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TO EVALUATE THE QUALITY OF LIFE THROUGH A SURVEY AMONG PATIENTS WITH CHRONIC ILLNESSES

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ABSTRACT **Background:** Chronic illnesses are long-term health conditions that may affect multiple aspects of an individual's life, including physical functioning, psychological well-being, social relationships, and daily activities. Assessment of quality of life provides a patient-centered perspective that complements conventional clinical outcomes. The present study was undertaken to describe quality-of-life ratings and selected demographic and clinical characteristics among patients living with chronic illnesses. **Methods:** A cross-sectional, questionnaire-based observational study was conducted among patients with chronic illnesses attending the hospital associated with the Department of Pharmacy Practice, Bhaskar College of Pharmacy. A total of 151 participants were included in the study. Demographic and selected clinical information was collected through direct interaction with participants. Quality-of-life information was collected using the WHOQOL-BREF questionnaire along with an overall quality-of-life rating recorded on a 1–5 scale. Data were entered into Microsoft Excel and analysed using descriptive statistics, including frequencies and percentages. **Results:** Among the 151 participants, 106 (70.20%) were female and 45 (29.80%) were male. The largest age group was 36–50 years, comprising 57 (37.75%) participants. The majority of participants belonged to the lower socioeconomic category (84, 55.63%), followed by the middle (55, 36.42%) and higher (12, 7.95%) socioeconomic categories. When individual disease prevalence was considered, hypothyroidism was the most frequently recorded chronic illness, identified in 71 (47.02%) participants, followed by diabetes mellitus in 70 (46.36%) and hypertension in 65 (43.05%). Because some participants had multiple chronic illnesses, these disease-specific percentages were not mutually exclusive. In the mutually exclusive classification, 53 (35.10%) participants had multiple chronic illnesses. Among 148 participants with interpretable duration-of-illness data, 65 (43.92%) had an illness duration of 1–5 years. Numeric pain scores were available for 150 participants, of whom 130 (86.67%) had mild pain, 17 (11.33%) had moderate pain, and 3 (2.00%) had severe pain. Self-reported depression was recorded in 49 (32.45%) participants. Overall quality-of-life ratings were recorded for all 151 participants, with a rating of 4 being the most frequently recorded response (63, 41.72%). **Conclusion :** The study provides a descriptive overview of quality-of-life ratings and selected clinical characteristics among patients living with chronic illnesses. The findings demonstrate the importance of considering patient-reported quality of life, psychological well-being, pain, and chronic disease burden as components of comprehensive chronic illness management. Further studies using standardized quality-of-life scoring procedures and appropriate inferential statistical methods are recommended.

KEYWORDS : Chronic Illness, Quality of Life, WHOQOL-BREF, Patient-reported Outcomes, Depression, Pain, Chronic Disease Management

1. INTRODUCTION

1.1 Background

Chronic illnesses represent a major and continuing public health challenge. Conditions such as diabetes mellitus, hypertension, chronic respiratory diseases, thyroid disorders, and chronic musculoskeletal diseases often require long-term treatment, regular monitoring, and lifestyle modifications. Although clinical management focuses on controlling disease progression and preventing complications, the effects of chronic illness extend beyond clinical parameters and may influence an individual's physical, psychological, social, and environmental well-being.

The World Health Organization defines quality of life as an individual's perception of their position in life within the context of their culture and value systems and in relation to their goals, expectations, standards, and concerns. Quality of life is therefore a multidimensional concept that incorporates several aspects of an individual's experience and cannot be assessed solely through clinical measurements.

Patients living with chronic illnesses may experience persistent symptoms, functional limitations, treatment-related burdens, psychological distress, financial difficulties, and changes in social participation. These factors may affect the way patients perceive their health and their ability to maintain daily activities and personal independence.

The WHOQOL-BREF is a widely used quality-of-life assessment instrument derived from the WHOQOL-100. It contains 26 items addressing broad aspects of quality of life and health and is commonly used in clinical and research settings to assess patient-reported quality of life.

1.2 Rationale of the Study

Traditional healthcare delivery often focuses primarily on disease-specific clinical outcomes. However, clinical measures alone may not fully capture the difficulties experienced by patients living with chronic illnesses. Patients may continue to experience fatigue, pain, psychological distress, limitations in daily activities, or social difficulties despite receiving appropriate medical treatment.

The hospital associated with Bhaskar College of Pharmacy serves patients from diverse backgrounds and surrounding areas. Assessment of quality of life in this setting may provide useful information about the patient experience of living with chronic illnesses and may help identify areas requiring greater attention during patient care.

The present study therefore aimed to describe quality-of-life ratings among patients with chronic illnesses and to examine selected demographic and clinical characteristics of the study population.

