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Review

Hope in the Context of Severe Illness: Integrating Medical, Psychological, Philosophical, and Spiritual Perspectives

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Abstract

Hope is important in severe illness, but its clinical implications vary. This narrative review examines how medical, psychological, philosophical and spiritual perspectives inform ethical, patient-centred care. PubMed and Europe PMC searches, philosophical bibliographies and citation tracing identified literature from January 2000 to October 2026, retaining older foundational works. Quantitative, qualitative, interventional and conceptual evidence were considered separately; no pooled analysis or comprehensive systematic risk-of-bias assessment was undertaken. Hope encompasses goal-directed agency and pathways, emotional orientation, relationships and existential possibilities. Observational studies associate hope with psychological adjustment; however, confounding, reverse causation and construct overlap limit causal inference. Intervention findings vary across hope, hopelessness, meaning, distress and quality of life. Hope has not been shown independently to prolong survival or alter disease progression. Prognostic realism can coexist with hope; however, awareness may carry emotional costs, and hope may accompany inaccurate expectations. Spiritual resources can support some patients, whereas religious struggle requires attention; meaningful hope does not require religious belief. Philosophical perspectives illuminate hope when cure is unavailable without establishing therapeutic efficacy. An evidence-informed, unvalidated framework distinguishes patients' hopes, medical expectations and care decisions, supported by symptom management, communication and individually chosen resources, while protecting autonomy and avoiding imposed optimism or religion.

Keywords: hope; severe illness; health psychology; spirituality; existential meaning; palliative care; patient-centred care; religious coping

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Academic Editor: Carlos Laranjeira

Received: 21 October 2026
Revised: 18 November 2026
Accepted: 21 November 2026
Published: 24 November 2026

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1. Introduction

Severe illness disrupts more than biological functioning. Breathlessness, pain, fatigue, dependence and uncertain prognosis may undermine a person's capacity to work, maintain

relationships or recognise a familiar future. Decisions about further treatment can become inseparable from fears about abandonment, identity, family responsibilities and death. Here, severe illness denotes substantial symptom burden or functional impairment, serious prognostic uncertainty, life-threatening complications or a realistic possibility of death. The related concept of serious illness includes conditions carrying high mortality risk that impair daily function or quality of life, or excessively strain caregivers. Neither term makes every chronic condition severe. Life-threatening illness indicates potential mortality, whereas terminal illness implies an advanced, life-limiting prognosis; palliative care addresses suffering and can accompany disease-directed treatment well before the terminal phase [1].

Hope enters these encounters in several forms. A patient may hope that treatment controls disease, that tomorrow brings less pain, that an important relationship can be repaired, or that family members will be supported after death. These hopes differ in their objects, perceived probabilities and time horizons. Acknowledging their diversity helps explain why people can remain hopeful while recognising that cure is unavailable. It also exposes an ambiguity: supporting hope may mean improving coping, sustaining relationships, encouraging action or preserving a belief about treatment success. Those activities have different evidential and ethical requirements [2].

Biomedical assessment remains indispensable for recognising reversible deterioration, treating symptoms and explaining realistic options. However, physiological measurements do not establish what makes a particular outcome worth pursuing. Psychological models describe motivation and adjustment; philosophical approaches examine possibility, vulnerability and meaning; spiritual perspectives address sources of significance and connection, including religious commitments where patients endorse them. These perspectives can enrich clinical understanding, but neither conceptual coherence nor personal conviction proves a medical benefit. Discussions of neurobiological possibilities and therapeutic applications therefore require separation from evidence that hope changes clinical endpoints [3].

Substantial overlapping scholarship already exists, including reviews of spiritual care and hope-focused interventions [4,5]. Cherny et al. conceptualise adaptive hope as a dynamic process involving recalibration of goals, prognostic honesty and interdisciplinary support [6], whereas Ricci et al. emphasise hope as moral accompaniment in palliative care [7]. Accordingly, the present review does not claim that an interdisciplinary account of hope, or the coexistence of hope and realism, is new. Its specific conceptual contribution is to distinguish three clinically related but non-equivalent domains: (i) what a patient hopes for, (ii) what the patient understands about medical probabilities, treatment intent and achievable outcomes, and (iii) which care option the patient chooses in light of personal priorities. Considering each domain through medical, psychological, philosophical and spiritual perspectives provides a proposed cross-check for locating apparent tensions, rather than treating a hopeful statement as evidence of prognostic misunderstanding or a treatment choice as a direct expression of hope. This analytical framework is intended to clarify clinical reasoning; it has not been validated as an assessment instrument or intervention.

The central question is how medical, psychological, philosophical and spiritual perspectives can inform ethically responsible, patient-centred care in severe illness. We evaluate favourable and conflicting evidence regarding adjustment, prognostic understanding, decision-making and spiritual experience. The review focuses primarily on adults able to communicate their experiences; family perspectives are considered without assuming that they represent patients, especially in intensive care or advanced neurological disease.

This review is guided by the conceptual proposition that hope in the context of severe illness is a multidimensional construct shaped by cognitive, emotional, existential, relational, and spiritual processes, which may contribute to psychological adjustment. Its clinical relevance may depend on the adaptive nature of hope, the realism of patients'

expectations, and their individual clinical and personal circumstances. This proposition is examined critically through the integration of empirical evidence and interdisciplinary conceptual perspectives.

2. Methods

This is a narrative review using a structured, iterative search and purposive evidence selection. The preparation drew on the substantive domains of the Scale for the Assessment of Narrative Review Articles (SANRA): importance, aims, search description, referencing, scientific reasoning and presentation of relevant endpoints. SANRA guided preparation; no independent SANRA score was assigned, and its use did not substitute for systematic-review methods [8].

2.1. Information Sources and Search Strategy

Searches were conducted on 1 October 2026. Nine PubMed queries were executed through the National Center for Biotechnology Information ESearch interface, with records verified using PubMed Extensible Markup Language (XML) and Europe PubMed Central (Europe PMC). Europe PMC searches complemented retrieval, including recent literature and targeted title, identifier and DOI searches. The principal publication window was 1 January 2000–1 October 2026. Older measurement studies and seminal conceptual works were retrieved without a date restriction. Recent relevant studies were prioritised without excluding foundational or contradictory evidence. Exact strategies, retrieval boundaries, source roles and access limitations are documented in Table S4.

Boolean combinations joined hope, hopelessness or hopefulness with cancer, heart failure, kidney failure, dialysis, neurological disease, intensive care, palliative care or serious illness, and with psychological outcomes, coping, spirituality, prognosis or interventions. PubMed queries combined Medical Subject Headings where relevant with title/abstract terms. Broad queries requested up to 100 records each, using the relevance setting; these bounded sets were supplemented by targeted and recent searches and citation tracing. No language restriction was imposed at electronic retrieval; selection prioritised material assessable in English. The search was extensive across the review's themes but did not exhaustively screen every database result.

