Cogitare Enfermagem

ORIGINAL ARTICLE

QUALITY OF LIFE AND RELIGIOUS/SPIRITUAL EXPERIENCES OF CANCER PATIENTS IN AN EMERGENCY SERVICE

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ABSTRACT

Objective: Evaluate the quality of life, spiritual experiences in cancer patients and their correlation.
Method: Cross-sectional study, carried out in the Emergency, from February to September 2017. Using the Medical Outcome Study 36 – Item Short-Form Health Survey for quality of life verification, with eight dimensions, the scores from 0 (worst condition) to 100 (best condition) and the Daily Scale of Spiritual Experience, with 16 items, scoring between 16 and 94 (lower scores reflect higher frequency of experience). The Spearman coefficient was used to correlate quality of life and spirituality.
Results: 83 patients, mean age 58 years, male predominance. The most compromised quality of life's dimension of was "physical aspect". The Spiritual Experience Scale presented a mean of 51, with a negative correlation between the quality of life and spirituality.
Conclusion: Spirituality is related to quality of life and should be considered in the care of cancer patients in the emergency.

DESCRIPTORS: Disease Impact Profile; Religion; Emergency Nursing; Oncology; Spirituality.

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QUALIDADE DE VIDA E EXPERIÊNCIAS RELIGIOSAS/ESPIRITUAIS DE PACIENTES COM CÂNCER EM UM SERVIÇO DE EMERGÊNCIA

RESUMO

Objetivo: avaliar qualidade de vida, experiências espirituais em pacientes com câncer e sua correlação.

Método: estudo transversal, realizado na Emergência, de fevereiro a setembro de 2017. Utilizado o Medical Outcome Study 36 – Item Short-Form Health Survey para verificação da qualidade de vida, com oito dimensões, escore de 0 (pior estado) a 100 (melhor estado) e a Escala Diária de Experiência Espiritual, com 16 itens, pontuação entre 16 e 94 (menores pontuações refletem maior frequência de experiências). Utilizou-se o Coeficiente de Spearman para correlacionar qualidade de vida e espiritualidade.

Resultados: 83 pacientes, média de idade 58 anos, predomínio masculino. A dimensão da qualidade de vida mais comprometida foi "aspecto físico". A Escala de Experiência Espiritual apresentou média 51, com correlação negativa entre qualidade de vida e espiritualidade.

Conclusão: a espiritualidade relaciona-se com qualidade de vida e deve ser considerada no atendimento a pacientes com câncer na emergência.

DESCRITORES: Perfil de Impacto da Doença; Religião; Enfermagem em Emergência; Oncologia; Espiritualidade.

CALIDAD DE VIDA Y EXPERIENCIAS RELIGIOSAS/ESPIRITUALES DE PACIENTES CON CÁNCER EN UM SERVICIO DE EMERGENCIA

RESUMEN:

Objetivo: evaluar la correlación entre la calidad de vida y las experiencias espirituales en pacientes con cáncer.

Método: estudio transversal, realizado en el Departamento de Emergencias, de febrero a septiembre de 2017. Par verificar la calidad de vida se utilizó el Medical Outcome Study 36 – Item Short-Form Health Survey, con ocho dimensiones, puntaje de 0 (peor estado) a 100 (mejor estado) y la Escala Diaria de Experiencia Espiritual, con 16 ítems, puntajes entre 16 y 94 (los puntajes más bajos reflejan una mayor frecuencia de experiencias). El coeficiente de Spearman se utilizó para correlacionar la calidad de vida y la espiritualidad.

Resultados: el estudio se realizó con 83 pacientes, edad promedio 58 años, predominantemente hombres. La dimensión de calidad de vida más comprometida fue el "aspecto físico". La escala de experiencia espiritual mostró un promedio de 51, con una correlación negativa entre calidad de vida y espiritualidad.

Conclusión: la espiritualidad está relacionada con la calidad de vida y debe considerarse en la atención de pacientes con cáncer en la sala de emergencias.

DESCRIPTORES: Perfil de Impacto de la Enfermedad; Religión; Enfermería de Emergencia; Oncología; Espiritualidad.

