Concept Analysis: Quality of Life

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**Concept Introduction**

The term “quality of life” is used frequently in health care and in nursing practice. However, this term is not very well defined and perceptions of the meaning of quality of life often vary. Advance practice nurses work to improve the quality of a patient’s life through health promotion, disease prevention, and disease management. Issues of quality of life are faced by advance practice nurses when dealing with health care advances that increase the life span. Advance practice nurses hold the goal of improving the quality of their patients’ lives, but the vague nature of this term leads to a lack of clarity on how this should be accomplished. Decisions for treatment and goals for care are based on the affect those will have on the quality of a patient’s life. Differences in what is meant by quality of life can lead to different treatment goals, choices, and outcomes.

How can advance practice nurses make decisions based on improving the quality of patients’ lives without knowing what that really means? The purpose of this concept analysis of the term quality of life is to bring clarity to the meaning of this term by examining the various ways it is used in health care and other disciplines. Clarifying what is meant by quality of life will help those in health care communicate with each other and with patients and their loved ones about quality of life. Clarification of the concept will also help guide treatment decisions and care goals related to improving quality of life. This clarification will be accomplished by looking in literature at the many ways that the term has been used. From these definitions, the critical attributes of the term will be determined followed by example cases using those attributes. The antecedents and consequences will then be determined followed by an operational definition of the term quality of life that includes all the critical attributes. The empirical referents will then be identified and described.
Uses of the Concept

Quality of life has been defined in a variety of ways by many different sources. The Oxford English Dictionary (2010) defines quality of life as “the standard of living, or degree of happiness, comfort, etc., enjoyed by an individual or group in any period or place” (para. 1). Mosby’s Medical, Nursing, & Allied Health Dictionary (1998) defines quality of life as “a measure of the optimum energy or force that endows a person with the power to cope successfully with the full range of challenges encountered in the real world” (p. 1370).

From a philosophical and ethical perspective, Jennings (2002) says that “the term quality of life seems to imply that life is not intrinsically worthy of respect, but can have greater or lesser value according to its circumstances” (para. 3). It is an “interaction between the person and his or her surrounding circumstances, including other people” (para. 7). He also points out that quality of life is “sometimes used to refer to the moral worth or value of a person and his or her life” (para. 9) and “hedonic theories identify quality of life with states of awareness, consciousness, or experience of the individual” (para. 11). Jennings says that rational preference theories define quality of life “in terms of the actual satisfaction or realization of a person’s rational desires or preferences” (para. 13) and that “individuals have a good life when the objective state of the world conforms to what they rationally desire” (para. 13).

From a religious perspective, O’Connell (2007) defines quality of life as spiritual wellbeing, spirituality, religious issues, feelings of hope, personal beliefs, religiosity, and inner peace.

The World Health Organization (WHO) (2004) defined quality of life as “the product of the interplay between social, health, economic and environmental conditions which affect human and social development. It is a broad-ranging concept, incorporating a person’s physical health,
psychological state, level of independence, social relationships, personal beliefs and relationship to salient features in the environment” (p. 48). WHO (2004) also defined health related quality of life measure as an “individual outcome measure that extends beyond traditional measures of mortality and morbidity to include such dimensions as physiology, function, social activity, cognition, emotion, sleep and rest, energy and vitality, health perception and general satisfaction” (p. 31).

Haas (1999) defined it as “a multidimensional evaluation of an individual’s current life circumstances in the context of the culture in which they live and the values they hold. [quality of life] is primarily a subjective sense of well-being encompassing physical, psychological, social, and spiritual dimensions. In some circumstances, objective indicators may supplement or, in the case of individuals unable to subjectively perceive, serve as a proxy assessment of [quality of life]” (p. 738).

Plummer (2009) discusses quality of life as being contextual and health related, defining it as “an intangible, subjective perception of one’s lived experience” (p. 139).

Kane (2003) defines quality of life as a “summary term, connotating a multidimensional appraisal of a variety of important aspects of life, including health outcomes” (p. 30) and health related quality of life as “aspects of life affected by a person’s health condition and its treatment” (p. 30). Some of the aspects of qualities of life he lists are physical health and functioning, emotional health, cognitive functioning, role performance and work productivity, sexual functioning, life satisfaction, ability to perform activities of daily living, psychological well-being, and social involvement.

