could take time to learn (Box 3).

This short-term focus was not simply denial of the children’s vulnerability. Parents consistently described their awareness of serious long-term threats, from treatment failure to problems of survivorship, before explaining their decision to set these fears aside in favor of a short-term focus. For example, D/F3 feared that his child might be one of the 20% whom he had been told are not cured, but he explained “you could worry yourself to death about him not being cured . . . I can’t

Box 1. The interpersonal basis of hope

The parents of D/K3 illustrated how trust, which was an immediate reaction to meeting the oncologist, underpinned their hope:

[Describing first meeting the oncologist]: "I thought he was incredibly calm, incredibly calm, incredibly sincere and honest and incredibly reassuring. and really left you with a, I won't say 'feel good' factor but you really did come up, like the weight, whatever weight was on your shoulders . . . had somehow just been lifted off it . . . and you felt actually, you know, I think this could be alright" (D/F3).

"[The oncologist] is the answer to everything. He is the person I have all my hope in and trust in . . . I don't expect from him miracles . . . but I know that man is completely in control of K3's cancer and knows what to do with it and . . . has much experience in it and will do everything necessary . . . so that's what I expect from [the oncologist] and hope and know I'll get" (D/M3).

Parents explicitly sought oncologists' positivity, as A/F7 explained:

"I always find it quite comfortable talking to [the oncologist]. Even if it is a bit of bad news . . . she'll bring the positives out of it as well . . . I mean, don't lie, but there's ways of putting things I think. If you're saying something, always back it up with something that can be positive 'Well this might not be the case because you know it might improve.'"

Being positive was crucial at crises, such as when a child did not respond to treatment, as C/M3 described:

"I did have a few tears in there with [the oncologist] . . . having said that, he was still very positive and very calm and still said, you know, 'Our ultimate aim is to cure every child, and some children do start slowly and catch up, maybe not every time.' So he still made us feel calm and confident and positive."

Parents' need for optimism belied apparently simple statements that they "wanted information." For example, D/F1 "wanted facts" but, elsewhere in his interview, was clear that he needed his doctors to emphasize positive messages.

You want the facts because the facts tell you where she's at . . . I want specifics, I want to know the details. I don't just want a broad 'Oh yeah, everything's fine,' you know. Well, what's fine? . . . What's right?"

There was a couple of times . . . where I wish he'd been a bit more enthusiastic about how she was progressing . . . but the last couple I've been to . . . he really was enthusiastic 'Yes, she's doing great, absolutely brilliant' . . . he started using words like 'Yes, she's doing brilliantly' and you, it obviously makes you feel better then."

Box 2. The paradox in parents' information needs

Parents' wish for information depended on whether it would be positive or negative.

"Especially at the beginning sometimes you might not want to know the answer in a way . . . You don't really want to ask because you don't want the answer but then when the answer was good" (A/F7).

Parents therefore relied on oncologists to gauge what information to give. This included explicitly restricting information, particularly soon after diagnosis. For many, the doctor's avoidance of statistics was crucial:

"We left that room [doctor's office] feeling a lot better. We were given real, without it being false optimism . . . we were given positive optimism. He said 'I'm not going to give you any statistics' . . . he said 'But I will tell you it's a very positive outcome . . . in the majority of cases' . . . and he said 'but it's going to be incredibly hard for you' . . . without saying, 'Hey I'm going to guarantee your son's here in three years time' . . . I wouldn't expect that. We know no matter how much our optimism or positive attitude, you just don't know" (D/M3).

A/F7 and A/M7 were unusual in criticizing an oncologist for describing results in a way that prevented them from being hopeful:

"You'd never want them to tell you lies but . . . I wouldn't have said 'grave concern' to start with. She could have said 'Right, obviously we're still concerned why his counts haven't come up but it could be for these reasons and hopefully you know all being well he'll pick up in the next week or so.' I mean you'd have been fine with that wouldn't you . . . You're worried anyway so . . . you need people to talk to you the right way I think" (A/F7).