Targeted update searches, also completed on 1 October 2026, reassessed contextual coverage using five additional PubMed queries restricted to 2017–2026. Each requested up to 60 relevance-ranked records without a language filter; targeted title, PubMed Identifier (PMID) and Digital Object Identifier (DOI) retrieval, complementary web discovery and citation tracing supplemented these bounded sets. Recent sources were selected for equivalent or stronger support of the relevant claim, with wording revised when their questions differed. Original measurement studies, seminal philosophical works and pivotal primary clinical evidence were retained. Table S4 preserves the initial searches and separately records these update searches and access limits.

Philosophical discovery used the public PhilPapers hope bibliography, domain-restricted web searches, the Stanford Encyclopedia of Philosophy, publisher records and available primary-text excerpts. These searches addressed hope, suffering, mortality, Marcel, Bloch, Frankl and autonomy rather than imposing exclusively biomedical terminology. The review did not include searches of Embase, Scopus, Web of Science, PsycINFO, Atla Religion Database or JSTOR, which may have limited the coverage of relevant literature, particularly in psychology, spirituality and philosophy.

2.2. Study Selection, Operational Definition, Verification and Extraction

Study selection was purposive and aimed to ensure conceptual relevance, clinical applicability, methodological transparency and diversity of findings rather than statistical representativeness. Priority was given to primary clinical studies, intervention trials, qualitative patient research, relevant syntheses and established conceptual scholarship. Studies were considered informative when they addressed clearly defined constructs, described relevant clinical populations, reported interpretable methods and outcomes, or contributed distinct, negative or conflicting findings. When several publications addressed similar questions, preference was given to those providing clearer methodological reporting, stronger clinical relevance or complementary perspectives. Decisions regarding the inclusion of studies in the narrative synthesis were made by the first author, based on the selection criteria described above. No independent duplicate screening was performed.

For this review, severe illness was operationally defined by documented advanced, life-threatening or incurable disease, substantial disease-related symptom burden or functional impairment, or critical-care or palliative-care contexts involving serious clinical deterioration. Diagnostic labels alone were not considered sufficient evidence of severity. Studies in which disease severity could not be established were used only as contextual evidence, with their indirect applicability explicitly acknowledged. Foundational measurement studies and conceptual works outside severe-illness populations were retained when necessary to define relevant constructs. Duplicate publications, unidentifiable references and non-scholarly commentary were excluded or deprioritised, while negative and inconsistent findings were retained.

An internal matrix recorded design, population, sample, setting, construct or instrument, outcomes, reported estimates, adjustment, limitations, applicability and source access. Quantitative, qualitative, interventional and conceptual evidence were distinguished. Bibliographic identities were checked against PubMed/Europe PMC, with Crossref and official publishers used where available. Accessible full-text methods, results and limitations were examined for pivotal studies. Where only abstracts were assessable, numerical and methodological claims were restricted accordingly; abstract access was not labelled full-text verification. Tables S1 and S2 identify representative evidence and access qualifications.

2.3. Synthesis and Reporting Boundaries

Evidence was synthesised through comparison of definitions, populations, endpoints, conflicting findings and clinical implications. Where information permitted, trials were examined for allocation, comparators, endpoint hierarchy and missing data; observational studies for temporality and confounding; and qualitative research for sampling, context and transferability. Philosophical and theological scholarship was assessed for argumentative coherence and clinical relevance, without assigning experimental status. No pooled estimate, registered systematic-review protocol, exhaustive systematic risk-of-bias assessment, independent duplicate screening or formal certainty grading was performed. These are design-informed narrative appraisals, with selection and interpretative limits.

3. Conceptual Foundations of Hope

Hope is operationalised differently across disciplines: a questionnaire score, a prediction of treatment success and a sense of future possibility are not interchangeable. These distinctions frame the clinical evidence and intervention findings.

3.1. Definitions and Multidimensional Characteristics of Hope

Dufault and Martocchio distinguished generalised and particularised hope and described affective, cognitive, behavioural, affiliative, temporal and contextual dimensions.

Their account arose from clinical observation and interviews, providing an interpretative framework whose mechanisms have not been universally demonstrated. Generalised hope can orient a person towards a worthwhile future without specifying one outcome; particularised hope concerns something more identifiable, such as leaving hospital or attending a family event. These forms can coexist, change or become difficult to articulate as illness advances [9].

Clinical instruments operationalise only parts of this experience. The Herth Hope Index (HHI) describes temporality and future, positive readiness and expectancy, and interconnectedness. Such dimensions connect individual orientation to relationships and immediate circumstances. In a synthesis of 24 patient-perspective studies in palliative care, Velić and colleagues identified beliefs about hope, its functions and the work involved in sustaining it, with relationships central to patients' accounts. These findings help explain why hope can remain important near death without implying that every patient experiences it or should be encouraged to express it [10,11].

3.2. Hope, Optimism, Resilience, and Coping

Dispositional optimism concerns relatively stable favourable expectations across important life domains. Hope in Snyder's model concerns agency and routes towards valued goals; a person can generate feasible plans while remaining uncertain about success. Optimism is therefore not simply a higher level of hope. Resilience concerns patterns of adaptation following adversity, assessed through functioning over time rather than a single positive belief. Self-efficacy concerns perceived capability to perform actions and can support agency without encompassing all the relational or existential meanings attributed to hope [12–15].

Coping comprises cognitive and behavioural responses to demands. Hope may sustain attempts to cope, while successful coping or improved circumstances may replenish hope. Meaning concerns coherence, purpose or significance; faith can involve trust or commitment extending beyond a particular expected outcome. Religious belief concerns commitments and practices within traditions, while spirituality may involve meaning, connection or transcendence without religious identification. Spiritual wellbeing is an evaluated state, not evidence that a person holds religious beliefs. These constructs should be measured and interpreted separately even when their questionnaire items overlap [16,17].

3.3. Psychological Models and Measurement Instruments

From a psychological perspective, hope is relevant to motivation, goal-directed thinking, coping and adjustment to uncertainty. Psychological models seek to explain these relationships, while measurement instruments assess selected dimensions of hope and their relevance to individual functioning and adaptation.

Snyder's agency–pathways model is particularly useful when patients can identify valued goals and feasible routes towards them. Trait and state instruments respectively address relatively enduring orientation and current goal-related thinking. Their clinical application requires attention to changing capacity: failure to complete a goal may reflect progressive disease, inadequate support or inaccessible services rather than deficient motivation. Transferring agency to a caregiver or revising a goal can preserve participation without requiring personal physical control [6,13,18].

