

EVALUATION OF QUALITY OF LIFE IN PATIENTS WITH CORONARY ARTERY BYPASS SURGERY USING CONTROLLED CLINICAL TRIAL

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Abstract- Quality of life has emerged as an important concept and outcome in health and health care. This study was performed to evaluate the ability of the health education program to improve quality of life of patients with coronary artery bypass graft surgery (CABG). In pre operation period, 70 patients were randomized in two groups, experimental and control group (35 patients in each). The demographic information, SF-36 and Nottingham Health Profile questionnaire were administered before surgery to all patients. Patients in the experimental group received the educational intervention according to Mico's education planning model. These patients were followed up to 1-month. At result, SF-36, Nottingham Health Profile questionnaires were administered 1-month after education by patients again. Significant improvements in quality of life between two groups, as measured by the Nottingham Health Profile, were seen in energy ($P < 0.001$), pain ($P < 0.006$), emotional reaction ($P < 0.00001$), sleep ($P < 0.01$), physical mobility ($P < 0.00001$) and total average quality of life ($P < 0.00001$). Significant improvements in quality of life between two groups, as measured by the SF-36, were seen in physical function ($P < 0.00001$), role limitations resulting from emotional status ($P < 0.007$), role limitations resulting from physical status ($P < 0.05$), mental health ($P < 0.03$), vitality ($P < 0.02$) and total average quality of life ($P < 0.02$). The findings demonstrate that health education result is improved quality of life for patients with CABG.

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Key words: Mico's model, Nottingham health profile, health education, coronary artery bypass graft surgery, and quality of life

INTRODUCTION

Coronary heart disease is the leading cause of death in the majority of countries (1). According to World Health Organization, 30% of all deaths (15.3 million deaths) as well as 10.3% of the total disability adjusted life year (DALY) lost in 1998 were attributable to CVD (2). WHO estimated that

CVDs accounted for 28.5% of all deaths in the developing countries (2).

Each year, approximately 150000 Iranian dies of cardiovascular disease (3). Cardiovascular disease account for 40% of Iranian deaths in 1999 (4). Future increases in CVDs are expected in the near future in the developing countries. According to the Global Burden of Disease study, a 55% rise would occur in CVD attributable loss, between 1990 and 2020, in the developing countries (5).

Quality of life has emerged as an important concept and outcome in health and health care (6). In public health and in medicine, the concept of health-

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related quality of life refers to a person or groups perceived physical and mental health over time. Physicians have often used health-related quality of life to measure the effect of chronic illness in their patients in order to better understand how an illness interferes with a person's day-to-day life. Similarly, public health professionals use health-related quality of life to measure the effects of numerous disorders, short-and long-term disabilities, and disease in different populations. Tracking health-related quality of life in different populations can identify subgroup with poor physical or mental health and can help guide policies or interventions to improve their health (7). Coronary artery bypass graft surgery is performed to restore blood flow to the heart. This relieves chest pain and ischemia, improves the patient's quality of life, and in some cases, prolongs the patient's life. The goals of the procedure are to enable the patient to resume a normal lifestyle and to lower the risk of a heart attack (8). The number of CABG procedures performed each year in the United States has risen from approximately 150000 in 1979 to 598000 in 1990-a 425% increase (9). In Iran, 60% of total open-heart surgery was CABG (10). Increasing attention has been given to monitoring health-related quality of life variables in relation to the outcome of surgery (11).

Therefore, with attention to increase of atherosclerosis and CABG surgery and regard to important quality of life in these patients and positive effect of health education on quality of life in bypass surgery patients this study was conducted.

MATERIALS AND METHODS

This study is clinical trial and experimental design Seventy men patients selected by random sampling method for the study, with 35 patients in the experimental and 35 patients in control group. All patients attending the Shahid Ragaee Heart hospital in Tehran (as a major heart center in Iran) between April to August 2002. Selection criteria were 40-65 years, having an atherosclerosis diagnosis by angiography. Eligible were considered patients planned to undergo coronary artery bypass graft surgery. These patients were interview 3-5 days

before operation and at an average time of 4 weeks after operation.

