

Quality of Life of Filipino Cancer Patients

a report by

Corazon A Ngelangel

Professor, Departments of Internal Medicine–Medical Oncology and Clinical Epidemiology, College of Medicine, University of the Philippines

Traditionally, end-points in healthcare are assessed through treatment effectiveness outcomes using indicators such as mortality rates and survival indices. However, with the modernisation of health technologies such health outcomes no longer suffice. In many countries, the number of expected life-years is increasing. In addition, many treatment programmes have little or no impact on mortality rates. With the World Health Organization (WHO) re-definition of health, which includes social and psychological wellbeing, alternative approaches to measuring health outcomes now include an analysis of the patient's quality of life (QoL), which is an all-encompassing term connoting the overall wellbeing of a person at a given period of time. Of particular interest is the attainment or maintenance of QoL of an individual who is diagnosed with cancer. What is the overall QoL of Filipino cancer patients? What are the best indicators of QoL among this population? Are there significant differences in terms of age, gender, level of education, civil status, stage of cancer and type of treatment?

Cancer management is one area where clinical decision-making becomes a critical and perplexing activity. Routinely, better response or remission rates and prolonged survival are used as a gauge for cancer treatment effectiveness. However, both the disease and the various care modalities can place tremendous strain on the patient's social, emotional and physical wellbeing. Pain has been explicated to be the single most important distress variable among cancer patients and impairs a person's actual and perceived 'life role', which consequently has a cumulative negative effect on distress over and above the effects of pain.¹ Furthermore, the prevalence of fatigue among patients after cancer treatment was about 61%.² Other studies indicate a relationship between lung cancer and symptom distress, fatigue and decline in functional status.³ Cancer therapies such as surgery can be mutilating, resulting in physical and psychological trauma. In their study of patients who underwent surgery for oral and pharyngeal cancer, Langius et al.⁴ found that psychological and physical functioning, sleep, recreation, work, eating and home management were impaired two to four months and 12 months after treatment. Brasilis et al.⁵ showed that in sexual functioning, continence and hardship, QoL scores of patients with prostate cancer deteriorated 12 months after radical prostatectomy. Studies on women with breast cancer have demonstrated that general psychological distress,

marital satisfaction and religious outlook did not differ when mastectomy and was compared with breast conservation, although those who underwent surgical removal rated their body image more poorly.⁶ Cancer patients experienced a significant increase in fatigue over a five- to six-week course of radiotherapy.⁷ Chemotherapy causes considerable toxicity resulting in hair loss, nausea, vomiting, fatigue and emotional problems. Women with breast cancer who underwent chemotherapy had more sexual dysfunction, a poorer body image and more psychological distress than women who underwent hormonal therapy and radiotherapy. Fatigue was also common over 14 days following treatment with chemotherapy.²

With these side effects, the chances of survival must be weighed against the QoL of the patient. Clinically, it is a measure of the patient's subjective perceptions and feelings of his or her health or diseased state and an assessment of the qualitative outcome of medical care. Singer⁸ posited that patients with chronic and life-threatening diseases, such as cancer, utilise both physical status and social function to define health and to re-establish self-integrity based on their continued social functioning even in the light of their acknowledged physical condition. While Fayos et al.⁹ defined QoL as the "ability of the patients to manage their lives...", Hornquist¹⁰ referred to it as "the degree of need satisfaction within the physical, psychological, social, activity, material, and structural areas". Shaw¹¹ suggested that QoL is the product of the patient's natural disposition and the efforts made on his or her behalf by family members and society. Harwood¹² referred to QoL as "the totality of those goods, services, situations, and state of affairs which are delineated as constituting the basic nature of human life which are articulated as being wanted or needed". Lieu¹³ thought that QoL is the "output of two aggregate input factors: physical and spiritual".

Most of these definitions differ in several ways. First, some studies measure QoL as a global indicator where several perceived components are weighed and combined to reveal the overall sense of wellbeing. Second, other studies consider only specific life dimensions such as the patient's physical, emotional, social, cognitive, functional and treatment-related state of wellness. Third, while some studies emphasise the descriptive nature of wellbeing or QoL, others provide utility scores that reveal the preferences of the patient with regard to the patient's state of health. Whichever method is used, QoL measures provide a more accurate assessment of an individual's state of health. QoL can be used to gauge the reactions of patients to diagnosis and therapy, measure the impact of certain treatment modalities on the non-physiological wellbeing of the patient and consequently use these data in decisions pertaining to the risks and benefits derived from specific treatments and provide insights into the psychological needs of the patient, which in turn can be used to enhance supportive care.

