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HEALTH RELATED QUALITY OF LIFE OF HOSPITALIZED PATIENTS

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ABSTRACT

An exploratory, descriptive and cross-sectional study to evaluate health-related quality of life (HRQoL) of hospitalized patients in a public university hospital. The unit has 31 beds and serves patients aged 14 and older, adults and elderly, of both sexes, for clinical and surgical treatment. It was elaborated an instrument for the data referring to sociodemographic characterization and clinical data. The WHOQOL-Bref instrument, abbreviated version, was used to evaluate HRQoL. The sample consisted of 110 individuals. The HRQoL assessment, through the WHOQOL-Bref, indicated that the Social Relations domain had a higher score, with an average of 73.03 ± 14.67, that is, a higher positive impact on HRQoL. The Physical domain had the lowest score, with 57.42 ± 16.74, indicating a greater negative impact on HRQoL. The HRQoL assessment among study participants presented values close to the total mean of the scale, which could indicate reasonable levels of quality of life, overall. The worst evaluation was for the Physical domain, easily understood due to the health condition in which they were. On the other hand, the best evaluation was for the Social Relations domain, comprising an adequate support network to support during the period of hospitalization.

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INTRODUCTION

The quality of life (QoL) is a comprehensive concept, being associated with several factors, both individual and socioenvironmental and sociocultural (Angelim *et al.,* 2015). Given the complexity of this term, the use of instruments to measure it has facilitated the understanding of the needs of individuals in their contexts (Angelim *et al.,* 2015). According to the WHOQOL Group (WHOQOL, 1995), QOL can be defined as "the individual's perception of their position in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns". Still, it is of paramount importance to consider the physical, psychological, level of independence, social relations, and spiritual pattern (WHOQOL, 1995). The evaluation of the Health Related Quality of Life (HRQoL) has as main concern how the disease or chronic condition, in addition to its symptoms, begin to interfere in the daily life of an individual, that is, how much the manifestations of the disease or treatment are felt by the patients. This term has been used to avoid ambiguity between the definition of quality of life under common sense and that used in clinical studies in the area of health (Fayers and Machin, 2007). For hospitalized individuals, it is important to evaluate their HRQoL, also considered as an indicator of health, considering the multidimensional factors that can affect it, such as: environmental, psychological, social, among others(Campos and Rodrigues Neto, 2008).

The WHOQOL-Bref (Fleck *et al.,* 2003) is considered one of the most used instruments for the evaluation of the HRQoL, understanding it as a construct that includes subjectivity, multidimensionality and presence of positive and negative dimensions (Fleck *et al.,* 2000). Thus, considering all the aspects that permeate the needs of the hospitalized individual, the main objective of this study is to evaluate the HRQoL of hospitalized patients.

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Table 1. Descriptive analysis of the sociodemographic characteristics of subjects hospitalized in the medical and surgical clinic unit of a public hospital in the interior of the state of Parana (n = 110). Cascavel, PR, Brazil, 2018

Variables	n (%)	Median	Amplitude	Average±S.D.
Sex				
Male	64 (58.2)			
Female	46 (41.8)			
Age (years)		50.5	18 a 89	49.7±18.4
Marital status				
Married/consensual union	52 (47.3)			
Single	34 (30.9)			
Widow	15 (13.6)			
Separated	9 (8.2)			
Religion				
Catholic	79 (71.8)			
Evangelical	23 (20.9)			
Other	8 (7.3)			
Level of Instruction (in years of formal study)*		6.0	0 to 17	6.7±4.3
Monthly family income **		2 minimum wages	500 to10000	2.3 minimum wages ±1.5
Number of people living in the same household ***		3.0	1 to 7	2.7±1.3
Up to 3	81 (73.6)			
4 to 7	26 (23.5)			
Has children				
Yes	92 (83.6)			
No	18 (16.4)			
If so, how many children		2.0	1 a 12	3.1±2.5
Occupation ****				
Active	53 (48.2)			
Inactive	48 (43.6)			

*n= 108; **Calculated in Reais; *** n=107; ****n=101.