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INTRODUCTION

Cancer is the name of a set of diseases that are characterized by the multiplication of cells in a disorderly way, by a mutation in the cellular DNA, in some tissue or organ of the body, and can invade other systems of the body through blood vessels, in a process called metastasis[1,2]. It is a public health problem recognized by the World Health Organization (WHO), being the second largest cause of death in Brazil, with an estimated of over 600,000 new cases for each year of the 2018-2019 biennium[1-4].

Cancer patients experience at least one emergency during their illness and the development of new treatments and strategies for cancer patients has resulted in prolonged life and an increase in the number of emergencies that can be experienced as a result of these new treatments[5].

Oncologic emergencies can be categorized as metabolic (hypercalcemia, Syndrome of Inappropriate Antidiuretic Hormone Secretion, Tumor Lysis Syndrome), hematologic (febrile neutropenia), structural (peripheral nerve or spinal cord compression, malignant pericardial effusion) or side effects of chemotherapeutic agents (diarrhea, leakage)[5,6].

The emergency unit requires high complexity assistance in caring for patients at imminent risk of life. The professionals of this sector live daily under the pressure caused by the need for time buying, speed, and precision, by the high demand for care services and by the daily experiences of death and suffering. It, therefore, becomes a challenge for nursing in this scenario to build its own doing, considering all the dimensions of care[6].

Humanized assistance aims to assist the human being in its entirety, taking care of both the sick and the healthy components of the being, such as spirituality/religiosity.

Spirituality and religion are considered popularly synonymous, but their definitions are different. The former has a broad and personal concept, is the way the individual relates to others, to nature, and to the universe, besides being the search for answers about the meaning and purpose of life; it is the capacity to deal with feelings and frustrations. Religion, on the other hand, is a set of organized beliefs associated with ritualistic practices, where one follows norms and dogmas of a doctrine, shared by a community to bring them closer to what is sacred, divine[4-7].

Spirituality can be a strategy for patient's confrontation with cancer, assigning meaning to the process of illness and suffering[8,9]. It is important to emphasize that the spiritual/religious practice, in the context of the treatment of chronic diseases, must exist together with the practice of medicine. The improvement in mental health provided by faith makes it possible to increase adherence to medical treatment[7].

WHO establishes that religiosity and spirituality are concepts that make up the Quality of Life (QL)[10]. A review study on health-related quality of life of patients with advanced cancer showed in results that spiritual interventions can promote significant improvement in clinical manifestations and QL[11]. Among the beneficial effects of religious/spiritual practices are reduced stress and depression, better blood pressure control, reduced use of alcohol or other substances, a higher level of well-being, optimism and hope[12].

Given the increase in the number of cancer patients in Brazil and the consequent growth in the demand for Emergency Service by this population, the knowledge about QL and its relationship with the religiosity/spirituality of the oncologic patient in an emergency situation is fundamental, with a view to comprehensive and welcoming assistance in this scenario of professional practice. Moreover, studies on this topic in the emergency are still scarce.

Given the above, this study aimed to evaluate the quality of life, measure the frequency of religious/spiritual experiences in patients diagnosed with cancer seen in an emergency service, and verify their correlation.

METHOD

This is an epidemiological, cross-sectional, and analytical study carried out in the emergency service of a teaching hospital in the city of São Paulo from February to September 2017. 83 patients were included in the study who met the inclusion criteria: age over 18 years, previous diagnosis of cancer, no respiratory discomfort nor hemodynamic instability at the time of data collection and accepted to participate freely in the research.

The sample calculation was performed by the stratified probabilistic sampling method proportional to the average number of patients over 18 years of age, who sought care in the Emergency Department of the study hospital in the six months preceding the survey. The calculation considered a confidence degree greater than or equal to 80% and an alpha of 5%, based on the characteristics of age, gender, education, marital status, occupation, religion, support network, color, and family income. The result pointed out the need to include 80 patients to accomplish the goals proposed.