"Certain words like that, 'grave concern,' will probably stick with me for the rest of my life . . . Some things you need to know and some things maybe I didn't need to know at that time, or not put in that way, and maybe a different way of putting it might have made me think 'Yes, there is still a worry,' but not to the extent that we [emphasized] had to worry, kind of thing" (A/M7).

The paradox was therefore that, while parents needed doctors to be asymmetric in providing information by emphasizing positive messages, they needed to believe that they were told the unbiased truth. One father stated this explicitly:

"I remember picking up on the positives, you know. She's a girl, her age . . . white blood count, blood cell count, wasn't massively high, so you know you pick up on the positives because you're looking for it, you know. I think at the same time the other side of you wants to know whether what you've been told is the truth" (A/F9).

go around worrying myself about it . . . we'll do it in little bits." D/F4 described fears of relapse, focused by seeing children who had been readmitted to the hospital following relapse, but explained "I'll worry about that . . . when we've finished all the treatment but at the minute, we're just dealing with now." Indeed, D/M7 explicitly distinguished her short-term focus from denial after recounting during phase 3 why she stopped reading

a book that detailed the risk for relapse: "I don't think it's a case of hiding your head in the sand, it's just a case of why worry about 'if that might,' you know, worry about that when it happens." Moreover, while short-term focus protected parents from the despair associated with fears that the child would die, it left them liable to feel devastated by objectively less serious adversities, including the child being unwell or unhappy, as well as by receiving adverse results.

Box 3. The psychological basis of hope

A/F9 illustrated how parents adjusted what they hoped for:

[Describing what he sought from medical care before his daughter's diagnosis]: "You would see that as just winning being healthy and losing being ill. Then you go in and you're told that your little girl's got something wrong, not just something wrong but something well serious, you know. So you . . . throw away that winning or losing and . . . you say 'Well, OK, what kind of ALL is it? Oh well it's the most common sort of type . . . that's good, it's the most common sort of type.' And so you're looking at your new reality, you're looking at what winning and losing is there . . . And all of a sudden you're feeling bloody good about where you are . . . you sit there and at each milestone . . . you're going 'Well what is it we're looking for from them, we want to get out of this?'"

The shortening perspective required parents' effort. C/M5 feared long-term treatment side effects, and described actively avoiding information about these:

"I do worry about the future and you know the damage as such that may well be done to, you know, her organs that we can't see, the long term implications of that and obviously you do worry about the future . . . but, you know, then I think 'Oh for goodness sake,' you know 'Just try and take day by day' and that's all you can do."

Therefore, the shortening perspective could take time to learn, as D/M7 described when reflecting back at phase 3:

"I think those first few weeks you, you want to know, I mean, most people want, want to know the worst . . . Then you . . . learn to sort of steady your pace a little bit, you know, but it's like anything . . . you sort of have to pace yourself."

Outlier Cases

Because of the emerging importance of parents' trust of the oncologist, we searched for cases in which interviews or consultations during phase 1 indicated doubt about oncologists' actions or advice. We found four. In one, a mother who lacked confidence in formal medicine and wanted to give her child nonconventional treatment complained to the interviewer about the oncologist's disapproval and never developed hope or trust in the oncologist. For the others, three fathers questioned or challenged the doctor. During an interview, they attributed this critical stance to their experience with previous bereavements from cancer and, in two cases, their occupations (health professional and scientist). In each case, interview evidence linked these parents' doubts about the oncologist to their difficulty in sustaining hope. Moreover, the close linkage of both trust and hope with the short-term future orientation was seen in the way that each father's developing trust and hope from phase 1 to phase 3 depended on becoming able to suspend doubts about the long term (Box 4).

DISCUSSION

Whereas hope is usually thought to be a psychological state of optimism about the future [1, 4–8], for parents in this study it had a short time frame and was inherently interpersonal, being built on faith in oncologists. Whereas oncologists are often

Box 4. Outlier case: the gradual evolution of a father's faith in the oncologist

A/F6 described cynicism about the future that he dated to losing two close family members as a young man. His trust during phase 1 was challenged specifically by learning from C3 that the minimal residual disease (MRD) test that C2 had previously implied indicated low risk was, in fact, inconclusive. Although C2 joined the phase 1 consultation with C3, neither clarified this mistake nor apologized for it. In this extract, F6 explicitly challenges C3.