MATERIALS AND METHODS

An exploratory, descriptive and cross-sectional study to evaluate the HRQOL of hospitalized patients in a public university hospital. The institution has 210 beds exclusively for the Brazilian Unified Health System. The unit has 31 beds and serves patients aged 14 and older, adults and elderly, of both sexes, for clinical and surgical treatment. The study sample consisted of systematized probabilistic sampling, involving hospitalized individuals in the medical and surgical clinical hospitalization unit in question, adopting the following inclusion criteria: that they had been hospitalized for at least two days, at least one day in the hospital referred to above, be over 18 years of age, be oriented in time and space and have verbal communication skills. The exclusion criteria established were: patients absent in the sector, at the moment of data collection, due to the performance of surgical exams or procedures, as well as those that were under isolation of any type. Data was collected between April and December of 2018, through individual interviews conducted by researchers and previously trained employees. The clinical data was collected in the patients' records. For the sociodemographic characterization of the study participants, an instrument was developed to collect the following data: gender, age at the time of interview, marital status, religion, level of education (in years attending formal education), family monthly income, occupation (later grouped into two categories: active or inactive in their occupation), number of people living with the individual (including the participant), and number of children. The clinical data investigated was: time of hospitalization and medical diagnosis that motivated hospitalization. In order to evaluate HRQoL, the WHOQOL-Bref instrument, an abbreviated version, constructed by the WHOQOL GROUP (1995) and validated in Brazil by Fleck *et al.* (2000). This instrument is composed of 26 questions, two related to general QoL and the individual's perception of their health; and the others, arranged in four domains (physical, psychological, social relations and environment), considering the last 15 days lived by the interviewee.

The answers follow a Likert scale, from 1 to 5 points, where the higher the score, the better the HRQoL. The data collected was compiled into spreadsheets of Microsoft Office Excel® software, version 2010. After tabulation, the data was exported to the Statistical Package for Social Sciences (SPSS®), version 21.0, to perform the descriptive and inferential statistical analysis. All variables were submitted to descriptive analysis, using measures of central tendency, dispersion, amplitude and proportion in percentage, depending on the nature of the analyzed variable. The study is part of a larger project titled "Quality of life related to health and its aspects: investigation of the positive and negative impact on the daily life of the human being" approved by the Research Ethics Committee of the institution to which researchers are linked, and a favorable opinion was issued for its development under number 2.588.565 / 2018 and Certificate of Ethics Appreciation for Presentation N. 84505918.6.0000.0107 and complied with all ethical requirements applicable to research involving human subjects.

RESULTS

The sample consisted of 110 individuals, predominantly men (n = 64, 58.2%), with a mean age of 49.7 ± 18.4 years, ranging from 18 to 89 years old, married or in a consensual union (n = 52, 47.3%), Catholic (n = 79, 71.8%), with a mean level of education of 6.7 ± 4.3 years, varying from zero to 17 years. The average family income was 2.3 national minimum wages, with an average of 2.7 ± 1.3 people living in the same household, and 92 (83.6%) had children, on average, 3.1 ± 2.5 children. Among the participants, 53 (48.2%) were considered active in their occupation (Table 1). Regarding the clinical characterization of the interviewees (Table 2), they remained on average 7.6 ± 8.1 hospitalized days, mainly due to gastric conditions (n = 39, 35.4%). The HRQoL assessment, through the WHOQOL-Bref, indicated that the Social Relations domain had a higher score, with an average of 73.03 ± 14.67, that is, a higher positive impact on HRQoL. However, the Physical domain had the lowest score, with 57.42 ± 16.74 (Table 3), indicating a higher negative impact on HRQoL.

Table 2. Clinical characterization of the subjects hospitalized in the medical and surgical clinic unit of a public hospital in the interior of the state of Parana (n = 110). Cascavel, PR, Brazil, 2018

Variables	n(%)	Median	Amplitude	Average (S.D.)
Length of hospitalization		5.00	2 a 54	7.60±8.1
Diagnosis				
Gastrointestinal conditions	39 (35.4%)			
Skin conditions	14 (12.72%)			
Pulmonary conditions	13 (11.81%)			
Cardiological conditions	8 (7.27%)			
More than one condition	8 (7.27%)			
Hematological conditions	7 (6.36%)			
External conditions	7 (6.36%)			
Urological conditions	5 (4.54%)			
Neurological conditions	5 (4.54%)			
Endocrinological conditions	3 (2.72%)			
Ophthalmic condition	1 (0.90%)			

Table 3. Distribution of the general QoL scores and in each WHOQOL-Bref domain among the subjects hospitalized in the medical and surgical clinic unit of a public hospital in the interior of Parana state (n = 110), Cascavel, PR, Brazil, 2018