The 12-item HHI was initially tested in 172 ill adults, with high internal consistency and test–retest reliability. High reliability alone leaves cross-cultural and cross-disease construct equivalence unresolved. A systematic review found inconsistent one-, two- and three-factor HHI structures. A broader review of hope scales identified limited evidence for responsiveness and measurement error. In 863 Spanish cancer patients, a recent psychometric study supported a one-factor structure rather than the original three factors.

These findings favour population-specific validation over treating one structural model as universal [10,19–21].

Newer measures also require caution. The Hope in Medicine scale differentiated several modes of hoping in 74 patients with allergic rhinitis; hope subscales did not predict symptom course or impairment. This is adjacent measurement research, not evidence in severe illness. Its relevance is the explicit separation of hope from treatment expectancy and the need to validate proposed dimensions before transferring them clinically. Conversely, measures of hopelessness assess negative orientation and are not simply interchangeable with reverse-scored positive hope [22,23].

3.4. Adaptive and Maladaptive Forms of Hope

Adaptive hope can be flexible, responsive to evidence and compatible with contingency planning. Hope for an exceptional response may coexist with arranging care if treatment fails. Maladaptation is more plausibly identified through consequences, such as inability to understand treatment intent or repeated acceptance of burdens inconsistent with expressed values, than by judging an emotionally important hope unusual. A low-probability hope is not necessarily a false belief; a clinician's false assurance about its probability is a different matter [6,24].

Hopelessness, depression, demoralisation and spiritual distress overlap but are not diagnostically equivalent. Demoralisation scholarship emphasises loss of meaning and perceived inability to cope, while recent concept analysis identifies differences among spiritual distress, hopelessness and depression. Philosophical critiques also warn against automatically medicalising existential vulnerability. Clinical assessment should therefore ask what the experience means, identify treatable psychiatric symptoms where present and avoid inferring a diagnosis from a low hope score alone [23,25,26].

These conceptual distinctions provide a foundation for examining hope through four complementary perspectives: medical (clinical possibilities and outcomes), psychological (motivation and adjustment), spiritual (individual sources of meaning and struggle), and philosophical (meaning, vulnerability and uncertainty). Sections 4–7 develop these perspectives separately, before Section 8 brings them together to examine the relationships among patients' hopes, their understanding of medical possibilities and their care decisions.

4. Hope in Medicine and Clinical Outcomes

Clinical studies provide evidence of how hope is experienced and what it is associated with, but populations, measurements and endpoints differ substantially. As detailed below and in Table S1, oncology accounts for most of the representative clinical evidence, whereas studies involving cardiovascular, renal and neurological diseases, and intensive-care survivors are fewer and more heterogeneous. Intervention research is also predominantly oncology-based, as summarised in Table S2. Consequently, findings derived from advanced oncology should not be generalised automatically to other severe-illness populations, particularly those for which direct evidence remains limited or unavailable.

4.1. Hope in Oncology and Life-Threatening Cancer

Patients' hopes extend beyond cure. In a longitudinal survey of 265 patients with incurable cancer, DeMartini and colleagues identified eight categories of treatment hope, including quality of life, life extension, tumour stabilisation, milestones and cure. Quality of life was the most frequent baseline category. A visual phenomenological study of six patients newly diagnosed with advanced cancer described internal, external, relational and transcendent aspects alongside hopelessness. The small qualitative sample illuminates possible experiences rather than their frequency [27,28].

In 350 end-of-life cancer patients with expected survival of four months or less and Karnofsky Performance Status no higher than 50, Bovero and colleagues found moderate-to-high hope despite substantial anxiety, depression and demoralisation. Meaning was an important statistical correlate. Hope therefore cannot be treated as evidence that distress is absent. In neuro-oncology, a 66-patient study found no difference in hope between higher- and lower-grade tumours; however, higher-grade disease was associated with more depression. An earlier 82-patient cross-sectional study linked recurrence to lower interconnectedness and greater mood disturbance. Neither study demonstrates that hope alters tumour behaviour [29–31].

4.2. Hope in Severe Chronic and Progressive Diseases

Among 93 hospitalised heart-failure patients, 58% were classified as New York Heart Association class III; the mean HHI was 37.69 (standard deviation 5.3). Hope was higher than in community controls after demographic adjustment, despite greater disease burden. Adaptation or response shift may explain this pattern, but either explanation remains an interpretation of cross-sectional data. A review of spirituality in heart failure likewise identifies a smaller, less mature evidence base than oncology and calls for controlled research [32,33].

Kidney failure provides contrasting findings. In 134 Hong Kong patients receiving peritoneal dialysis, trait hope was associated with better mental wellbeing and fewer depressive symptoms. Among 127 haemodialysis patients, hope correlated with spiritual beliefs, but concurrent questionnaires limit directional interpretation. Importantly, a 120-patient Iranian haemodialysis study found no significant relationship between hope and treatment adherence. Its title's predictive language should not obscure this null result or the limitations of cross-sectional self-reported adherence [34–36].

Neurological studies show both possibility and tension. In 40 people with amyotrophic lateral sclerosis (ALS), hope agency accounted for approximately 41% of variance in satisfaction with life; physical impairment was not correlated with satisfaction. Sixteen-person interview research described diverse hopes, including adaptation, relationships and living in the present. However, interviews with 12 people with ALS found that hope could be experienced as either a coping resource or an obstacle to accepting control over practical decisions. None establishes a uniform psychological response to progressive disability [37–39].

In chronic obstructive pulmonary disease, a cross-sectional study of 221 patients linked hope and meaning with post-traumatic growth. Because disease severity was insufficiently established in the accessible abstract, these findings cannot be attributed specifically to advanced respiratory failure [40].

4.3. Hope in Critical Illness and Palliative Care

Critical illness may compress hope into short, observable changes. Interviews with 13 intensive-care survivors highlighted acknowledging small improvements, sustaining relationships and being recognised as a person. A Norwegian prospective cohort of 523 intensive care unit (ICU) survivors found stable hope across three, six and twelve months. More social support was independently associated with higher hope (B = 0.37; 95% confidence interval (CI) 0.31–0.43), while post-traumatic stress symptoms were inversely associated (B = −0.08; 95% CI −0.11 to −0.04). Hope was the modelled outcome; these results do not show that increasing hope improves recovery [41,42].