A face-to-face structure questionnaire was administered to all participants. The questionnaire consists of up to 118 questions and could generally be administered in 20-25 minutes. It examined demographic information (18 questions), knowledge, attitude and practice (26 questions), SF-36 questionnaire (36 questions) and Nottingham health Profile (38 questions).

After received Ethics Committee approval, 80 men patients were selected and allocated in experimental and control group. For the limitation of bias used to matching for groups. Nine patients were lost to follow-up and one patient had died. Total the remaining 70 participants in the study. In the stage one, 35 patients in experimental group received the questionnaires at 3-5 days before operation. Then, was doing educational planning according to Mico's Health Education Planning Model. Mico's model for health education planning (also applicable to health promotion) is designed in two dimensions. The model is divided into six phases, include: 1- Initiation of the planning activity, 2-Need assessment, 3- Goal setting, 4- Planning or programming the activity, 5- Implementing the activity, and 6- Evaluating the activity's effectiveness (12).

According to this model, Success or failure of the activity often depends upon what happens in phase 1 (initiate). The key elements understanding the client's problems and the client's system, devising an entry strategy, making an initial contract, and making the clients aware that a problem exists so they are ready to change.

Obviously, the health educator's credibility is pivotal to initial success of the project. Phase 2 of the model is Need Assessment. Mico pointed out that the technology for needs assessment can be simple and inexpensive or highly refined and costly, depending on the purpose. In this study, for phase two of the model, had measured knowledge, attitude and function in patients. Knowledge questionnaire includes of 6 questions that measured knowledge patients in nature of Atherosclerosis and bypass surgery, risk factors, diet, exercise, procedures in prevention of pain, activity for control pain and control of disease. Attitude questionnaire includes 13

questions that measured attitude patients. Motivation refers to a process that is directed toward the future goal and an integrative process of goal setting and self-evaluated reaction. Function or behavior questionnaire includes of 8 questions that measured function patients in healthy diet, use of fruit and vegetable, physical activity and walking, blood examination, giving up smoking and consuming alcohol, sleep, rest interval activities and healthy sexual function.

Then, all data analyzed by SPSS software and assessed need education in patients. Phase 3 of the model is Goal setting. Mico defined goal as a future event toward which a committee endeavor is directed. He defined objectives as step to be taken in pursuit of a goal. Objectives often carry built-in indicators of success. In this study, for phase 3, assessed the goals in 3 domains cognitive, affection and motion -mental. Examples for cognitive goals include, what is atherosclerosis? What is major sign of disease? What risk factors in atherosclerosis? Examples for affection goals include correctly perceived to control of atherosclerosis, believed to positive affect of surgery, correctly perceived in control of disease and prevention. Examples for motion-mental goals include, patients used healthy diet for control of disease, patients done blood test regularly.

In phase 4 of the Mico model, planning/programming, an implementation plan is established, system and tools for managing the activity are designed, and commitment from those involved is negotiated. In this study, for phase 4, was planning 3-education meeting for experimental patients group. The average length of the educational intervention in per meeting was only 20-25 min.

Educational method was face-to-face education for patients. The experimental group received a booklet that it focus in exercise, diet, healthy sexual function , deep breathing, anatomy and physiology of heart , procedure of bypass surgery , important of lipid in atherosclerosis formation , healthy travel in road, use of drug regularly, . . .

Phase 5 of the Mico model is implementation. In this study, for phase 5 of model, educational meeting was performed in 3 meeting (20-20 min in per meeting) for experimental group.

Phase 6, evaluation, is a four-step procedure that is crucial to success of the new program.

1- Clarify the evaluation measures.

2- Collect and analyze data.

3- Report the evaluation so participants will have feedback on the extent of success of the activity.

4- Use what was learned in evaluation to redefine the problem, and refine measures and standards to determine its nature and extent.

In this study, for phase 6, evaluation was 1-month post operation by measurement of knowledge, attitude, function and quality of life in patients that similar questionnaires were used.

After that performance educational intervention for experimental group and discharge patients, 35 patients selected of control group. In pre operation, 35 patients administered the questionnaires. Finally, all patients in two groups were followed up to 1-month.