For the survey of socio-demographic data, a structured questionnaire prepared by the researchers was applied. In order to evaluate QL, the Medical Outcome Study 36 – Item Short-Form Health Survey (SF-36)[12] instrument was applied, translated, and validated in Brazil. SF-36 is a generic questionnaire composed of eight dimensions (functional capacity, physical aspect, pain, general health status, vitality, social aspect, emotional aspect, and mental health), and the score for each dimension varies from 0 (worst health status) to 100 (best health status)[12]. To measure the frequency of religious/spiritual experiences, the Daily Spiritual Experience Scale was used[12]. It evaluates the frequency that people live, in their daily lives, experiences such as the sensation of God's presence, strength, and comfort in religion or spirituality, connection with life in general, love for others, admiration for nature, inner peace, gratitude for blessings and desire for closeness with God. It consists of 16 items and is considered a one-dimensional measurement. The total score is obtained by summing the scores of the 16 items and can vary from 16 to 94. Lower scores reflect a higher frequency of religious/spiritual experiences[13].

The categorical variables were presented by means of tables in their absolute and relative frequencies, and the continuous variables by mean, standard deviation, median, minimum and maximum.

To verify the relationship between QL and religious/spiritual experiences, Spearman's Correlation Coefficient was used. The Statistical Package for the Social Sciences program was used for analyses, version 19. The significance level adopted was 5% and the statistics with a descriptive p less than or equal to 0.05 were considered significant.

The data were collected upon approval by the Ethics Committee of the Federal University of São Paulo (Opinion No. 1,903,796 /CAAE No. 63925317,4,0000,5505) and signature of the informed consent form by the participants. The survey was carried out within the ethical standards described.

RESULTS

The sample consisted of 83 patients with a mean age of 58 years, ranging from 25 to 84 years, 54.2% male, 46.9% married and 33.7% black. Among the patients involved in the study, 42 (50.6%) were pensioner/retired, 36 (43.3%) reported having attended until elementary school and 28 (33.7%) had a family income of up to two minimum wages, as shown in Table 1.

Table 1 - Sociodemographic and economic data of patients diagnosed with cancer seen in the Emergency Department. São Paulo, SP, Brazil, 2017

Variables	n (%)
Age	
Mean (SD)	58.1 (12.4)
Median (minimum - maximum)	60 (25-84)
Gender	
Male	45 (54.2)
Female	38 (45.7)
Marital status	
Married	39 (46.9)
Widow/Widower	19 (22.8)
Divorced/separated	15 (18.0)
Single	10 (12.0)
Skin color	
Black	28 (33.7)
White	27 (32.5)
Brown-skinned	26 (31.3)
Asian	2 (2.4)
Occupation	
Pensioner/retired	42 (50.6)
Employee	16 (19.2)
Unemployed	15 (18.0)
Housewife	10 (12.0)
Schooling	
Elementary School	36 (43.3)
High school	26 (31.3)
Higher education	18 (21.6)
Illiterate	3 (3.6)
Family income	
up to 1 MW†	11 (13.2)
2 MW	28 (33.7)
3 MW	25 (30.1)
4 MW	17 (20.4)
5 MW	2 (2.4)
Number of the family income dependents	
Mean (SD)	2.3 (0.9)
Median (minimum - maximum)	2 (1-4)

†SM (MW) - Minimum Wage (amount = R$ 937,00)

Table 2 presents the clinical characteristics of the patients who composed the sample. The most frequent type of cancer was that of the reproductive system, followed by the gastrointestinal. 66 (79.5%) patients had comorbidities, with cardiopathy prevailing, 14 (69%). Among the participating patients, 81 (97.5%) used continuous medication, the most frequent class being analgesics, 49 (49%). The average length of stay was 1.7 days, ranging from one to seven days.