Survivor selection is particularly important here. People who died, remained cognitively impaired or could not complete questionnaires are poorly represented. Family hope may concern survival, while the patient's priorities later concern function or identity. Syntheses of palliative experiences and nursing concept analyses emphasise relationships

and changing circumstances. Their clinical interpretation should leave room for uncertainty and ambivalence without prescribing a psychologically correct way to die [11,43].

4.4. Hope, Emotional Distress, and Quality of Life

A systematic review of 33 quantitative cancer studies found positive associations with quality of life, social support and spiritual/existential wellbeing, and inverse associations with symptom burden, distress and depression; the relationship with anxiety was less clear. These patterns support clinical attention to hope but are compatible with several explanations. Less severe symptoms may enable hope, supportive relationships may influence both hope and adjustment, and meaning-related items may partly duplicate quality-of-life content. Statistical adjustment cannot fully resolve these alternatives [44].

Evidence concerning prognostic awareness further qualifies a simple protective account. In 632 patients with metastatic cancer, cognitive acknowledgement of prognosis was not significantly associated with quality of life ($B = -2.3$; $p = 0.114$), whereas emotional coping was associated with better quality of life and less distress. A two-wave study of 176 Singaporean patients in the last year of life also found psychologically complex relationships with changing awareness. Understanding information and being emotionally able to live with it should therefore be assessed separately [45,46].

4.5. Hope, Treatment Engagement, and Clinical Decision-Making

Hope can coexist with inaccurate expectations. In 200 advanced-cancer patients, each one-point higher HHI was associated with greater odds of believing the illness curable (odds ratio (OR) 1.06; 95% CI 1.01–1.11) and expected survival 0.33 years longer (95% CI 0.17–0.49). These are cross-sectional associations, not proof that hope produces misunderstanding. Other research demonstrates widespread uncertainty about treatment intent: among 1193 patients with metastatic lung or colorectal cancer, many did not understand that chemotherapy was unlikely to cure their disease. A separate 90-patient study found limited agreement between patient and oncologist perceptions of curability and treatment goals [47–49].

Conversely, realistic expectations need not entail a clinically large loss of hope. In 672 Care Management by Oncology Nurses to Address Supportive Care Needs (CONNECT) participants, Loučka and colleagues found that all expectation domains met their prespecified six-point HHI non-inferiority margin. Their full-text results qualify the abstract's broad no-difference summary: realistic treatment intent was associated with a lower adjusted HHI score (difference −1.22; 95% CI −1.94 to −0.49), while other principal domains were not significantly different. The margin permits more than zero difference and does not establish equivalence or the effects of an actual disclosure intervention [50].

In a related CONNECT analysis, end-of-life conversations and advance-directive completion were associated with modestly higher adjusted changes in hope over three months: differences of 0.95 (95% CI 0.08–1.82) and 1.31 (95% CI 0.13–2.49), respectively. These behaviours were not randomised. Among 590 patients with advanced cancer, recalled prognostic disclosure was associated with more realistic survival estimates without worse adjusted sadness, anxiety or physician relationships. Together, these studies challenge inevitable hope destruction while leaving individual emotional responses uncertain [51,52].

Potential harms should also be considered when hope becomes closely linked to inaccurate expectations about treatment benefit. Such circumstances may contribute to delayed care planning, prolonged engagement with burdensome interventions or decisions that do not reflect the patient's informed priorities. However, the available evidence largely concerns prognostic understanding, treatment preferences and related psychological constructs, rather than demonstrating that hope itself causes these outcomes. Clinicians should therefore explore the patient's understanding of likely benefits and burdens, revisit goals as

illness evolves and distinguish informed low-probability preferences from decisions based on misunderstanding [47–49,51,52].

4.6. Limitations and Inconsistencies in Clinical Evidence

The findings reviewed in Section 4.5 require two further qualifications: accurate prognostic understanding may be emotionally distressing, and associations involving hope do not establish effects on survival. In the 550-patient NEOetic study, inaccurate awareness was associated with greater interest in low-efficacy treatment (adjusted OR 2.27; 95% CI 1.31–3.84), whereas realistic understanding was associated with more anxiety, depression and poorer quality of life. Differences in measurement, clinical state and emotional coping may contribute to apparently conflicting studies. The clinical objective is supported understanding and preference-sensitive decisions, rather than maximising either a hope score or an awareness score [53].

Survival requires especially clear boundaries. In 429 patients starting chemotherapy for metastatic colorectal cancer, hope and optimism were not independently associated with survival after adjustment for known prognostic factors. Although drawn from a chemotherapy trial, this was an observational analysis of psychological exposures. It provides neither proof of a survival benefit nor a definitive estimate of absence across all diseases. Current evidence does not justify telling patients that their attitude determines progression, treatment response or longevity [54].

5. Psychological Mechanisms and Therapeutic Approaches

Psychological approaches address distress, disrupted goals and threatened meaning. However, interventions measuring hope or hopelessness must be distinguished from those evaluating meaning, depression, quality of life or communication, as detailed in Table S2.

5.1. Cognitive and Motivational Mechanisms

Agency and pathways offer plausible, modifiable processes. Identifying a valued goal, recognising obstacles and finding alternative routes may sustain engagement when illness disrupts an established future. For someone unable to return to work, the valued purpose might be contribution rather than employment itself; participation could then take another form. This is a theoretical application of hope theory, not evidence that goal revision necessarily improves a clinical endpoint. Goals should be elicited from patients and calibrated to capacity and available resources [6,13,18].

A secondary analysis of meaning-centred psychotherapy explored meaning as a potential mediator, but shared measurement, confounding and uncertain temporal ordering limit causal interpretation. This does not establish a mechanism linking meaning or hope to tumour control, organ recovery or immune benefit [55].

5.2. Emotional Regulation, Uncertainty, and Coping

Hope may help people tolerate uncertainty, direct attention towards attainable possibilities and continue activities that matter. Equally, symptom relief, supportive communication and successful practical coping may make hope possible. Folkman's account of stress, coping and hope emphasises these relationships without reducing adaptation to positive thinking. Patients can alternate between grief, fear, realistic preparation and hopeful anticipation; clinical support need not eliminate negative emotion to be helpful [16].

The treatment context also matters. Early integrated palliative care in a 151-patient metastatic lung-cancer trial improved quality of life and mood, while the 150-patient Palliative Care in Heart Failure (PAL-HF) trial improved quality-of-life, psychological and spiritual outcomes in advanced heart failure. PAL-HF reported a six-month Kansas City

Cardiomyopathy Questionnaire difference of 9.49 points (95% CI 0.94–18.05), without a rehospitalisation or mortality effect. Neither trial directly establishes hope enhancement or a hope-mediated mechanism. Multicomponent clinical care should not be reinterpreted as a psychological hope experiment [56,57].