1.2 Objectives

The objectives of the study were:

1. To assess quality of life among patients with chronic illnesses using a structured quality-of-life assessment approach.
2. To describe the demographic and selected clinical characteristics of patients living with chronic illnesses.
3. To describe the distribution of overall quality-of-life ratings among the study participants.
4. To document selected patient-reported factors, including depression and pain, that may be relevant to quality of life.
5. To provide observations that may support patient-centered care and future research on quality of life among individuals with chronic illnesses.

2. MATERIALS AND METHODS

2.1 Study Design and Setting

A cross-sectional, questionnaire-based observational study was conducted among patients with chronic illnesses attending the hospital associated with the Department of Pharmacy Practice, Bhaskar College of Pharmacy.

A total of 151 participants were included in the study.

2.2 Study Population

The study included patients diagnosed with chronic illnesses. The conditions represented in the study included hypertension, diabetes mellitus, thyroid disorders, osteoarthritis or arthritis, chronic obstructive pulmonary disease (COPD), epilepsy, and goitre. Participants with more than one chronic illness were also included.

2.3 Inclusion and Exclusion Criteria

Participants diagnosed with at least one chronic illness and able to participate in the survey were considered for inclusion.

Patients who were unable to communicate or complete the questionnaire because of cognitive impairment or who were experiencing acute medical or psychiatric emergencies were excluded.

2.4 Data Collection and Study Variables

Data were collected through direct interaction with participants using a structured data collection approach. Information relating to demographic characteristics and selected clinical variables was recorded.

The variables considered included:

- Age
- Sex
- Socioeconomic status
- Chronic illness
- Duration of illness
- Pain
- Depression
- Quality of life

2.5 Quality-of-Life Assessment

Quality-of-life information was collected using the WHOQOL-BREF questionnaire. The questionnaire was administered through direct interaction with participants, with questions asked verbally where required and responses recorded.

An overall quality-of-life rating on a 1–5 scale was also recorded as part of the study data. The recorded overall ratings were used for descriptive analysis.

The present manuscript reports these values as overall quality-of-life ratings. Standard WHOQOL-BREF domain scores are not reported because the official domain-scoring procedure could not be independently reproduced from the available final dataset.

2.6 Data Management and Statistical Analysis

The collected data were entered and organised in Microsoft Excel. Descriptive statistical methods were used to Summarize the study findings.

Categorical variables were expressed as frequencies (n) and percentages (%). The distribution of overall quality-of-life ratings, chronic illnesses, duration of illness, pain, and self-reported depression was described using descriptive statistics.

No inferential statistical tests, including chi-square tests or analysis of variance, were performed for the present analysis. Therefore, the study does not report p-values or statistical significance.

2.7 Ethical Considerations

The study was conducted with attention to ethical principles applicable to research involving human participants. The purpose and procedures of the study were explained to participants before data collection. Participation was voluntary, and confidentiality of participant information was maintained.

3. RESULTS

3.1 Demographic Characteristics

A total of 151 participants were included in the study. The age distribution showed that the largest proportion of participants belonged to the 36–50-year age group, comprising 57 (37.75%) participants. This was followed by participants aged 51–65 years, accounting for 38 (25.17%) participants, 18–35 years with 35 (23.18%) participants, above 65 years with 18 (11.92%) participants, and below 18 years with 3 (1.99%) participants.

Regarding sex distribution, 106 (70.20%) participants were female and 45 (29.80%) were male.

Table 1. Age-wise Distribution of Study Participants (N = 151)

Age group	n	%
Below 18 years	3	1.99
18–35 years	35	23.18
36–50 years	57	37.75
51–65 years	38	25.17
Above 65 years	18	11.92
Total	151	100.00

Table 2. Sex Distribution of Study Participants (N = 151)

Sex	n	%
Male	45	29.80
Female	106	70.20
Total	151	100.00

3.2 Socioeconomic Characteristics

Socioeconomic status was assessed among the 151 study participants and classified into lower, middle, and higher categories. The majority of participants belonged to the lower socioeconomic category, comprising 84 (55.63%) participants. This was followed by the middle socioeconomic category, comprising 55 (36.42%) participants, while 12 (7.95%) participants belonged to the higher socioeconomic category.

Table 3. Socioeconomic Status of Study Participants (N = 151)

Socioeconomic status	n	%
Lower	84	55.63
Middle	55	36.42
Higher	12	7.95
Total	151	100.00

3.3 Clinical Characteristics

The study population included participants with a range of chronic illnesses, including hypothyroidism, diabetes mellitus, hypertension, osteoarthritis or arthritis, hyperthyroidism, chronic obstructive pulmonary disease (COPD), epilepsy, and goitre. Some participants reported more than one chronic illness.