F6: If the test has failed you won't know if he's low, medium, or high?

C3: No, you're quite right actually

. . .

F6: So you might be treating him for a low to medium risk when he could be high

. . .

F6: Couldn't they have said "This test failed, can you come back in, we can re-do it" or that's not possible?

C3: [explains why the test failed]

F6: I've just looked at the date [of meeting C2] there though . . . We've seen C2 at that time and he hasn't mentioned this.

In the phase 1 interview, F6 referred to hope only once and this was linked not to doctors but to learning about people who had survived leukemia. He described the news of the MRD test as a "kick in the teeth" three times, complained that "they are keeping things back" and "there are mistakes being made" and criticized aspects of the oncologist's manner.

During the phase 2 interview, he described still being "really, really depressed." He made no reference to hope, and risk of treatment failure was prominent. His mistrust focused on inexperience of a junior doctor ("She doesn't have a clue") and his disagreement with the oncologists' advice to tell his child that treatment success is not guaranteed. At this time, he began to describe a need for oncologists to give him good news, although this contrasted with his continued inability to trust such news.

"It's not so much that I'd like to know if it was a high risk of it coming back, just I'd like to know if it was low risk of it coming back. Because it puts your mind at ease . . . You just think, if he gets through this, will it come back again. So it would just be nice to know if it was low risk. It would just settle you a bit."

"You just don't believe people at first. You think people are just trying to make you feel better and they're lying . . . I don't think you trust anyone."

During phase 3, he referred to hope seven times, explicitly linking hope to doctors' positivity and short-term focus:

"The reassurance you get. He's got a cough, you go in there and they go . . . 'Yeah, it's fine.' And because you respect them as a doctor that's your reassurance. They don't go 'He's going [emphasized] to be fine' . . . But you feel better. When you're there 'He's doing really well. He's doing great. His blood level's fantastic.' Reassurance that way, but they won't give you any outcome, which is what you want really, but they give you reassurance in the fact that he's doing well."

criticized for promoting unrealistic hope by restricting the information they give, parents' ability to continue to act effectively in the face of despair depended on oncologists cushioning them from longer-term uncertainties.

Psychologically, the defining feature of parents' hope was its short-term focus. Most parents described a time frame constrained by events associated with treatment, typically the next consultation or the next results; avoiding information about the longer term was critical. Hope is, therefore, an ambiguous term; hope meant *not* hoping for, or thinking about, the long-term outcomes that mattered most. Our analysis demarcates hope from denial. Parents were not denying reality; hope was a process of engagement with their child's cancer that was life affirming rather than death denying [30, 31].

Hope was also interpersonal in that parents could not achieve hope alone. Trusting oncologists with the child's care allowed parents to relinquish concern with the longer term, and being able to rely on oncologists not to introduce uncertainties about the longer term allowed parents to focus hope on the short term. Similarly, Mack et al. [32] reported that parents of children with cancer found peace of mind when they trusted the oncologist and Back et al. [33] described how patients faced with the news of recurrence were able to find comfort in focusing on the present when oncologists showed that they had a plan of action for the future. Parents needed more from oncologists, however. Although not wanting them to lie, parents wanted them to manage information in order to foster hope. This presented a dilemma. Parents needed to believe oncologists' positivity and to trust them to be truthful, despite knowing that they wanted oncologists to bias the truth. This dilemma cannot be solved rationally; to solve it, parents had to suspend criticism and doubt in oncologists. Parents spoke of "faith" to describe this process. Faith in the oncologist, combined with the short-term focus, allowed parents to avoid the dilemma of wanting to be given positive news and to believe it.