5.3. Psychological Interventions Targeting Hope

Earlier programmes provide preliminary direct evidence. Herth's study of 115 patients with first cancer recurrence reported greater hope and quality of life following a structured nursing programme than comparison conditions. The paper describes the design as quasi-experimental while reporting random assignment, requiring caution about methodological classification. Duggleby's randomised 60-patient Living with Hope pilot combined a video and a selected activity for older terminally ill patients at home. Hope was higher after one week ($U = 255$; $p = 0.005$), but the short follow-up does not establish durability [58,59].

More recent development has focused on valued activities. Formative research explored metastatic lung-cancer patients' preferences for a hope-enhancing approach. The subsequent single-arm Pathways trial enrolled 52 participants and reported improved hope ($d = 0.51$; $p < 0.05$) and reduced goal interference ($d = -0.70$; $p < 0.005$). Although adherence, retention and acceptability targets were met, enrolment of 54% missed the prespecified 60% threshold. Without a control group, attention, concurrent treatment or regression to the mean could explain change. These are feasibility and preliminary outcome findings, not established efficacy [60,61].

5.4. Meaning-Centred and Dignity-Oriented Interventions

Meaning-centred psychotherapy has stronger controlled evidence for selected existential and psychological outcomes. In a 253-patient trial, group therapy was compared with supportive group psychotherapy. Intention-to-treat analyses retained benefits for quality of life, depression and hopelessness, while other effects depended on analysis and attendance. In a 321-patient individual-therapy trial, advantages over enhanced usual care were generally small and outcome-specific. Hopelessness and depression were not significantly improved, and advantages over supportive psychotherapy were confined to quality of life and meaning. This pattern does not support treating all existential interventions as equally effective hope treatments [62,63].

Managing Cancer and Living Meaningfully (CALM) addresses symptom management, relationships, meaning and mortality. In 305 patients with advanced cancer, depressive symptoms improved relative to usual care, with small effect sizes at three months ($d = 0.23$) and six months ($d = 0.29$). The demonstrated benefit concerns depressive symptoms in the studied setting; a distinct positive-hope effect was not assessed. The 25.5% six-month attrition also illustrates the challenge of evaluating interventions during progressive illness [64].

Dignity therapy uses guided reflection and a legacy document to support personhood. In the influential 441-patient randomised trial, 326 participants contributed analysed outcomes, and primary distress changes did not differ significantly among dignity therapy, client-centred care and standard palliative care. Participants nevertheless rated several secondary end-of-life experiences more favourably. A 2024 trial involving 68 terminally ill cancer patients and family caregivers reported a quality-of-life increase within pooled intervention groups and a favourable group-by-time distress interaction. Small groups, attrition and combined intervention analyses limit certainty. Perceived usefulness remains valuable without being equivalent to demonstrated efficacy on primary distress endpoints [65,66].

A 2025 home-care pilot randomised 65 patients to brief nurse-delivered meaning-centred psychotherapy or usual care. Complete-case between-group change-score effects for meaning were $d = 0.59$ at six weeks and $d = 0.39$ at ten weeks. The hopelessness effect attenu-

ated from d = −0.47 to d = −0.03. This distinction matters: an initial change in hopelessness did not persist simply because meaning-related benefits remained. The study supports feasibility and further evaluation, with missing-data and comparator limitations [67].

5.5. Evidence for Effectiveness and Methodological Limitations

Salamanca-Balen and colleagues synthesised 35 studies involving 3296 palliative-care participants. Interventions increased measured hope (g = 0.61; 95% CI 0.28–0.93), but not hopelessness (g = −0.08; 95% CI −0.18 to 0.02); anxiety, quality of life and symptom burden did not show significant pooled improvement. Overall evidence was rated low. These divergent endpoints are more informative than a general statement that hope interventions work [5].

A 2022 dignity-therapy meta-analysis of 14 randomised trials reported a hope mean difference of 3.41 (95% CI 2.82–4.00), without a significant quality-of-life effect. Another synthesis of 16 palliative-care studies reported benefits for hope and selected outcomes but no significant psychological or spiritual wellbeing difference. An umbrella review identified substantial diversity and limited follow-up across spiritual interventions, while a 2026 rapid review found hope changes more consistent than broader clinical or psychological changes. These syntheses overlap in their constituent studies and cannot be counted as independent replications. Differences in comparators, baseline distress, intervention content and assessment timing prevent confident ranking of modalities [68–71].

6. Religious and Spiritual Dimensions of Hope

Religion and spirituality may provide meaning and support, contribute to distress or be irrelevant to an individual patient. Their clinical relevance depends on patients' experiences and the distinction between empirical evidence and personal or theological interpretations.

6.1. Spirituality, Religiosity, and Existential Meaning

Spirituality may concern meaning, purpose, connection, transcendence or the sacred. Religiosity more specifically involves beliefs, practices and communal identification within religious traditions. Neither can be reliably inferred from demographic labels. A person may value spiritual practices without institutional affiliation, or identify culturally with a religion without believing in God. Conversely, atheist or agnostic patients may reject the word spiritual while valuing relationships, moral commitments, nature or legacy. Clinical assessment should permit their preferred vocabulary [72,73].

Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being (FACIT-Sp) distinguishes meaning/peace from faith-related content, illustrating how spiritual wellbeing can partly overlap with existential and emotional adjustment. Balboni and colleagues' evidence review supports attention to spirituality in person-centred serious-illness care, without providing a basis for prescribing religious belief. A 2026 integrative review similarly describes associations and implementation barriers; broad statements of benefit still require checking the underlying study designs and population differences [4,17,74].

A complementary approach is provided by the Hope, Organised religion, Personal spirituality and practices, and Effects on medical care (HOPE) questions, developed by Anandarajah and Hight as a structured guide to spiritual history-taking rather than a quantitative psychometric scale. The four domains cover sources of hope, meaning, comfort, strength, peace, love and connection (H); organised religion (O); personal spirituality and practices (P); and effects on medical care and end-of-life issues (E). Unlike FACIT-Sp, which measures selected dimensions of spiritual wellbeing, HOPE facilitates an open-ended exploration of individual spiritual resources, concerns and preferences, including among patients without religious affiliations. A recent scoping review documented its international

use and evidence concerning acceptability and feasibility. These approaches are therefore complementary rather than interchangeable, and the use of HOPE should not be interpreted as a direct quantitative assessment of hope or evidence of clinical effectiveness [75,76].

