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## Original research article

# The quality of life of hospitalized and outpatient oncological patients

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## ABSTRACT

The quality of life of sufferers of chronic and serious diseases is a phenomenon which has come to the attention of contemporary medicine, nursing and other supporting professionals working with cancer patients. This research set out to determine whether there is a difference in the self-perception of the quality of life of hospitalized cancer patients and cancer outpatients.

This study deals with the comparison of quality of life in 128 outpatient and hospitalized cancer patients in the curative stage of cancer. The QLACS (Quality of Life in Adult Cancer Survivors) "How do I live with the disease?" questionnaire was used in the survey. To ascertain the total value of the quality of life we used scoring with a potential spread of responses from 1 to 7 in the QLACS questionnaire. Using this scale, various items in the questionnaire measured the level of each frequency of problems (1 = never, 7 = always). The resulting value of quality of life of the patient was higher when the final score was lower. A significance level of 0.005 in the resulting value of quality of life (sig. = 0.000) in the study group of patients confirmed the hypothesis, which assumed that the quality of life of hospitalized cancer patients is significantly lower than the quality of life of cancer outpatients. The quality of life of hospitalized cancer patients is significantly lower than the quality of life of cancer outpatients (sig. = 0.000) since admission to hospital with all the accompanying negative factors for the patient – the separation from family and loved ones, unfamiliar environment, undergoing often difficult and invasive diagnostic or therapeutic procedures, which amongst others, are very stressful for the patient, with a potentially negative impact on the patient's quality of life.

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## Introduction

Cancer can be characterized as cell growth of unregulated autonomous nature. Uncontrolled cell growth in this way leads to an enlargement of affected tissue which compresses the surrounding structures [1]. Malignant tumour growth is invasive, destructive and unconfined. It grows into blood and lymphatic vessels and metastasizes [2]. Worldwide, cancer affects nine million people every year, and 6 million people die due to cancer [3]. A prerequisite for understanding the quality of life of oncological patients is the perception of factors that are involved in human life satisfaction. Sirgy [4], the author of the theory of life satisfaction, indicates that a person has various adjustment mechanisms to restore homeostasis when it undergoes disruption. Through compensation, self-review of personal history, self-perception, choice of objectives, and the implementation of the person's own desired objectives, they create their own assessment of quality of life. Quality of life is a universal phenomenon, which is a difficult area to examine in many institutions in different countries [5]. It is a feeling of overall life/well-being resulting from a set of objective living conditions and their subjective evaluation by, in this instance, the patient. It is a subjective impact assessment on aspects of the patient's physical, emotional, and social life. Individual components interact and their impact on the quality of life increases exponentially – for example, pain worsens dyspnoea, performance, self-sufficiency, emotional well-being [6]. Quality of life was introduced into psychology in the late 1930s by Thorndike and was recognized in medical fields of oncology and traumatology in the early 1970s [7]. Quality of life interests the health professionals because it is a basic human desire to be satisfied and happy, and also because it affects interaction with patients. These terms are often associated with health, but also with social capital, marital status, education and appropriate livelihood [8]. The issue of the quality of life of patients has increasingly become an area of attention within healthcare over the last three decades. Finding out if the patient is experiencing a good quality of life as well as an individual's values and concerns relating to his/her current quality of life, is important for planning interventions and care planning. Quality of life is also important in terms of prognosis. The positive perception of their quality of life by the patient is a prerequisite for better management of the disease. Quality of life of patients is affected by several aspects: physical condition, functional ability, mental health, satisfaction with treatment and social status, society, religious and economic aspects, age, sex, polymorbidity, family situation, preferred values, education, religiosity, and cultural background [9,10].

In connection with our research that deals with the quality of life of cancer patients, we set out to determine whether there is a difference in the perception of the quality of life of hospitalized cancer patients compared to cancer outpatients.

## Materials and methods

The research was conducted with cancer outpatients and cancer patients who were hospitalized at the oncology centre

of the same institutions. The research was conducted in two hospitals in eastern Slovakia: Faculty Hospital in Prešov (Radiotherapy Department, Department of Clinical Oncology, Department of outpatient chemotherapy) and in the East Slovakia Cancer Institute in Košice. After approval by the ethics committees of individual clinical departments, the research proceeded by the direct administration of questionnaires and through interactions with patients. The research sample consisted of a total of 128 cancer patients. There were 67 hospitalized patients and 61 outpatients.

We had the following criteria for the inclusion of possible research participants: patients without cognitive disorder; where there was his/her active agreement to participate in the research; the patient had been undergoing oncological treatment for at least 3 months; and that the patient was in the curative stage of the disease. The largest group in the survey sample consisted of patients aged 60–69 years (32.81%,  $n = 42$ ). The second largest group was that of patients aged 50–59 years (20.31%,  $n = 26$ ). In terms of age the least represented group of patients were those aged 30–39 years (2.32%,  $n = 3$ ). The average age of patients participating in the study was 56 years. Representation of men and women in the survey sample was uniform. Males comprised 51.78% ( $n = 65$ ) and women 49.22% ( $n = 63$ ).

The QLACS (Quality of Life in Adult Cancer Survivors) “How do I live with the disease?” questionnaire was used in the survey. The QLACS concept is based on monitoring the quality of life that reflects physical, psychological and social aspects, and of patient satisfaction with their own lives and their sense of coping with the disease [11]. The questionnaire has been used since 2005, and its advantage lies in the pursuit of understanding the quality of life of patients with a long-standing presence of oncological disease and in patients with metastatic relapse after several years of treatment. It was developed in the USA and tested with patients with a disease duration from 2 months to 18 years, and was also used with patients with breast cancer, bladder cancer, head and neck cancer, gynaecological cancer, prostate tumour, and colon cancer. QLACS has a high correlation with the SF36 questionnaire and the FACT-6 – Functional Assessment of Cancer Therapy [12]. QLACS is an instrument with established internal consistency (Cronbach's alpha 0.72) [12,13]. The questionnaire consists of 47 closed items. It contains seven generic domains focusing on the positive and negative feelings, cognitive problems, sexual problems, physical pain, fatigue, social issues and five specific domains associated directly with cancer – including the change in image of his/her own body after oncological treatment, financial problems in connection with cancer disease, distress caused by cancer, the impact of the disease on the family, as well as the possible contribution of the development of the disease on the patient's personality [12]. Respondents were asked to indicate their responses on the 7-point Likert scale (1 = never; 7 = always). Administration of the questionnaire was carried out after personal invitations to each patient asking him/her to cooperate. Each patient was individually trained in working with the scale items in the questionnaire. Collection of questionnaires was carried out in agreement with patients each day in the administration of the questionnaire, most often taking between 30 and 40 min, allowing the immediate

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