Study of the evolution of hope in the few parents who initially doubted oncologists confirmed that a lack of faith left parents vulnerable to despair. The delay in these parents' achieving hope exposed how becoming able to hope depended on parents becoming able to suspend doubt in oncologists and to commit to faith in their short-term reassurance—a process that occurred at the first meeting for most parents. Hope as faith has properties of attachment relationships. Under conditions of threat, people are inclined to invest their hope for evading danger in entities that they perceive as offering safety, and they preserve this investment by suspending appraisal or judgment that would threaten that sense of safety [20, 34, 35]. To draw on the psychoanalytic concept of "projective identification," parents projected their hopes and fears for the future onto oncologists, leaving themselves better able to cope day to day, and oncologists identified with this projection in that they took responsibility for those hopes and fears [9]. That is, hope was not driven by oncologists; oncologists had a crucial role, but this was because parents gave it to them.

Previous research has indicated that oncologists' sensi-

tive communication can reconcile realism with hope [24]. By observing oncologists in routine practice, we showed ways in which they achieve this. However, the crucial feature of our method is that we did not evaluate oncologists' communication just by observing consultations but also by interviewing parents. What parents told us exposed how what was said, and not said, in consultations influenced hope. Nevertheless, we must be cautious about the generalizability of our qualitative findings. We did sample 30% of all U.K. specialist pediatric oncology centers serving sociodemographically diverse populations, and consistency in parents' accounts suggests that we identified common features of parent–oncologist relationships. Moreover, we recruited 80% of eligible consultants and 66% of eligible families. Interviews with oncologists suggested that, although they necessarily had access to the study protocol, they displayed well-rehearsed consultation styles and did not vary practice for this study [36], although the possibility of this cannot be excluded. We did not record the first diagnostic consultation, during which longer-term outcomes are discussed as a prelude to therapy. This consultation usually occurs within hours of diagnosis and it was considered unethical to invite participation at that time. Therefore, our findings refer to how hope is sustained once those prognostic discussions have occurred. Also, all children were treated curatively and our findings say nothing about hope after failure of first-line treatment or with poorer prognosis cancers. Our study's relevance to adult patients is not clear. Salander et al. [9] observed that carers lacked access to some coping strategies available to sufferers and, partly in consequence, parents might need to invest more in the relationship with practitioners than would patients themselves. Nevertheless, the need for confidence and faith in doctors is a strong feature of adult cancer care [13].

CONCLUSION

Our findings can inform education. Oncologists face the challenge of balancing honesty and hope, and many find this difficult [37]. For most parents, the clinical relationship relies on certain information not being sought or given. Therefore, if communication education is to be relevant to practice, it needs to address how oncologists can constrain information, not just give it [38]. Our findings inform clinical practice by clarifying the role that parents give pediatric oncologists and by identifying why problems might arise. Whereas oncologists were working clinically toward long-term goals, their consultations were normally successfully aligned with parents' short-term perspective. Problems arose when parents were unable to relinquish responsibility for the longer term. To be able to provide what each parent needs, oncologists need to be able to identify and address the possible divergence between their approach and parents' needs explicitly with such parents.

For researchers, the *opportunity* in our data is to learn from oncologists and parents how dilemmas in cancer care might be addressed when, as with the literature on hope and information, basic principles are ambiguous or contradic-

tory in practice [39]. The *challenge* is to understand how oncologists can sustain hope in parents who feel unable to invest faith in them.

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AUTHOR CONTRIBUTIONS

Conception/Design: Peter Salmon, Jonathan Hill, Timothy Eden, Bridget Young

Financial support: Peter Salmon, Jonathan Hill, Timothy Eden, Bridget Young

Collection and/or assembly of data: Joanne Ward, Katja Gravenhorst

Data analysis and interpretation: Peter Salmon, Jonathan Hill, Joanne Ward, Katja Gravenhorst, Timothy Eden, Bridget Young

Manuscript writing: Peter Salmon, Jonathan Hill, Joanne Ward, Katja Gravenhorst, Timothy Eden, Bridget Young

Final approval of manuscript: Peter Salmon, Jonathan Hill, Joanne Ward, Timothy Eden, Bridget Young

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