Table 2 - Clinical characteristics of patients diagnosed with cancer seen in the Emergency Department. São Paulo, SP, Brazil, 2017

Variables	**n (%)**
Types of neoplasia (systems)	
Reproductive	19 (22.9)
Gastrointestinal	18 (21.6)
Blood	9 (10.8)
Lymphatic	7 (8.43)
Respiratory	7 (8.43)
Urinary	11 (13.2)
Pele	4 (4.82)
Endocrine	4 (4.81)
Central Nervous	2 (2.41)
Skeletal muscle	2 (2.41)
Comorbidities	
Cardiopathy	28 (33.7)
Arterial Hypertension	27 (32.5)
Diabetes Mellitus	26 (31.3)
Nephropathy	2 (2.4)
Respiratory diseases	
Medicines in use	42 (50.6)
Analgesic	16 (19.2)
Antihypertensive	15 (18.0)
Hypoglycemic	10 (12.0)
Gastric protector	26 (31.3)
Hypolipid	36 (43.3)

Of those interviewed, 74 (89.1%) had some religion, with a predominance of Catholic 30 (40.5%), followed by Evangelical 29 (39.1%).

Among the participants, 45 (54.2%) said they did not have any support network. Basic Health Units (*Unidades Básicas de Saúde*, UBS) were the most cited 16 (42.1%) by those who reported having support. The church, combined with the UBS, was cited as a

support network by five (13.1%) participants.

Table 3 shows that the dimensions of quality of life most compromised were "Physical Aspect" (23.1), followed by "General Health Status" (28.1) and "Functional Capacity" (38.3). For the Daily Spiritual Experience Scale, those involved in the study had an average score of 51.

Table 3 - Quality of life (SF-36) and the frequency of religious/spiritual experiences of patients diagnosed with cancer seen in the Emergency Department. São Paulo, SP, Brazil, 2017

SF-36 Dimensions	Mean (SD)
Functional capacity	38.3 (21.7)
Physical aspect	23.1 (26.4)
Pain	43.8 (14.2)
General health status	28.1 (9.2)
Vitality	40.5 (14)
Social aspects	44.3 (16.7)
Emotional aspects	39.2 (32.6)
The scale of religious/spiritual Experience	51 (13.7)

There was a statistically significant negative correlation between all dimensions of the SF-36 and the score of the Daily Spiritual Experience Scale. Therefore, the lower the frequency of religious/spiritual experiences, the worse the QL score, as shown in Table 4.

Table 4 - Correlation of SF-36 dimensions with religious/spiritual experiences in patients diagnosed with cancer seen in the Emergency Service. São Paulo, SP, Brazil, 2017

Dimensions SF-36	Religious/spiritual experience scale	
	R†	p-value
Functional capacity	-0.40	0.0002
Physical aspect	-0.22	0.0485
Pain	-0.45	0.0001
General health status	-0.44	0.0001
Vitality	-0.54	0.0001
Social aspects	-0.54	0.0001
Emotional aspects	-0.46	0.0001
Mental health.	-0.63	0.0001

†Spearman Correlation Coefficient

DISCUSSION

The profile of the studied sample shows a predominance of men, with an average age of 58 years, Catholic religion and elementary education. Among the systems affected by cancer, most cases involve the neoplasms of the reproductive system. Similar results such as age between 41 and 60 years, elementary school, a predominance of the Catholic religion and neoplasia of the reproductive system were found in patients of another study whose objective was to investigate interrelationships between spiritual well-being, depression, and quality of life during the treatment of cancer; the main difference was that women composed the majority of the sample[14].

Most of the participants (79.5%) in this study had comorbidities, the most prevalent being heart disease (69.0%), and 97.5% used medicines, analgesics were the most cited. This can be explained by the increase in life expectancy and, consequently, in chronic non-communicable diseases such as cardiovascular diseases[15]. The high use of painkillers can be explained by the fact that pain is one of the main symptoms affecting cancer patients; in Brazil, it is estimated that from 62% to 90% of cancer patients have some form of pain[16].

Most of the interviewees in this study responded that they have a support network, with the Basic Health Units being the most cited. A study aimed at investigating the interrelationships between spiritual well-being, depression, and quality of life during the treatment of cancer has shown a significant search by oncologic patients for spirituality and an improvement in their quality of life, and the support of their spouse, other family members, friends, and religious people constitute a social network to support these patients[14]. The interrelationships of the individual in their various environments: family and work, health and culture, values, beliefs, affect relationships. Thus, the ties established in the support network may or may not enhance the development process of the individual to deal with their disease[17].