6.2. Hope Across Religious Traditions

Traditions offer interpretative possibilities rather than uniform patient responses. Marcel's Christian philosophical account links hope with trust, communion and transcendence; however, its application to healthcare has been interpreted in broader existential terms. This is conceptual scholarship, not a comparison demonstrating superior outcomes among Christian patients. Within Muslim and Sikh experiences, longitudinal Scottish research involving 25 patients, family members and professionals found changing hopes shaped by social roles, clinical encounters and, for some, religious belief. A review of Muslim end-of-life experiences found important differences around disclosure, family obligations and faith, while acknowledging a relatively weak and predominantly cancer-based evidence base [77–79].

Jewish identity likewise cannot determine preferences. Rosenberg and colleagues' clinical guidance emphasises diversity in Jewish identity, observance and belief and recommends asking how these matters affect individual care. This is practice guidance, not evidence of a uniform Jewish response to severe illness. Thai Buddhist qualitative research with 12 terminal cancer patients described death as natural, noted limited control over it, and highlighted practices associated with calmness and a peaceful life before death. A separate 363-patient Buddhist cancer study examined death acceptance rather than hope. Neither supports translating Buddhist acceptance into a universal hope score or requiring religious practices as clinical treatment [80–82].

These examples should not become cultural scripts imposed on individuals. In a focus-group study including people with and without Muslim backgrounds, participants valued realistic information delivered sensitively and assurance of continuing care; however, preferences concerning family involvement and terminology differed. The practical implication is to establish individual preferences for information, family participation and religious consultation [83].

6.3. Spiritual Coping and Adaptation to Severe Illness

Positive religious coping can involve seeking strength or support; negative coping can include spiritual abandonment, anger or punitive interpretations. These are not equivalent to positive and negative hope. In a prospective mixed-stage breast-cancer cohort, including 86 women with stage IV disease, positive religious coping was not associated with wellbeing outcomes, whereas negative coping predicted poorer mental health and life satisfaction. This qualifies assumptions that religious coping is consistently protective, while the mixed-stage sample limits severe-illness-specific inference [84].

Care context may modify associations. In 343 advanced-cancer patients, medical-team spiritual support was associated with greater hospice use (adjusted OR 3.53; 95% CI 1.53–8.12) and better quality of life near death. A related cohort report associated religious-community support with less hospice use and more aggressive end-of-life care (adjusted OR 2.62; 95% CI 1.14–6.06). These overlapping observational data do not prove opposite causal effects of clinical and religious support. They suggest that content, communication and treatment expectations matter more than a binary label of spiritual support [85,86].

6.4. Spiritual Care and the Clinical Environment

Patient-led spiritual care begins with permission to explore sources of strength, meaning or concern. Clinicians can listen, recognise distress and offer referral to chaplaincy, culturally appropriate religious advisers or secular psychological and existential support.

Consensus and clinical guidance support collaboration while recognising differences in professional competence. Qualitative chaplaincy research contributes experiential understanding; intervention efficacy requires separate testing [72,87,88].

Access and measurement deserve attention. A recent review of 46 low- and middle-income-country studies derived from an earlier serious-illness evidence review found that 38 used instruments developed in high-income countries. It identifies culturally distinctive concerns and the role of families and communities, but remains a secondary synthesis with inherited selection criteria. Integration should therefore include locally meaningful language, interpretation and feasible referral routes, rather than assuming that imported questionnaires capture every relevant experience [89].

6.5. Religious Distress, Spiritual Struggle, and Potential Harms

Spiritual struggles may challenge hope by unsettling sources of meaning, trust or connection, yet they can coexist with continued hope and religious commitment and should not be interpreted as evidence of failed faith. Patients may experience guilt, perceived punishment, exclusion or disagreement with family and religious communities. Religious resources may also accompany intensive treatment expectations: in 345 advanced-cancer patients, high positive religious coping was associated with ventilation or resuscitation near death after extensive adjustment (OR 2.90; 95% CI 1.07–7.89). This does not establish that the care was unwanted or that faith caused it, but it challenges a uniformly beneficial interpretation [90].

Potential harms also arise from clinical conduct. Offering prayer without permission, attributing illness to deficient belief, or privileging a clinician's worldview can compromise autonomy and trust. Equally, dismissing a patient's beliefs as irrational can close discussion of treatment preferences. The ethical task is to understand how beliefs relate to decisions, identify coercion or distress and preserve access to appropriate care. A religious proposition should never be presented as an experimentally demonstrated medical fact [6,87].

7. Philosophical and Existential Perspectives

Philosophical approaches consider hope when control, certainty or cure is unavailable. They offer interpretative and ethical resources rather than estimates of clinical effectiveness.

7.1. Hope, Suffering, and Human Vulnerability

Severe illness exposes dependence on bodies, caregivers, institutions and events beyond individual control. Accounts defining hope entirely through successful personal agency risk excluding patients who can no longer act independently. Poppe's account of pre-intentional hope examines a relational openness that may precede particular hopes, especially in motor neurone disease. It offers a conceptual way to understand dependence and possibility, whose clinical implications require empirical investigation [23].

7.2. Existential Meaning and the Possibility of Hope

Frankl places the search for meaning within suffering and constrained freedom. In palliative care, this perspective invites attention to relationships and commitments when cure is unavailable, without implying that suffering necessarily produces growth or that meaning prolongs life. Clinical application should follow patients' values and avoid moralising experiences of grief or meaninglessness [91].

Bloch's philosophy addresses unrealised possibilities within historical and material conditions rather than bedside care. A cautious clinical analogy is to identify personally valued possibilities supported by symptom relief, family contact and practical assistance

while communicating treatment limits. This remains our interpretation, not a validated clinical application of Bloch's theory [92].

7.3. Hope in the Face of Mortality

Marcel's account allows hope to exceed prediction of a particular successful outcome and gives interpersonal communion an important role. Szabat and Knox examine both its relevance and the difficulties of transferring its metaphysical commitments to end-of-life care. In palliative care, this perspective suggests how honest prognostic communication may coexist with relational presence and assurance of continuing care. Wrigley offers a secular account grounded in solidarity for extreme circumstances where familiar objects of hope seem unavailable. These religious and secular resources should retain their differences, with their relevance determined by the patient's commitments [77,93].

Recent discussion of radical hope further considers circumstances in which patients cannot yet identify what a worthwhile future would mean. Such accounts can explain why immediate pressure to name goals may be premature. They do not show that every experience of despair conceals hope, or that professionals should reinterpret a patient's account against their wishes [94].

7.4. Philosophical Tensions Between Hope, Uncertainty, and Realism

The standard philosophical account links hope with desire for an outcome and belief that it is possible. Contemporary debates ask whether those elements are sufficient, since people can desire and recognise a possibility while responding very differently to it. The distinction between hoping and predicting is clinically useful: wishing for an exceptional response need not imply judging it likely. Conversely, sincere hope cannot make an empirically unsupported probability accurate [95].