Xavier (2003) says that quality of life “is increasingly acknowledged as an assessment strongly dependent on the person’s subjectivity” and “two persons with the same functional state
or the same ‘objective’ health condition…can have very different qualities of life due to these subjective aspects” (p. 30).

Lowey (1992) defines quality of life as short term health outcomes that are influenced by the health state in which one resides.

Morgan (2009) says that quality of life is evaluated in cancer survivorship based on a perception of control, aches and pains, uncertainty, satisfaction, future appearance of cancer, fatigue, family income, valuing and living life to the fullest, and increased family closeness.

Grewal (2006) defines aspects of quality of life as being relationships with family and others, own health, health of close others, independence, emotional or psychological health, religion and spirituality, finances and standard of living, social and leisure activities, home and surroundings, enjoyment, security, and control.

Johnson (1997) discusses quality of life as being personal job satisfaction, income, neighborhood schools, status of the region’s arts and cultural amenities, air quality, and racial tolerance. Johnson also defines non health related quality of life as the quality of the environment, personal resources, leisure time, houses paid for, successful investments, disposable income, opportunities to develop interests and create satisfying environments, housing, and air quality.

Sugiyama (2009) talks about quality of life being related to neighborhood open spaces, the pleasantness and safety of these open spaces, social interaction, social activity, and regular physical activity.

Albert (2002) makes a distinction in discussing health related quality of life. He defines health related quality of life as relating to functional status, mental health, emotional wellbeing, social engagement, and symptom states. Health related quality of life refers to ambulation,
mobility, body care and movement, communication, alertness behavior, emotional behavior, social interaction, sleep and rest, eating, work, home management, and recreation.

Meeberg (1993) discusses quality of life as being subjective and individualized with the critical attributes of a sense of well-being, happiness, conditions of living, life satisfaction, an acceptable state of physical, mental, social, and emotional health, or an objective assessment by some one else that the living conditions of that individual are adequate and not life threatening.

Taylor (2008) describes quality of life as subjective, multi-dimensional, and dynamic. It is the relationships between individual circumstances and culture and an individual’s appraisal of life and fulfilling life goals. Some of its attributes are sanctity of life, economic growth, gross national product, and a rise in life expectancy.

Mandzuk (2005) also describes quality of life as multidimensional, subjective, dynamic, and on a continuum with attributes of spiritual well-being, income, housing, education, social relations, happiness, and morale.

The critical attributes are the “characteristics of the concept that appear over and over again” (Walker & Avant, 1995, p. 41). The critical attributes of quality of life are subjective satisfaction, multidimensional, and dynamic. It is a subjective evaluation of life satisfaction. This subjective nature of the term quality of life is seen in the definitions of the term when descriptive words such as perception, context, interpretation, and individualized are used. It is unique to each individual and based on their assessment and evaluation of their situation. However, it can be measured through objective evaluation if a subjective assessment is not available. Satisfaction is multidimensional which means it can include a variety of physical, psychological, spiritual, and social domains of life. The physical domains include those
attributes in the definitions such as activities of daily living, functional status, exercise, physical health, cognitive function, sexual function, sleep and rest, and comfort. The psychological domain includes those attributes from the definitions such as fulfillment, emotion, happiness, enjoyment, security, control, independence, and satisfaction. The spiritual domain includes attributes from the definitions such as meaning, inner peace, morale, religion or spirituality, and sanctity. The social domain includes attributes from the definitions such as relationships with others, work productivity, income, role performance, recreation, social engagement, personal resources, and environment. It is also dynamic in that it is continually changing and on a continuum depending on life circumstances, disease state, developmental state, etc.

**Model Case**

A model case is “a ‘real life’ example of the use of the concept that includes all the critical attributes of the concept” (Walker & Avant, 1995, p. 42). The following is a model case for the concept of quality of life. Mary is a 43 year old mother of two children with a loving husband and supportive friends. She just paid off her house and has already set aside money for her children for college and for retirement. She recently got promoted in her job, which included a raise, so she is financially secure. In reflecting on her life Mary feels a sense of happiness and satisfaction. She is satisfied with her health, family, friends, and financial stability. She feels loved and supported and thinks that life in general is very good.