Domains	N. items	Average ± S.D.	Median	Minimum	Maximum
Social relations	3	73.03±14.67	75.00	41.67	100.00
Psychological	6	69.07±12.20	70.83	29.17	95.83
Environment	8	64.11±12.36	65.62	31.25	93.75
Physical	7	57.42±16.74	58.92	21.43	100.00
General QoL	2	65.56±18.32	62.50	25.00	100.00

DISCUSSION

Research on health-related quality of life (HRQoL) has occupied a prominent place among researchers, in order to know and describe the various aspects of populations, dealing with the personal and subjective focus of how each reacts to the disease process (Carvalho *et al*. 2013). Regarding the sex of the participants, this study differs from results found in other studies, also involving hospitalized patients, indicating a female predominance (Wittmann-Vieira and Goldim, 2012; Fleck *et al.,* 2000; Duarte *et al.,* 2016; Terra *et al.,* 2013). Other studies showed a predominance of men (Faria *et al.,* 2016; Aragão *et al.,* 2018). It is difficult to infer the reason for the predominance of males in the sample studied. It may be due to the lower care of the man regarding his own health, culturally, making them more susceptible to hospitalization related to the worsening of his health condition (Gomes *et al.,* 2007). Another possibility would be a seasonal effect, in which it coincided with a larger number of men hospitalized in the unit in question. Regarding age, another study involving hospitalized patients also presented data similar to this investigation, with a mean age of 48.8 years, but affected by renal conditions dependent on hemodialysis (Gomes *et al.,* 2018).This mean age, involving young adults, may have contributed to a good HRQoL assessment, that is, with a mean value of 65.56. Regarding marital status, there was a predominance of married or stable union, similar to the results found in a study about the QoL of cancer patients attended at a philanthropic hospital (Terra *et al.,* 2013), as well as a study conducted in the sectors of Medical and Surgical Clinic of a teaching hospital in the interior of Minas Gerais (Faria *et al.,* 2016).Other studies also highlight the participation of married or stable union individuals (Aragão *et al.,* 2018; Fleck *et al.,* 2000; Gomes *et al.,* 2018; Gorayeb *et al.,* 2012; Soto *et al.,* 2017).Studies addressing social support have shown that married individuals have better QoL scores, which could explain the HRQoL results of current research (Azevedo *et al.,* 2017). The religion most cited by participants was Catholic, similar to an international study, conducted in a hospital in Mexico, with patients hospitalized with ischemic heart disease (Soto *et al.,* 2017).

Another study, carried out with cancer patients and peripheral arterial disease, also pointed to the prevalence of the Catholic religion (Terra *et al.,* 2013; Aragão *et al.,* 2018). Religion is something that can contribute to the positive impact on HRQoL during the hospitalization period, when individuals become more susceptible and seek strength in their faith to cope with illness. This situation is pointed out in a study that shows that even patients who were said to be not religious or even who belonged to no religious institution and did not consider themselves religious, confessed that they practiced religious activities in the face of the disease (Silveira and Azambuja, 2017). Regarding education, the study had a mean level of education of 6.7 years of study, similar to the study developed with hospitalized adults diagnosed with cancer, in a Brazilian hospital (Wittmann-Vieira and Goldim, 2012). Another study carried out in Clinical and Surgical Clinics, with elderly patients, indicated education close to the one found in the present study, presenting from four to eight years of study in its majority (Faria *et al.,* 2016). It diverts from the result found by Gomes *et al*. (2018), which indicate predominance in individuals with more than nine years of study. The educational level is considered as a factor that can influence the determinants of health (Badziak and Moura, 2010).

The average family income corresponded to 2.3 national minimum wages, similar to two other studies that showed predominance of family income of up to three minimum wages and up to two minimum wages, respectively (Gomes *et al.,* 2018; Gorayeb *et al.,* 2012). However, some studies have obtained different results, presenting a family income of one minimum salary or less than this value (Faria *et al.,* 2016; Aragão *et al.,* 2018), and higher values indicating an income of three to four minimum wages (Terra *et al.,* 2013). The data obtained on the average family income suggests that this may be associated with the health conditions of the people, becoming one of the main explanations for the health problems (Celeste and Nadanovsky, 2010). Regarding the number of people living in the same household, there was an average of 2.77 people, representing the families of the present time, with a smaller number of members in the nuclear families. Among the interviewees, the majority had children and were