At result, SF-36, Nottingham Health Profile questionnaires were administered 1-month of post operation by patients again. SF-36 questionnaire: The SF-36 is a validated (9), concise, 36 item health status questionnaire measuring 8 dimensions:

Physical function (10 items); role limitation caused by physical problems (4 items); bodily pain (2 items); mental health (5 items); role limitations caused by emotional problems (3 items); vitality-energy/fatigue (4 items); and general health perception (5 items). Nottingham Health Profile questionnaire:

The NHP is in two parts. In this study, put to used part I of NHP questionnaire for measurement quality of life. Part I contains 38 questions in the six dimensions of physical mobility, pain, energy, social isolation, and emotional reactions. A score from 0 to 100 is calculated for each dimension, with higher scores indicating higher levels of dysfunction or distress.

The survey of association between quantity demographic information and quality of life were analyzed with Pearson correlation analysis and survey of association between quality demographic information and quality of life were analyzed with chi-square test. Mean and interaction effect of education on knowledge, attitude, function and quality of life in per group (in pre and 1-month post

education) were analyzed with paired *t* test. Comparison knowledge, attitude, function and quality of life between two groups in the stage pre and 1-month post education were analyzed with independent sample *t* test. A *P* value less than 0.05 was considered to be statistically significant. Analyses were performed using SPSS (version 9.0).

RESULTS

Of the 80 patients, 9 were lost to follow-up; 1 patient had died. Completed questionnaire were returned by 70 patients in two experimental and control groups. The mean age of patients in experimental and control group in sequence was 53.5 and 52.8 years. Majority of patients in two groups were retired and had initial education. There was no significant difference in mean of age, level of education and job status. 60% of patients into groups

had history of smoking habit. Between experimental and control groups, there was no significant difference in history of smoke habit (62% vs. 58%), diabetic mellitus disease (17.1% vs. 20%), history of high blood pressure (31.4% vs. 37.1%), high blood lipid (68.6% vs. 71.4%) history of bypass surgery (2.9% vs. 5.7%). Table 1 shows significant difference between two groups in knowledge and attitude after education. The standard deviation of quality of life in pre-test is 82.79 and in post test is 70.45.

Two groups had no significant difference in total mean quality of life before education but there was a significant difference in total mean QOL 1-month post education (by Nottingham Health Profile and SF-36 questionnaires) (Table 1). Table 2 show results of correlation analysis between age, number of children, salary and quality of life in experimental and control group before and post education by SF-36 and NHP questionnaires.

Table 1. Mean comparison of KAP in experimental (n = 35) and control group (n = 35) at pre-educational and 1-month post-educational intervention

	Pre-education		<i>P</i> Value	Post-education		<i>P</i> Value
	experimental group	control group		experimental group	control group	
KAP						
Knowledge	18.40	17.68	NS	23.14	19.97	< 0.00001
Attitude	26.51	32.63	< 0.009	42.77	39.31	< 0.01
Function	14.11	13.91	NS	17.06	16.66	NS
Quality of life						
Energy	4.43	4.5	NS	11.05	7.2	<0.001
Pain	21.54	22.03	NS	33.63	29.1	<0.006
Emotional reaction	27.37	21.7	<0.02	38.57	29.4	<0.00001
Sleep	12.26	13.3	NS	19.02	14.9	<0.01
Physical mobility	25.57	21.2	<0.004	32.97	26.1	<0.00001
Social isolation	18.03	17.09	NS	20.9	18.8	NS
Total mean QOL	108.9	99.9	NS	154.83	125.5	<0.00001
SF-36 construct						
Physical function	19.6	14.4	<0.00001	25.3	21.8	<0.00001
Role limitation (physical)	5.5	4.8	<0.004	5.8	5.2	<0.05
Role limitation (emotional)	4.5	4	<0.02	4.7	4.3	<0.007
Vitality	11.8	12.1	NS	11.3	12.9	<0.02
Mental health	18	17.3	NS	20.4	18.9	<0.03
Social function	6.1	6.2	NS	6	6.1	NS
Pain	6.8	7.3	NS	7.03	6.6	NS
General health	17.4	20.3	<0.00001	17.6	18.2	NS
Total mean QOL	89.5	86.2	NS	98.4	94.4	<0.02

Abbreviation: QOL, quality of life.