This case represents all the critical attributes of quality of life. Mary makes a subjective analysis of her life situation and is satisfied with it on many dimensions including emotional happiness, social satisfaction, financial security, and physical health. It is important to note that those are the dimensions that are important to Mary’s life satisfaction. Not all dimensions need
to be included, but the subjective assessment can be multidimensional or one dimensional depending on what is important to each individual. This is dynamic since it changes. Mary is currently satisfied with her life but these circumstances and her satisfaction may have changed previously and may continue to change with time.

**Borderline Case**

Borderline cases "contain some of the critical attributes of the concept being examined but not all of them (Walker & Avant, 1995, p. 43). The following is an example of a borderline case for the concept of quality of life. John is 58 year old male who lost his wife to cancer one year ago. He has three children and five grandchildren. He owns his own home and is set to retire next year. He is an active member at his temple and is involved in social activities through the temple. He has personally had no health problems and remains very active, walking several miles every morning. John is happy with his life but is struggling with depression after the loss of his wife.

This case represents most of the critical attributes of quality of life but not all of them. John has subjectively assessed his situation and even though he is fairly happy and seems from the outside to have a great life, he is not satisfied. It is multidimensional since he is assessing many areas of his life but deciding that what is important to him is his relationship with his wife. He is not completely satisfied with life because of a loss of the relationship with his wife. This is dynamic since his satisfaction has recently changed due to the loss of his wife and might change in the future as he adjusts to life without his wife. This scenario includes all aspects of quality of life except for satisfaction.
Related Case

Related cases are cases that are “related to the concept being studied but that do not contain the critical attributes” (Walker & Avant, 1995, p. 44). Julie is watching the news and there is a clip about an elderly gentleman who just won quite a bit of money in the lottery. She thinks that he will always be happy in life since he is financially set for life.

It may, on the surface, seem like this man is experiencing a high quality of life, but this scenario is missing many of the critical attributes. It does not contain a subjective analysis of satisfaction with life but an observation by someone who does not know what is important to that individual that he must be happy. It is not multidimensional since it is not taking into account any other aspects of life other than financial security and is not looking at what might be important for quality of life for that individual. It is not dynamic since it assumes that the gentleman will always have a high quality of life because of one incidence.

Contrary Case

Contrary cases are examples of “not the concept” (Walker & Avant, 1995, p. 44). Phyllis is an 89 year old female with terminal cancer. She has been hospitalized for almost three months. She is confused and unable to make decisions regarding her care. She cannot feed herself and is incontinent. She frequently moans or calls out for help and says she wants to die. Phyllis’ son has power of attorney and insists that his mom would want everything done for her but will not allow her to receive pain medicine since it makes her too sleepy. A feeding tube is placed, and Phyllis is intubated and weaned off on several occasions. The son says he wants the doctors and nurses to do whatever they need to in order to keep his mother alive.
This case is the opposite of the critical attributes of quality of life. Phyllis has not subjectively assessed her life situation, and there is no objective assessment of her life satisfaction but instead only with the fact that she is alive. Care is based on keeping Phyllis alive rather than assessing her needs or satisfaction on the many dimensions of her life and is thus not multidimensional.

**Antecedents**

Antecedents are the “events or incidents that must occur prior to the occurrence of the concept” (Walker & Avant, 1995, p. 45). The major antecedent to quality of life is having life itself (Haas, 1999) since that life must be present before quality of life can occur. One cannot discuss the quality of life of something without life. Several sources suggest that another antecedent is cognitive ability (Haas, 1999) or state of consciousness (Meeberg, 2003). Taylor (2008) suggests that an antecedent to quality of life is the ability to assess, appraise, and evaluate life, and the ability to make decisions. Even when quality of life is evaluated by others, they must also have cognitive ability to assess, appraise, and evaluate life. The two major antecedents to quality of life are then life itself and a cognitive ability to assess quality of life.