Because participants with multiple chronic illnesses could have more than one disease, two approaches were used to describe the disease distribution. First, individual disease prevalence was Summarized, allowing participants with multiple illnesses to be counted under each applicable disease. Second, a mutually exclusive classification was used to assign each participant to either a single chronic illness category or a multiple chronic illnesses category.

When individual disease prevalence was considered, hypothyroidism was the most frequently recorded chronic illness, identified in 71 (47.02%) participants, followed by diabetes mellitus in 70 (46.36%) and hypertension in 65 (43.05%). Because some participants had more than one chronic illness, these percentages are not mutually exclusive and therefore do not sum to 100%.

When participants were classified into mutually exclusive categories, 53 (35.10%) participants had multiple chronic illnesses. Hypothyroidism alone was recorded in 45 (29.80%) participants, followed by diabetes mellitus alone in 30 (19.87%) and hypertension alone in 19 (12.58%).

Table 4. Individual Prevalence of Chronic Illnesses Among Study Participants (N = 151)

Chronic illness	n	%
Hypothyroidism	71	47.02
Diabetes mellitus	70	46.36
Hypertension	65	43.05
Osteoarthritis/arthritis	4	2.65
Hyperthyroidism	3	1.99
COPD	1	0.66
Epilepsy	1	0.66
Goitre	1	0.66

Note: Participants with multiple chronic illnesses may be included in more than one disease category; therefore, percentages do not sum to 100%.

Table 5. Mutually Exclusive Classification of Chronic Illness Status (N = 151)

Chronic illness category	n	%
Hypothyroidism only	45	29.80
Diabetes mellitus only	30	19.87
Hypertension only	19	12.58
Osteoarthritis/arthritis only	2	1.32
Hyperthyroidism only	1	0.66
COPD only	1	0.66
Multiple chronic illnesses	53	35.10
Total	151	100.00

Note: The mutually exclusive categories represent each participant once. Participants with more than one chronic illness were classified under "Multiple chronic illnesses."

3.3.1 Duration of Illness

Duration of illness was recorded in years or months in the study dataset. For participants with multiple chronic illnesses, the longest reported duration of any chronic illness was used for participant-level categorisation. Duration values expressed in months were converted into years where applicable.

Among participants with interpretable duration data, 65 (43.70%) had a reported illness duration of 1–5 years, followed by 46 (31.08%) with a duration of 6–10 years and 23 (15.23%) with a duration of less than 1 year. Sixteen (10.5%) participants reported a duration exceeding 10 years.

Table 6. Distribution of Duration of Chronic Illness Among Participants with Interpretable Data (n = 151)

Duration of illness	n	%
<1 year	23	15.23
1–5 years	66	43.70
6–10 years	46	31.08
>10 years	16	10.59
Total	151	100.0

Note: Percentages are calculated among 151 participants with interpretable duration data. For participants with multiple chronic illnesses, the longest reported duration was used for participant-level categorisation.

3.3.2 Pain Characteristics

Pain intensity was recorded as a numerical score in the study dataset. The recorded values ranged from 1 to 10. Some records included a numerical pain score accompanied by a description of the location or nature of pain, such as headache, knee pain, joint pain, body pain, or burning sensation in the feet. The numerical component was used for quantitative analysis.

A numeric pain score was available for 150 (99.34%) participants, while one participant had a non-numeric description of pain and was therefore excluded from the numerical pain analysis.

Among the 151 participants with interpretable pain scores, 131 (86.76%) had mild pain scores of 1–3, 17 (11.26%) had moderate pain scores of 4–6, and 3 (.98%) had severe pain scores of 7–10.

Table 7. Distribution of Pain Intensity Among Participants with Interpretable Numeric Pain Scores (n = 151)

Pain intensity category	Numeric score	n	%
Mild	1–3	131	86.76
Moderate	4–6	17	11.26
Severe	7–10	3	1.98
Total	1–10	151	100.00

Note: Percentages are calculated among 151 participants with interpretable numeric pain scores. One participant had a non-numeric pain description and was excluded from the numerical pain analysis.

3.4 Self-Reported Depression

Among the 151 participants, 49 (32.45%) reported depression, whereas 102 (67.55%) did not report depression.

The depression variable is presented as self-reported depression status and should not be interpreted as a clinically confirmed psychiatric diagnosis unless such a diagnosis was documented in the original patient records.

Table 8. Self-Reported Depression Status (N = 151)

Depression status	n	%
Yes	49	32.45
No	102	67.55
Total	151	100.00

3.5 Overall Quality-of-Life Ratings

Overall quality-of-life ratings were recorded for all 151 participants. The most frequently recorded overall quality-of-life rating was 4, reported by 63 (41.72%) participants. This was followed by a rating of 2 in 36 (23.84%) participants, a rating of 3 in 34 (22.52%) participants, and ratings of 1 and 5 in 9 (5.96%) participants each.