considered active in their occupation, which could be considered a negative impact factor in the HRQoL, considering that, apart from remuneration during hospitalization, wages may decrease, the family. More studies would be needed for further inferences on this subject. Gastrointestinal conditions were more prevalent among study participants. Despite the rising incidence of gastrointestinal conditions in recent years, especially in Europe and North America (Burish and Munkholm, 2015; Bernstein and Shanahan, 2008; Goh *et al.,* 2009; Gasparini, 2018), it was not the focus at that time. New investigations could be proposed, in order to check the correlations between the most varied health conditions with the evaluation of HRQoL. The evaluation of the general QoL among the participants presented an average value of 65.56, as mentioned previously. This value differs from another study performed with inpatients in a hospital that attends vascular surgeries, which pointed to the average overall QoL score of 97.9 (Aragão *et al.,* 2018). Another study carried out with patients in palliative care points to the general QOL score of 54.16, which differs from this study (Wittmann-Vieira and Goldim, 2012).

Such differences may have been due to the fact that these studies included patients with differentiated health conditions, which is also a factor that may interfere positively or negatively in the HRQoL, as well as in the evaluation of general QoL. In addition, it is important to comment on how complex the evaluation of QoL is, since it has a broad concept and reflects the subjective nature of the evaluation that is inserted in the cultural, social and environmental context, focused on the perception of the respondent/patient being evaluated (Fleck, 2000). Among the domains contained in the WHOQOL-Bref, the Social Relations domain was the one with the highest score. Based on this data, it is suggested that even when filled in a hospital, the participants were able to maintain their personal relationships and social support, as assessed. This may be due to the fact that the questions of the instrument refer to the 15 days prior to the date of the interview, which would therefore describe the days when they were not hospitalized, considering the average time of hospitalization of the sample studied (7.60 days of hospitalization). However, many patients still have the difficulty in making this distancing, expressing themselves about information regarding the days in which they are experiencing. In this sense, what could explain this score pointed to the Social Relations domain, that is, the maintenance of this registered welfare would be the visits of relatives, often.

Such visits occur daily, at specific times, and also, according to the state of health and age of the individual. An accompanying person is allowed to remain with the patient during the hospitalization period, which could offer a better balance on their social relations and social support. The fact that patients may be close to the patient during hospitalization can be considered as a support in the treatment of the disease (Terra *et al.,* 2013), and may have a positive impact on HRQoL. A national study conducted Hospital de Clínicas of the Federal University of Paraná indicated that when any health problem occurs with one of the family members, it may affect the whole family system, leading to a process of disorganization of family dynamics (Dallalana and Batista, 2014). Another study corroborates the idea that there is family influence during hospitalization, evidencing that the support received by family and friends contribute to better conditions and coping with the disease, as well as adherence to the proposed treatment (Sorte and Modesto, 2014). The lowest score identified in the QoL assessment using the WHOQOL-Bref was for the Physical domain, and may be indicative of the presence of the affected health condition itself, which led to the need for hospitalization. Another factor that could explain the worse evaluation of the QoL for the Physical domain is the sleep and rest condition, which can be impaired as a result of the noise present in the hospital environment, generating fatigue and lack of energy in situations where rest is not effective (Heidemann *et al.,* 2011). A study performed with patients on hemodialysis also showed a lower score in the physical domain (Gomes *et al.,* 2018), as well as a study performed with hospitalized elderly individuals, which showed this lower score than others (Faria *et al.,* 2016); and, other studies indicated lower scores in this context (Gorayeb *et al.,* 2012; Wittmann-Vieira and Goldim, 2012; Duarte *et al.,* 2016; Aragão *et al.,* 2018).No comparisons were made between these variables in this study, which limits assertions about the impact of such factors. The Psychological Domain obtained a score of 69.07, that is, the second best HRQoL assessment for this sample. In the period of hospitalization, individuals are susceptible due to their clinical condition and may present negative feelings, impaired body image and appearance and low self-esteem. However, it is possible to note that in the face of illness individuals tend to resort to spirituality, not dwelling on a particular religion, but on their personal beliefs, as a support to endure and face this moment of hospitalization, accelerating their recovery.