There remains a tension between flexible hope and professional pressure towards acceptance. A clinician may regard comfort as the most realistic goal while a patient continues to value a small chance of additional life. Ethical reasoning must examine understanding, burdens, alternatives and voluntariness rather than making psychological realism a condition of respectful care. Wrigley's solidarity account offers one possible basis for remaining alongside a person when outcomes cannot be repaired, without requiring deception or religious agreement [93].

7.5. Relevance to Patient-Centred Medicine

These approaches broaden clinical questions: what remains worth protecting, who can help sustain it, and what would constitute abandonment? Their contribution to patient-centred medicine is interpretative and ethical; they complement symptom management and shared decisions without replacing clinical assessment, treatment of psychiatric illness or accurate prognostic information. Table S3 summarises their conceptual distinctions and evidential status.

These perspectives inform the discussion of patients' hopes, medical expectations and choices in Section 8.

8. Discussion: Towards an Integrated Clinical Framework

Building on the medical, psychological, spiritual and philosophical perspectives examined in Sections 4–7, this discussion proposes an analytical cross-check of three distinct but interacting domains: patients' hopes, their understanding of medical possibilities and their care decisions. The purpose is to make the source of an apparent mismatch identifiable and discussable without automatically classifying a patient's hope as denial. This framework is a proposal for clinical reasoning, not a validated assessment tool or care pathway.

8.1. Integrating Medical, Psychological, Philosophical, and Spiritual Perspectives

The medical perspective establishes the condition, symptom burden, reversible problems, treatment intent and uncertainty. The psychological perspective examines distress, agency, coping and capacity to consider alternatives. Philosophical reflection asks what remains meaningful when possibilities narrow and recognises vulnerability beyond individual control. Spiritual enquiry, when desired, addresses religious or secular sources of connection, significance and struggle. Relationships and material circumstances operate across all four perspectives, including whether proposed goals are practically achievable.

Integration requires three distinct descriptions. First, identify the object of hope and its personal importance: for example, reaching a family event. Second, establish the patient's understanding of medical possibilities, including how likely and burdensome further treatment may be. Third, examine the decision: whether accepting that treatment fits the person's priorities and alternatives. Discordance between these descriptions is a reason for exploration, not automatic evidence of denial. Someone can hope for cure, recognise non-curative treatment and choose comfort-focused care; another person may express modest hopes while misunderstanding treatment intent [24,27,50].

Existing adaptive-hope frameworks already emphasise recalibration of goals, honest communication, interdisciplinary support and the coexistence of hope and realism [6]; moral-accompaniment accounts emphasise relational presence and ethically grounded support [7]. The present framework is therefore not offered as a new theory of hope or a replacement for these approaches. Its distinctive analytical step is to examine the correspondence between hopes, medical expectations and choices as separate questions across the four perspectives. This distinction invites the clinician to consider whether an apparent conflict reflects misunderstanding of treatment intent, difficulty coping with uncertainty, threatened existential meaning, a spiritual concern, a practical obstacle or an informed value-based preference. By identifying which question requires attention, the framework seeks to make interdisciplinary reasoning more explicit, without presuming that all three domains must agree or that disagreement is necessarily maladaptive.

The evidence informing this framework can be distinguished into three categories. First, findings supported across several disease groups include diverse experiences of hope and associations with psychological wellbeing, social support and adaptation, as reported in selected studies involving cancer, heart failure, kidney failure, amyotrophic lateral sclerosis and intensive-care survivors. However, differences in study design, measurement and clinical context preclude conclusions about uniform effects or shared causal mechanisms [29,32,34,37,39,41,42]. Second, findings concerning prognostic understanding, treatment expectations, advance-care planning and the effectiveness of hope-related or existential interventions are predominantly derived from advanced oncology populations, limiting their generalisability to other severe illnesses [47,50–53,58,61–64]. Third, the proposed integration of patients' hopes, medical expectations and care decisions across medical, psychological, philosophical and spiritual perspectives represents an author-generated conceptual synthesis rather than an empirically validated clinical model. Its applicability and potential benefits, particularly outside oncology, require further investigation. Tables S1–S3 document these distinct evidential foundations and their limitations.

8.2. Clinical Assessment of Hope and Existential Needs

Assessment can begin by asking what the person is hoping for, what worries them most and what helps them continue. These are illustrative clinical prompts, not a validated screening instrument. Asking about current understanding separately reduces the risk of interpreting a statement of hope as a probability estimate. Where serial measurement is useful, the HHI or a goal-oriented hope scale can supplement conversation, provided its

linguistic and population validity is appropriate. No universal threshold identifies healthy hope or justifies overriding a patient's preferences [20,21].

Hope assessment should sit alongside symptom burden, function, mood, cognition, social support and spiritual or existential distress. A patient may be hopeful and depressed, or have low hope without a depressive disorder. Communication disability, fatigue or delirium can make self-report unreliable; assisted communication may help, but proxy descriptions should be identified as such. Reassessment is particularly relevant after progression, hospital discharge, major functional loss or a change in treatment goals [29,42].

8.3. Communication of Prognosis While Preserving Realistic Hope

Communication should establish how much information patients want and whom they wish to involve, explain treatment intent and uncertainty clearly, and check understanding. Prognostic estimates are conditional, especially when outcomes vary, or treatment options evolve. Reviews support combining explicit information with affective support and considering more than one plausible survival scenario when appropriate. An assurance of continuing care can be truthful even when reassurance about cure would be false [96]. A synthesis of clinicians' perspectives also identifies tensions around delivering prognosis, referring to hospice and supporting shifting hopes. These are reported communication challenges, not evidence of intervention efficacy [97].

Conversation quality is not guaranteed by a guide alone. The Serious Illness Care Program trial was null for its coprimary outcomes; however, selected psychological outcomes improved. A related descriptive analysis found that many patients experienced conversations positively; this is supportive acceptability evidence rather than an independent efficacy trial. The Values and Options in Cancer Care (VOICE) trial likewise illustrates that improving communication processes does not automatically improve every downstream outcome. Teams should evaluate understanding and decisions alongside acceptability [98–100].

8.4. Individualised Psychological and Spiritual Support

Support should respond to the identified difficulty. Severe symptoms require clinical management; depressive or anxiety symptoms may warrant psychological or psychiatric assessment; disrupted meaning may prompt discussion or a suitable meaning-centred approach. Referral should consider patient preference, illness capacity, timing, intervention burden and the availability of trained practitioners. For patients requesting spiritual care, collaboration with an appropriate specialist may be useful; those declining religious discussion should have equally credible secular options [63,64,87].