Table 9. Distribution of Overall Quality-of-Life Ratings Among Study Participants (N = 151)

Overall QoL rating	n	%
1	9	5.96
2	36	23.84
3	34	22.52
4	63	41.72
5	9	5.96
Total	151	100.00

3.6 Overall Quality of Life

The overall quality-of-life ratings demonstrated variation among the study participants. Rating 4 was the most frequently recorded response, reported by 63 (41.72%) participants. Ratings of 3 and 2 were recorded in 34 (22.52%) and 36 (23.84%) participants, respectively, while 9 (5.96%) participants each reported ratings of 1 and 5.

These findings indicate that the most commonly recorded overall quality-of-life perception in the study population was a rating of 4 on the 1–5 scale used in the study. The results are presented descriptively and do not establish associations between quality-of-life ratings and demographic or clinical characteristics.

4. DISCUSSION

The present study evaluated the quality of life of 151 patients with chronic illnesses attending a tertiary care teaching hospital. The findings provide a descriptive overview of demographic characteristics, chronic disease burden, and patient-reported quality-of-life ratings.

The study population was predominantly female, with most participants belonging to the 36–50-year age group and the lower socioeconomic category. These findings describe the characteristics of the study population but should not be interpreted as evidence of an association with quality of life, as inferential statistical analysis was not performed.

Hypothyroidism, diabetes mellitus, and hypertension were the most frequently reported chronic illnesses. More than one-third of the participants had multiple chronic illnesses, indicating a considerable burden of multimorbidity in the study population. Although no statistical comparison was performed, multimorbidity has consistently been associated with poorer health-related quality of life in previous studies, highlighting the importance of comprehensive chronic disease management.

Most participants had a disease duration of 1–5 years and reported mild pain, while approximately one-third reported self-reported depression. These findings emphasise that chronic illnesses affect not only physical health but also psychological well-being. However, because depression was self-reported and no validated psychiatric assessment was performed, these findings should be interpreted cautiously.

Overall quality-of-life ratings showed that rating 4 was the most frequently reported response, suggesting that many participants perceived their quality of life favourably despite living with chronic illnesses. Since the available dataset did not permit independent calculation of standard WHOQOL-BREF domain scores, the present study reports overall quality-of-life ratings rather than domain-specific outcomes.

The present findings are broadly consistent with previous Indian studies that have reported the influence of multimorbidity and psychological health on patient-reported quality of life. Although direct comparison is limited by differences in study populations and quality-of-life instruments, the available literature supports the importance of incorporating patient-reported outcome measures into chronic disease management.

A major strength of this study is the inclusion of patients with a variety of chronic illnesses in a real-world tertiary care setting. In addition to demographic characteristics, the study documented multimorbidity, duration of illness, pain, self-reported depression, and overall quality-of-life ratings, providing a comprehensive description of the study population.

The study has several limitations. It was conducted at a single centre using a cross-sectional design and convenience sampling, limiting the generalisability of the findings. Inferential statistical analyses were not performed; therefore, associations between demographic or clinical variables and quality of life could not be established. Furthermore, some variables, including pain and depression, were based on self-reported information and may be subject to reporting bias. Standard WHOQOL-BREF domain scores could not be independently reproduced from the available dataset, and consequently only overall quality-of-life ratings are presented.

Overall, the findings contribute to the limited evidence on quality of life among patients with chronic illnesses in a tertiary care hospital in Hyderabad and highlight the importance of incorporating patient-reported quality-of-life assessment into routine chronic disease management.

5. CONCLUSION

The present study provides a descriptive overview of quality-of-life ratings and selected clinical characteristics among patients living with chronic illnesses in a hospital-based setting. The study population was predominantly female, and participants represented a broad range of age groups and chronic disease conditions.

Hypothyroidism was the most frequently recorded individual chronic illness, followed by diabetes mellitus and hypertension. More than one-third of participants were classified as having multiple chronic illnesses when mutually exclusive participant categories were used. The majority of participants with interpretable duration data had been living with their illness for 1–5 years, while most participants with available numeric pain scores reported mild pain.

Self-reported depression was present in approximately one-third of the study population. Among all 151 participants, a rating of 4 was the most frequently recorded overall quality-of-life response.

These findings highlight the importance of considering patient-reported quality of life, psychological well-being, pain, socio-economic circumstances, and the burden of multiple chronic illnesses as components of comprehensive chronic disease management.

However, the findings are descriptive and do not establish statistically significant associations between clinical or demographic characteristics and quality of life. The absence of inferential statistical analysis should be considered when interpreting the results. Further research using validated quality-of-life scoring procedures, complete and Standardized data collection, and appropriate statistical methods is recommended to better understand the factors influencing quality of life among patients living with chronic illnesses.

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