The sympathy with the team that is providing care is also essential for the subject to feel supported in that moment of fragility that is hospitalization. The way the health team behaves in front of the hospitalized subject may also be responsible for the best coping with the period away from the family. He encouragement and encouragement of the belief that the patient possesses, performed by the nurse, is considered an adequate intervention, which can influence the Psychological domain, as it presents itself as a support, understanding and help. Thus, spiritual care can be performed concomitantly with other care (Araújo *et al.,* 2015). Faced with hospital admission, the significance and influence that the power of will, faith and prayer exert in the healing process is highlighted (Araújo *et al.,* 2015). When people are hospitalized, they face their illnesses with good spirit and a state of optimism, it is possible to notice a more rapid recovery, surprising the multiprofessional team, as well as influencing other patients (Araújo *et al.,* 2015). Finally, regarding the Environment domain, a score of 64.11 was obtained, which suggests that during the hospitalization period patients feel more susceptible regarding their physical security and protection, since they are in a strange environment, having that adapt to the routines of the hospital institution, different from those experienced in their daily lives.

It is also possible to notice that the patients feel lack of the home environment, where there is a greater interaction with the relatives and friends. Another important factor that should be considered in this area is the financial resources, since not all the individuals who need hospitalization, mainly for long periods, receive sickness aid, can shake the financial structure of the home and negatively impact the HRQoL. Another study showed a lower score in the Environment domain (3.29) (Terra *et al.,* 2013). In a national study, conducted in the state of Rio Grande do Sul, analyzing the QoL scores in the hospitalization period and after hospital discharge, an increase in the score of

the Environment domain from 53.13 during hospitalization to 60.23 at hospital discharge, evidencing that the hospital environment may interfere with the QoL of the individual. It was also added that the other scores increased after discharge, except for the social relations domain, which presented 72.50 during hospitalization and 71.21 at hospital discharge, suggesting that even during hospitalization, the family ties and socializing with the team of health may have strengthened social relationships, even at a susceptible time (Dorneles *et al.,* 2014). The non-homogeneity of the patient profile, as well as the number of subjects studied, were considered as limitations of this study, involving a single hospital institution, reducing the chances of possible comparisons. New studies are already being sent by the research group to investigate new objectives and clarify doubts that still remain about the HRQoL of hospitalized patients and the factors that influence it.

Conclusion

The HRQoL assessment among the study participants presented values close to the total mean of the scale and could indicate reasonable levels of QoL overall. The worst evaluation was for the Physical domain, easily understood due to the health condition in which they were. On the other hand, the best evaluation was for the Social Relations domain, comprising an adequate support network to support during the period of hospitalization and coping with the disease. The results of the research may support the decision-making of health professionals in understanding the factors about QoL in treating this profile of patients, as well as make possible future comparisons of studies using the same QoL assessment instrument.

REFERENCES

Angelim RCM, Fiqueiredo TR, Correia PP, Bezerra SMMS, Baptista RS, Abrão FMS. 2015. Evaluation of quality of life through the WHOQOL: Bibliometric analysis of nursing production. Rev. Baiana de Enfermagem. 4:400-410.

Aragão JA, Santos RM, Neves OMG, Aragão ICS, Aragão FMS, Mota MIA *et al*. 2018. Quality of life in patients with peripheral artery disease. J Vasc Bras. 2:117-121.

Araujo MAM, Batista RA, Silva Júnior IA, Sampaio CL, Martins LGF, Guerra DR *et al.* 2015. The nurses' perception about the spiritual care. Revista da Associação Brasileira de Logoterapia e Análise Existencial. 1:84-94.

Azevedo C, Pessalacia JDR, Mata LRFD, Zoboli ELCP, Pereira MDG. 2017. Interface between social support, quality of life and depression in users eligible for palliative care. Rev Esc Enferm USP. 51 e03245:1-8.

Badziak RPF, Moura VEV .2010. Determinantes sociais da saúde: um conceito para efetivação do direito à saúde. R. Saúde Públ. Santa Cat. 1:69-79.

Bernstein CN, Shanahan F .2008. Disorders of a modern lifestyle: reconciling the epidemiology of inflammatory bowel diseases. Gut. 9:1185–1191.

Burish J, Munkholm P. 2015. The epidemiology of inflammatory bowel disease. Scand J Gastroenterol. 8: 942-51

Campos MO, Rodrigues Neto, J. F. R. 2008. Life quality: an instrument for health promotion. Rev. Baiana Saúde Pública. 2:232-240.