Table 2. Correlation of between age, number of children, salary and quality of life in experimental group

	QOL before education (NHP)	QOL1-month post education (NHP)	QOL before education (Sf-36)	QOL 1-month post education (Sf-36)
Experimental Group				
Age of patients	r=0.04, P=0.8	r=0.26, P=0.1	r=0.18, P=0.2	r=0.07, P=0.6
Number of children	r=-0.22, P=0.1	r=0.8, P=0.6	r=-0.05, P=0.7	r=-0.29, P=0.009
Salary	r=0.07, P=0.6	r=0.04, P=0.7	r=0.12, P=0.4	r=0.008, P=0.9
Control Group				
Age	r=0.02 P=0.8	r=0.5 P=0.6	r=-0.05 P=0.7	r=0.1 P=0.5
Number of children	r=-0.08 P=0.6	r=0.25 P=0.1	r=0.02 P=0.8	r=0.07 P=0.6
Salary	r=0.4 P=0.005	r=0.2 P=0.1	r=0.13 P=0.4	r=0.05 P=0.7

Abbreviation: QOL, quality of life.

DISCUSSION

The results showed that knowledge and attitude had significant difference between two groups 1-month after educational intervention. Comparisons of two groups showed that function had no significant difference into groups 1-month after education. Probably, cause of this result is high intensive perception of disease in patients. Patients in two groups would try to attach function (behavior) soon. The results of study show positive affect health education on knowledge and attitude in bypass surgery patients. Attention to results shows significant difference in quality of life (by SF-39 and NHP) between experimental and control group 1-month post educational intervention. Significant improvements in quality of life between two group, as measured by the Nottingham Health Profile, were seen in energy, pain, emotional reaction, sleep, physical mobility and total average quality of life. Significant improvements in quality of life between two group, as measured by the SF-36, were seen in physical function, role limitations resulting from emotional status, role limitations resulting from physical status, mental health, vitality and total average quality of life. The findings demonstrate that health education result is improved quality of life for patients with CABG.

In a study by Shuldham *et al.* demonstrated the beneficial that pre-operative education exerts on postoperative recovery of patients having cardiac surgery. The results of this study showed significant difference in length of hospital stay in experimental group related to control group (13).

Christopherson and Pfeiffer selected 41 patients in experimental and control group. Experimental patients receive a booklet at the time of 1-2 days before bypass operation. The booklet contained information on tests and procedures, actions that would be expected of patients post-operatively, *e.g.* deep breathing and coughing, sensations that might be experienced such as pain, and facts about the heart, atherosclerosis and the operation. The findings suggested that, although there were differences in knowledge and anxiety within groups between the two measurement points, with significant increased in knowledge in those who read the booklet, there were no significant difference between two groups. Length of stay in ICU was reduces for people in the experimental arm (14).

Baghery showed that group-counseling had positive effect on quality of life in MI patients. In this study, 62 patients (35-65 years) with MI were divided to experimental and control group and patients in experimental group counseled in the 6-8 meeting. Analysis the data 1-month post counseling showed that quality of life had significantly improved pre and post counseling difference in experimental group but not in control group (15).

Ahmadzadeh demonstrated the positive effect of health education on reduce anxiety in bypass surgery patients. She selected 80 patients in experimental and control group before operation. Experimental group received the education intervention (face to face and booklet) before operation. Data showed significant difference in anxiety between two groups after operation (16).

Cupples in a study showed that pre-operation education had positive effect in knowledge the patients (17). Anna Stromberg evaluated the effect of education to patients with heart failure. Results showed patient education is an important component in the care of patients with heart failure and improved quality of life the patients (18). Devine and Cook's meta-analysis showed a positive effect in respect of pain, psychological well being and satisfaction (19). In 1992, Davine reported a sequel meta-analysis and demonstrated that with respect to recovery, pain and psychological distress in patients receiving psycho-educational interventions benefited more than those in the control group (20). Patient education includes all educational activities directed at patients, including aspects of therapeutic education, health education and clinical health promotion (21) and can be improved the knowledge and skills (18) and education for people with a chronic disease gets a growing attention and improve quality of life in this people (22).

According to our study assessment of quality of life and health education is improved health quality of life for patients with CABG.

Conflict of interests

We have no conflict of interests.

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