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EDITORIAL

Implementing health-related quality of life assessment in clinical practice

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Even with the continuous development of scientific and technological knowledge in healthcare and medical treatments that are billions of people from different countries and of all ages experiencing health impairments with some sort of chronic non-communicable or infectious disease[1]. Although one of the main challenges for healthcare professionals is the restoration of people's health, the preservation of the quality of life (QoL) is equally important[2].

QoL is multidimensional and subjective. The World Health Organization Quality of Life Assessment group defined QoL as the individual's perceptions of their position in life in the context of the culture and value system in which they live, and regarding their goals, expectations, patterns, and concerns[3]. Several factors are said to influence QoL[3-5], such as sociodemographic status (gender, age, education level, and marital status), physical health (such as energy, fatigue, pain, sleep quality), and a person's psychological status (physical appearance, positive/negative feelings, self-esteem). People also occupy social and physical spaces. Thus, the relationships in terms of social support and sexual activity, and aspects of the surrounding physical and home environment (financial situation, freedom, safe environment, recreation, transportation, climate, pollution), can affect one's QoL. Religious/spiritual status also refers to social and physical spaces, as one believes in and seeks support from members of one's religious community, attends in places of worship, receives support, provide religious attendance, meaning in life, peace, optimism, faith[3-5].

Unidimensional models regarding biophysical aspects of people's lives, such as numbers of comorbidities, deaths, and perceived health status, are no longer sufficient to assess the complexity of the health-related circumstances of patients or populations. Accordingly, health-related QoL (HRQoL) has gained popularity among clinicians and researchers. There is a lack of consensus about how to define HRQoL and its constituents. Nonetheless, HRQoL mostly concerns physical and mental health status. Economic and political circumstances are not included in the assessment[6]. The US Food and Drug Administration (FDA) defines HRQoL as "a multi-domain concept that represents the patient's general perception of the effect of illness and treatment on the physical, psychological and social aspects of life"[4,6].

Many practitioners describe difficulties in incorporating HRQoL assessments into day-to-day practice. Practitioners can simply ask a patient: "How is your health today… and your QoL?" However, loosely worded questions are not necessarily valid and do not provide reliable questions. The practitioner may also ask what aspect of the patient's life lacks quality. Alternatively, practitioners can choose from a wide array of generic or disease-specific HRQoL questionnaires. Such questionnaires tend to be domain-oriented and can help the clinician to better identify aspects of the patients' lives that lack quality. We recommend that practitioners study generic and disease-specific HRQoL questionnaires used in a variety of different healthcare settings and consult with researchers and clinicians who have hands-on experience using them[7].

Practitioners may also use HRQoL models to guide their work with patients. Bakas et al.[8] favor adopting Ferrans et al. model, and thus a broader non-conventional perspective. A popular HRQoL model developed by Wilson and Cleary primarily focuses on biological functioning, signs and symptoms, functional status, and perceptions of health status. People's lives can and do encompass more than solely physical and mental health states. People who are living with acute conditions and chronic non-communicable diseases also live out their lives as members of families and surrounding communities. Religion and spirituality enhance physical and mental health and functioning among ill and healthy adults of all ages[5]. Practitioners should consider how people's religious and spiritual beliefs and practices contribute to the quality of their lives.

Although there is strong evidence in favor of practitioners using HRQoL assessments, published evidence is fraught with inconsistencies about its usefulness and applicability in day-to-day practice settings. In keeping with the work of Calmer and colleagues[9], we recommend that clinicians: 1) select valid and reliable HRQoL questionnaires that address domains of life deemed as most important by patients and family members; 2) explore ideal frequencies for HRQoL assessments to minimize patient burden, and make use of adjunct clinical information for patients who are averse to completing questionnaires; 3) share HRQoL assessment findings in a palatable format for patients and his families, and in a clinically viable format for practitioners; 4) use familiar descriptive statistics to summarize HRQoL scores to better capture the attention of other practitioners and clinicians.

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The main objective of clinical care is to improve patients' health and their QoL. Modern medicine increasingly demands the use of personalized, precise, and multidimensional treatments. This editorial has touched upon the importance of assessing HRQoL and how the clinician could incorporate such assessments into their day-to-day clinical practice. We recommend that practitioners use HRQoL assessments to keep up with the demands of modern evidence-based medicine, and to share what they have learned with patients and families, and with researchers and clinicians in patient care conferences. Only then can HRQoL have practical value in clinical settings.

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