Practical support may help patients pursue valued activities, maintain relationships or prepare contingency plans. These are illustrative applications rather than tested components of the framework; their relevance depends on patient preferences and clinical circumstances.

8.5. Ethical Considerations

Honesty and respect require distinguishing hope from the clinician's endorsement of a probability. Professionals should avoid promising that faith, optimism or determination will produce recovery, and should not make patients responsible for adverse biological outcomes. Equally, a patient's hope should not be used to justify a treatment without discussing likely burdens and alternatives. The relevant ethical endpoint is an informed, voluntary and values-consistent decision, with continuing opportunities to revise it [6,52].

Family members can sustain hope and facilitate understanding, but their wishes do not automatically establish the patient's preferences. Cultural sensitivity does not remove the need to ask how information and decisions should be shared. Professional boundaries also apply to spiritual care: clinicians should not proselytise, require a worldview or assume

permission for religious activity. The option to decline hope-focused, existential or spiritual enquiry is part of patient-centred care.

9. Limitations and Future Directions

The principal limitations concern the available evidence and the review's purposive methodology.

9.1. Limitations of the Evidence and Review Approach

Clinical studies often use small, selected samples and concurrent self-report measures. Reverse causation and shared causes, including symptom control, socioeconomic resources, relationships and depression, remain plausible. Attrition through deterioration or death can selectively remove patients with different experiences. Advanced oncology dominates the selected clinical literature, whereas evidence involving cardiovascular, renal and neurological diseases, and intensive-care survivors remains comparatively sparse and heterogeneous. Patients unable to communicate are particularly underrepresented, and the included studies do not establish applicability to advanced respiratory illness or transplantation.

Measurement heterogeneity also limits synthesis. Hope, hopelessness, meaning, spiritual wellbeing and treatment expectancy are distinct, while instruments can contain overlapping emotional or relational content. Cross-cultural factor structures and responsiveness remain incompletely established [19,20,101]. Prognostic awareness itself has multiple operational definitions, complicating comparisons between studies describing realism as compatible with hope and those associating awareness with distress [102]. Narrative interpretations of these differences should not be mistaken for resolved mechanisms.

Intervention studies differ in baseline distress, personnel, treatment intensity, control condition and follow-up. Improvements against usual care may reflect attention or therapeutic alliance; active-comparator effects are often smaller. Several syntheses contain overlapping studies. Adverse experiences, treatment burden and opportunity costs receive less attention than beneficial questionnaire changes. Philosophical arguments and clinical consensus can clarify practice, but cannot increase the empirical certainty of an intervention result.

Because literature selection was purposive and access to some sources was limited, relevant studies may have been missed. These constraints, detailed in Section 2 and Table S4, should be considered when interpreting the synthesis.

9.2. Priorities for Interdisciplinary and Clinical Research

Future observational studies should distinguish objects of hope, general hope, medical expectations and decisions, while measuring illness severity, symptoms, cognition, mental health, social context and relevant spiritual constructs separately. Repeated assessments around clinical transitions could test temporal relationships and within-person change. Multicentre work should include non-cancer populations, patients with communication limitations, and culturally diverse, atheist and agnostic participants, without presuming that the same scale is invariant across groups. Other relevant clinical contexts for future research include healthcare-associated infections and complex surgical conditions [103–105].

Trials should specify whether hope, hopelessness, meaning or another endpoint is primary, use credible comparators, and report clinically interpretable change and longer-term follow-up where feasible. Mediation studies require measurement timing that can distinguish proposed mechanisms from concurrent improvement. Missing data associated with deterioration and death need explicit handling rather than exclusion without qualification. The benefits of supportive care should be evaluated in their own terms, with survival investigated only where adequately designed and biologically justified.

The integrated framework could first be assessed through patient and clinician interviews examining acceptability, comprehensibility and unwanted pressure. Prospective feasibility studies could then evaluate whether separate documentation of hopes, expectations and decisions identifies unmet needs without increasing burden. Controlled evaluation would require outcomes such as understanding, decisional conflict, goal concordance and distress, alongside hope and unwanted effects. These are proposed research steps, not evidence that implementation already improves care.

10. Conclusions

Hope in severe illness encompasses cognitive, emotional, motivational, relational and existential dimensions, with spiritual significance for some patients. Clinical studies associate hope with aspects of psychological adjustment, and selected interventions affect specific patient-reported outcomes; evidence does not establish effects on disease progression or survival.

Medical care clarifies feasible options and treatment intent; psychology addresses coping and adaptation; philosophy examines meaning and vulnerability; and spiritual care, when welcomed, explores individually valued sources of significance or struggle. These contributions complement one another without carrying equivalent empirical support, and religious belief is not required for meaningful hope.

A central implication is to distinguish what patients hope for, what they understand about medical possibilities and which care options they choose. Exploring these domains may clarify tensions while preserving honest communication, autonomy and patients' right to ambivalence, without imposing optimism. The proposed framework remains a conceptual approach to clinical reasoning, and its applicability beyond advanced oncology requires evaluation.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/healthcare14234041/s1, Four separate editable Word documents accompany this review. Table S1: Clinical Evidence Concerning Hope and Related Psychological, Prognostic, and Spiritual Outcomes in Severe Illness; Table S2: Psychological, Existential, and Spiritual Interventions Relevant to Hope in Severe Illness; Table S3: Comparative Conceptual Frameworks of Hope Across Medicine, Psychology, Philosophy, and Spirituality; Table S4: Literature Search Strategy and Source Selection Approach. References cited in Table S1–S4 correspond to the reference list of the main manuscript.

Author Contributions: Conceptualisation, G.Ț., B.I.Ș., R.M., L.Ț., L.S.M., I.E.M. and M.D.; methodology, G.Ț. and R.M.; validation, G.Ț., R.M. and L.S.M.; formal analysis, G.Ț. and B.I.Ș.; investigation, A.P.C., V.L., M.N.M., O.M.M., I.E.M. and M.D.; resources, R.M., L.S.M. and M.N.M.; data curation, G.Ț., V.L., L.Ț. and O.M.M.; writing—original draft preparation, G.Ț. and L.Ț.; writing—review and editing, G.Ț., B.I.Ș., A.P.C., V.L., R.M., L.Ț., L.S.M., M.N.M., A.N., O.M.M., I.E.M., M.D., L.T.H., S.I.C. and E.M.; visualisation, G.Ț. and B.I.Ș.; supervision, R.M. and L.S.M. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analyzed in this study. Data sharing is not applicable to this article.

Conflicts of Interest: The authors declare no conflicts of interest.

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