Carvalho ARS, Ciol MA, Tiu F, Rossi LA, Dantas RAS. 2013. Oral Anticoagulation: the impact of the therapy in health-related quality of life at six-month follow-up. Rev. Latino-Am. Enfermagem. 21 spe: 105-112.

Celeste RK, Nadanovsky P. 2010. Issues regarding the effects on health of income inequality: contextual mechanisms.Ciênc. saúde coletiva. 5:2507-19.

Dallana TM, Batista MGR . 2014. Quality of life of caregivers during the hospitalization of the patient under care in an Emergency Unit: some associated factors. Ciênc. saúde coletiva. 11:4587-4594.

Dorneles SQ, Signori LU, Corrêa LQ, Silveira DF, Guerreiro LF, Teixeira AO. 2014. Effects of hospitalization on functional capacity and quality of life of cardiometabolic patients. ConScientiae Saúde. 1:101-109.

Duarte A, Joaquim N, Nunes C. 2016. Quality of Life and Social Support of the Patients of Continued Care Units of Algarve. Psic.: Teor. e Pesq. 2:1-10.

Faria PM, Dias FA, Molina NPFM, Nascimento JS, Tavares DMS . 2016. Quality of life and frailty among hospitalized elderly patients. Rev. Eletr. Enf. 18 e1195:1-9.

Fayers MP, Machin D. 2007. Quality of life. Assessment, analysis and interpetation. Chichester, England: John Wiley & Sons, p.3.

Fleck MPA, Borges ZN, Bolognesi G, Rocha NS. 2003. Development of WHOQOL spirituality, religiousness and personal beliefs module.Rev. Saúde Pública. 4:466-55.

Fleck MPA, Louzada S, Xavier M, Chachamovich E, Vieira G, Santos L *et al*. 2000. Application of the Portuguese version of the abbreviated instrument of quality life WHOQOL-bref. Rev Saúde Pública. 2:178-83.

Gasparini RG. 2018. Incidência e Prevalência de Doenças Inflamatórias Intestinais no Estado de São Paulo – Brasil. Tese de doutorado. Faculdade de Medicina (FMB) – Botucatu, pp 1-91.

Goh K, Xiao SD . 2009. Inflammatory bowel disease: a survey of the epidemiology in Asia. J Dig Dis. 1:1–6.

Gomes NDB, Leal NPR, Pimenta CJL, Martins KP, Ferreira GRS, Costa KNFM. 2018. Quality of life of men and women onHemodialysis. Rev baiana enferm. 32 e24935: 1-10.

Gomes R, Nascimento EF, Araujo FC . 2007. Why do men use health services less than women? Explanations by men with low versus higher education.Cad. Saúde Pública. 3: 565-574.

Gorayeb R, Facchini GB, Schmidt A. 2012. Psychosocial Characterization of Patients in a Cardiac Ward. Rev Bras Cardiol. 3:218-225.

Heidemann AM, Cândido APL, Kosour C, Costa ARO, Dragosavac D (2011). The influence of noise levels on the perception ofstress in heart disease patients. Rev. bras. ter. intensiva 1:62-67.

Silveira PS, Azambuja LS (2017). A influência da religiosidade e espiritualidade no enfrentamento da doença. Psicologia. 1: 1646-6977.

Sorte ETB, Modesto AP (2014). Quality of life in people with chronic kidney disease: anintegrative review. Revista Saúde e Desenvolvimento. 3:154- 166.

Soto MEJ, Magaña MGP, Estrada JCC, Arreola SSO (2017). Calidad de vida y perspectiva espiritual de los pacientes hospitalizados con enfermedad cardiovascular. Rev Enferm Inst Mex Seguro Soc. 1:9-17.

Terra FS, Costa AMDD, Damasceno LL, Lima TS, Filipini CB, Leite MAC (2013). Quality of life evaluation in

cancerpatients to submitted to chemotherapy. *Rev Bras Clin Med.* 2:112-7.

WHOQOL (1995). The WHOQOL Group. The World Health Organization Quality of Life assessment (WHOQOL): Position paper from the World Health Organization. Soc. Sci. Med. 10:1403-1409.

Wittmann-Vieira R, Goldim JR (2012). Bioethics and palliative care: decision making and quality of life. Acta paul. Enferm. 3:334-9.

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