In this study, the dimensions of quality of life most compromised were "Physical Aspect", followed by "General Health Status" and "Functional Capacity". In the same way, a study that evaluated the quality of life of lung cancer patients[18] showed lower quality of life scores for all domains when compared with healthy individuals, bringing also, like the present study, the domain of physical aspects as the one with the lowest score.

The domain Physical aspects evaluates the limitations regarding the type and load of work, as well as the extent to which these limitations make it difficult to carry out the work and activities of daily life[19]. We can infer that a decrease in the score value of physical aspects may be related to the symptoms arising from the disease and/or treatment, although we have not applied a scale to quantify symptoms. These symptoms can bring limitations to the performance of daily life and work activities, interfering directly with the quality of life.

A study that evaluated the health-related quality of life of cancer patients in palliative care showed the Health General State dimension as also being one of the worst evaluated[20].

Other studies[18,20,21] corroborate the influence of cancer on functional capacity and quality of life in cancer patients, with impairments to daily life activities, social relationships, and financial situation.

A study that found an association between quality of life and functional capacity during the treatment of hematological cancer also found an association between lower QL scores and functional disability, with fatigue being the symptom that was shown to be associated with disability for basic daily life activities and insomnia for instrumental activities[22].

A review study[9] identified signs and symptoms as low QL predictors: pain, fatigue, sleep disorder, depression, nutritional changes, among others.

Given that cancer can strike any organ and that treatment approaches have the

potential for multi-systemic effects, cancer nursing practice, at any level of attention, requires a broad knowledge of all organ systems, as well as accurate problem identification assistance. The above findings show that nursing care focused on controlling signs and symptoms is essential to improve the quality of life of the cancer patient.

Respondents to this survey had a low mean score for religious/spiritual experiences This result deserves attention since religious individuals can behave healthier since most religions guide on healthy life habits[23]. Religious and spiritual living is something that can provide greater contact with the inner subjective reality and favor possible changes in attitudes and ideas regarding the current experiences of each individual's reality[24].

The present study verified that the lower the frequency of religious/spiritual experiences, the worse the quality of life. Other studies involving cancer patients have also shown a positive influence of religiosity and spirituality, both in physical health and in mental and social health, as well as in the confrontation of illness and other health hazards, that is, religiosity/spirituality has a direct influence on QL[14,25,26].

A cross-sectional study conducted in Chile with 208 patients, evaluating the association between spiritual pain and quality of life in cancer patients, showed that lower scores in the evaluation of the quality of life were associated with younger people, with greater physical suffering, anxiety or depression and less religiosity and religious confrontation. In the multivariate analysis, QL was independently associated with spiritual pain, religious confrontation, and physical suffering[27]. These findings may propose that the evaluation of religiosity/spirituality can give subsidies to the health team to implement actions for the quality of life improvement.

For cancer patients, the relationship between illness and the possibility of death makes religious confrontation a strategy for reducing stress and improving quality of life .

We can point as limitation of this study the fact that it has been performed in only one center, with assistance given only to patients in the public health system, which may not represent other realities. Other studies involving the subject with this population should be encouraged. However, this study reinforces that the oncologic patient, including the one treated in an emergency, must be cared for in their entirety, and that religious/spiritual issues must be considered by the health team so that their positive influence contributes to the quality of life and the confrontation of the problems experienced.

CONCLUSION

The present study showed that the QL dimension most compromised was "Physical Aspect", followed by "General Health Status" and "Functional Capacity". The interviewees presented a low frequency of religious/spiritual experiences. A correlation between QL and religious/spiritual experiences was observed for cancer patients in an emergency service, and the lower the frequency of religious/spiritual experiences, the more compromised QL was.

This study is expected to contribute to positive changes in the professional practice of emergency nurses. Seeking to provide safe and humane care to cancer patients are important aspects that need to be pursued at all times, as well as valuing and respecting spirituality/religiosity in care practice so that professionals can contribute to improving the quality of life of these patients in health services.

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