**Consequences**

Consequences are “those events or incidents that occur as a result of the occurrence of the concept” (Walker & Avant, 1995, p. 45). It is difficult to discuss the consequences of a quality of life but instead the consequences of quality of life have to do with a degree of quality of life or a change in status of quality of life, either positive or negative. It can result in increased or decreased life satisfaction (Sugiyama, 2009), happiness, a feeling of well-being, self-esteem, and pride (Meeberg, 1993). It can result in improved physical and psychological health (Mandzuk,
The change can also result in a changed perception of life and thus in decisions to make changes to one’s circumstances (Haas, 1999) and changes in choices of daily activities (Albert, 2002). It can result in the provision for individual choices, opportunities for participation in self care (Kane, 2003), and achieving important life functions (Grewal, 2006). Another consequence can be disease management and changes in treatment and practice choices (Plummer, 2009). It can also result in an increase in empowerment (Taylor, 2008) or resiliency (Xavier, 2003), especially in the face of illness or aging (Albert, 2002). It could also result in restitution for biopsychosocial losses (Xavier, 2003), acceptance of life’s circumstances (Taylor, 2008), or improved coping (O’Connell, 2007). It can result in the maintenance of the dignity of the individual and a respect for individuality and preferences (Kane, 2003). Another consequence can be cost containment.

**Operational Definition**

Quality of life is a subjective assessment of an individual’s personal satisfaction with the dynamic life circumstances that can include multidimensional domains of life including physical, psychological, spiritual, and social aspects.

**Empirical Referents**

Empirical referents are “classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself” (Walker & Avant, 1995, p. 46). Because the critical attributes of quality of life include a subjective component, an empirical referent of quality of life would be an individual subjective analysis of life satisfaction (Taylor, 2008). That is truly the best case when quality of life can be determined. The best way to determine the presence of quality of life is if patients themselves can rate their quality of life...
(Albert, 2002) or their feelings of satisfaction, happiness, or well-being (Meeberg, 1993). The World Health Organization (WHO) developed a tool to evaluate quality of life called “WHOQOL.” It consists of a 28 item questionnaire that taps into physical, functional, psychological, social, and satisfaction elements (Kane 2003).

Several tools have been developed to objectively determine the occurrence of quality of life when subjective statements are not available. Although these are not exactly empirical referents since they do not, by their existence, demonstrate the occurrence of the concept but instead are useful tools, and a close approximation of quality of life in the absence of an individual’s subjective analysis of their own quality of life. Those quality of life questions can be asked of proxy informants such as family members who are presumed to know the individual well (Kane, 2003). Observations can also be made that can determine quality of life which include observations of individual’s behavior and information about their physical, social, and care environments (Kane, 2003) and ability to set and achieve goals, express feelings of discontent, initiate and respond to change, and develop and maintain satisfactory relationships (Taylor, 2008). An absence of quality of life can also be determined through observation of evidence of abuse, inadequate living conditions to support life (Taylor, 2008), and intense suffering (Haas, 1999). However, it is important to note that these things do not mean that there is a decreased or absence of quality of life. Since quality of life is an individualized subjective analysis of one’s own situation, individuals may not consider some of these factors to decrease their quality of life. They may, for example, find meaning in their suffering that in fact improves their quality of life. This is why the best determinant of quality of life is the individual’s own subjective assessment.
Conclusion

Quality of life is a term that is used often in health care but is not clearly defined. The aim of this concept analysis was to bring more clarity to the term for use in clinical practice. The literature review and analysis showed that the term is hard to pin down to one objective definition applicable in any context. However, clarity was accomplished through the analysis of the uses of the concept in literature, the identification of the critical attributes, and ultimately the articulation of an operation definition based on those critical attributes.

What is most important for advanced practice nurses to take from this analysis is the subjective nature of quality of life. In the absence of subjective assessments of quality of life, however, objective assessments can be made by those close to the individual who may know what they would have valued. However, it must be remembered that quality of life is multidimensional where many of the dimension are assessed and quality of life is ultimately determined by what is important to the individual. When deciding on care goals and treatment plans, these must be made in collaboration with the patient so that the patient can determine what he/she values and what would improve his/her quality of life. The practitioner needs to put aside his/her personal opinions are on what would improve quality of life and instead listen to the patient’s wishes and goals. Quality of life is ultimately what an individual says it is, and when that is heard and respected, the highest and most individualized quality of care can be provided.
References

Comment: References would be listed here according to APA formatting. Also include the concept table, either in a separate attachment for copied and pasted to the end of the paper, which ever is easiest.