QoL assessments are necessary to develop and maintain the ethical standards of cancer medicine. However, the relative definition of the



Corazon A Ngelangel is a Professor in the Department of Internal Medicine–Medical Oncology and the Department of Clinical Epidemiology in the College of Medicine at the University of the Philippines in Manila. She is Co-Project Leader of the Philippine Study Group on Cancer Genetics, and was Secretary General of the eighth Asia Clinical Oncology Society International Convention in Manila in 2008. Professor Ngelangel is a member of many professional organisations, including the American Society of Clinical Oncology (ASCO).

E: cangelangel@cm.upm.edu.ph

concept makes measurement more complicated. Operationally, QoL is modified by cultural, socioeconomic, psychological and health-related factors. Ethnic origin, disease status and education have been shown to significantly influence QoL.¹⁴ Tchen et al.¹⁴ observed that there is a limited understanding of how patients from different cultural backgrounds assess their QoL. Moreover, there are several QoL measurement scales that may be applicable only to the population on which they have been validated. In the Philippines, the University of the Philippines (UP) Department of Epidemiology was commissioned by the Department of Health (DOH) (under the Philippine Cancer Control Programme) to make such a scale for Filipinos, the so-called UP-DOH QoL scale. This QoL scale was specifically designed to fill in the need for a culturally appropriate instrument that could measure the QoL of Filipino cancer patients.

The UP-DOH QoL scale¹⁵ defined the QoL of Filipino patients accordingly, and to Filipino cancer patients QoL meant: being free from disease; feeling well; being able to do the things one has been used to do; having no feelings of pain; not being afraid of dying; having the means to pay for the treatment (no financial concerns); having a good and comforting doctor; not undergoing surgery and chemotherapy because of the negative effect; being totally cured (getting out of the hospital); knowing that God will not forsake (me); having an understanding and supportive family; obtaining emotional support from family, friends and relatives; not seeing the husband and children suffer because of (her) ailment; ensuring a good future for the children even if (I am) gone; being able to still work and earn money; having hope in the future; going to the movies and malls alone and without fear of collapsing; and having a good memory. More than their own health, the majority of the patients expressed anxiety over money matters, the possibility of a premature separation from the family, the family's reaction to his/her diseased status and the effectiveness of treatment. Social support has been viewed as both a positive and a negative factor. Social support encourages and strengthens the patient to 'fight' for life; others find his/her status more painful and distressing the more the family provides concern, attention and love. God's mercy has been sought by almost all of the subjects.

However, overall the QoL of the cancer patients was moderate to high. Physical wellness, cognitive ability and self-care were rated as 'moderate'. Emotional wellbeing and social status were perceived as 'high'. Factors affecting QoL were:

- age – younger patients had better a QoL than those who were older, particularly in terms of physical, emotional and cognitive wellbeing;
- gender – female patients experienced significantly better QoL than males in most aspects except for cognitive ability; males suffer from greater mental anguish;

- civil status – single unmarried patients have significantly better QoL than married and separated/widowed patients, in all aspects;
- education – the higher the education, the better the QoL, in all domains except for self-care and related functions;
- site of cancer – patients with breast, cervical cancers and lymphomas experienced better QoL than those with lung, rectal/colon and nasopharyngeal cancers;
- stage of disease – stage I/II patients had better QoL than those with late-stage disease, particularly in physical and functional domains; and
- type of treatment – chemotherapy seemed to result in better QoL, except when in combination with surgery and pain control; among the single treatment methods, pain control and surgery resulted in the poorest QoL, followed by patients who had not undergone any treatment at all.

It has been assumed that cancer has a negative impact on the patient's QoL and in fact it does, particularly for older-age individuals. However, overall Filipino cancer patients are able to maintain a moderate to high QoL. A significant factor contributing to rather good QoL among Filipino cancer patients is their seemingly strong tendency to find meaning in their suffering. As a nation, and individually as well, Filipinos are said to be 'survivors'. The Filipino's spiritual richness – his/her great faith and hope in God's plan for his/her life, his/her attitude towards God's providence and his/hers' often fatalistic and deterministic attitude towards life – have given substance to the physical pain and the feelings of emptiness brought about by his/her diseased status. They can metamorphose themselves from an existentially sick person to an existentially well person. This same spiritual affluence has led the patients to have a strong sense of hope, either imagined or real. In another study among Filipino cancer patients, their relatives and doctors,¹⁶ instilling a sense of hope made the patients feel better. It helped them go through the initial stages of anger, denial and grief until they finally learned to accept their health status.

Coupled with this is his or her deep attachment to his or her family and friends, who reciprocally provide the love, concern and caring needed to meet the psychological requirements of everyday life despite uncertainties. Unlike in many cultures, Filipino families are supportive of one another in times of both greatness and doom. As Cordero et al.¹⁷ stated, "The Filipino family is an institution of security which protects its members from the exigencies of living. The members are bound to help each other...they protect members against all kinds of misfortunes..." In these changing times, particularly culturally, we hope that this unique Filipino culture stands the test of time in supporting the Filipino in times of greatness and doom, in times of health, psychological and social illness. The recommendation is for the continued awareness and positive practice of such Filipino values among Filipinos within the family, schools, the workplace and the community. Now, how can other Asian cancer patients assess their QoL? ■

1. Lancee WJ, Vachon ML, Ghadirian P, et al., The impact of pain and impaired role performance on distress in persons with cancer, *Can J Psychiatry*, 1994;39(10):617.
2. Schover LR, Sexuality and body image in younger women with breast cancer, *Natl Cancer Inst Monogr*, 1994;16:177.
3. Moynour CM, Measuring quality of life: An emerging science, *Semin Oncol*, 1994;5(Suppl. 10):48.
4. Langius A, Bjovell H, Lind MG, Functional status and coping in patients with oral and pharyngeal cancer before and after surgery, *Head Neck*, 1994;16(6):559.
5. Brasilis KG, Santa-Cruz C, Brickman AL, et al., Quality of life 12 months after radical prostatectomy, *Br J Urol*, 1995;75(10):49.
6. Schover LR, Yetman RJ, Tuason LJ, et al., Partial mastectomy and breast reconstruction, A comparison of their effects of psychosocial adjustment, body image and sexuality, *Cancer*, 1995;75(1):54.
7. Irvine D, Vincent L, Graydon JE, et al., The prevalence and correlate of fatigue in patients receiving treatment with chemotherapy and radiotherapy, A comparison with fatigue experienced by healthy individuals, *Cancer Nurs*, 1994;17(5): 367.
8. Singer MK, Redefining health: Living with cancer, *Soc Sci & Med*, 1993;37(3):295.
9. Fayos JV, Beland I, An inquiry on the quality of life after curative treatment. In: Kager AR (ed.), *Head & Neck Oncology Controversies in Cancer Treatment*, Boston, MA: Boston Hall, 1981;99.
10. Homquist JO, The concept quality of life, *Scan J Med*, 1981;10: 57.
11. Shaw A, Defining the quality of life, *Hastings Cent Rep*, 1977; 7(5):11.
12. Harwood P de L, Quality of life: descriptive and testimonial conceptualization, *Soc Indic Res*, 1976:471.
13. Liu BC, Quality of life indicators: A preliminary investigation, *Soc Indic Res*, 1974;1:187.
14. Tchen N, Bedard P, Yi Q-L, et al., Quality of life and understanding of disease status among cancer patients of different ethnic origin, *Br J Cancer*, 2003;89:641–7.
15. Ramiro LS, Ngangel CA, Amarillo ML, Streiner D, The UP-DOH QOL scale measures of quality of life of Filipino cancer patients, *Phil J Int Med*, 1997;35:179–88.
16. Ngangel CA, Ramiro LS, Process of disclosure in Philippine oncological practice, *Phil J Onco*, 1996;2(1):13–27.
17. Cordero FV, Panopio IS, *General Sociology: Focus on the Philippines*, Quezon City, Philippines: Ken Inc, 1969.