Chapter 3

Research Methodology
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Breast cancer is studied as a severely distressing life event among women who are diagnosed with this illness (Hewitt, M, Herdman, R, Holland, J, 2004). In addition to the demands and pressures it causes a physical challenge to cope with, the persistence of treatment side effects affects the person in all aspects her life. Cancer diagnosis affects not only the patients but their families as well; they are often in dilemma of managing their anxieties and stress of the loved one’s cancer diagnosis and taking care of the person who suffer with cancer (Carroll et al, 1993). The psychological effects of diagnosis and treatment side effects hinder the persons to comprehend and adapt to medical care (Siteman Cancer Center, 2006). Therefore, it is essential to understand the elements which affect a person’s navigation through cancer in order to have better quality of life. Since the persons with cancer spend a long duration at hospitals for the treatment; the need for supportive care becomes an important concern in cancer care.

This chapter discusses the methodology adopted for this study; which includes statement of the problem, significance, conceptual framework; research questions, objectives, research design, sampling, recruitment, data collection, and data analysis are outlined.

3.1. STATEMENT OF THE PROBLEM

This study is to understand the health related quality of life and supportive care needs of women with breast cancer with special reference to the cancer specialty hospitals of Kerala state.
3.2. SCOPE AND SIGNIFICANCE

Adverse life events occur across the life span in various contexts and settings and it has impact on the social, emotional and spiritual well being of individuals. Many adverse life events such as accidents, illness, violence, divorce, separation and family breakdown, unemployment, poverty, loss of services and death all affects aspects of quality of life. There is considerable evidence that the experience of illness has potentially negative effects on mental and physical health of individuals and also affects a person's well being (David B. Beaton, 2003).

Quality of life can be defined as the extent to which people's 'happiness requirements' are met - those requirements which are a necessary (although not sufficient) condition for anyone's happiness - those 'without which no member of the human race can be happy.' (McCall, 1975). It reflects the difference, the gap, between the hopes and expectations of a person and their present experience. “Quality of life” (QOL) subsumes two distinct domains in research. One is health-related quality of life (HRQOL); the other, non-health or environment-based quality of life. Health-related quality of life (HRQOL) encompasses domains of life directly affected by changes in health. Generally, it covers the subjective perceptions of the “positive and negative aspects of patients' symptoms,

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31 David B. Beaton (2003) explained that chronic psychological stress impacts the inflammatory responses by reducing immune system reactions there by harm or delay the prognostic factors. He argued by quoting several literature, the significant role of perceived mood in the effectiveness of immune system especially in diseases which needs long term treatment.

32 Janssen (2003) described in his notes on quality of life as “QOL reflects the difference, the gap, between the hopes and expectations of a person and their present experience. It is the degree to which a person enjoys the important possibilities of his/her life. Human adaptation is such that life expectations are usually adjusted so as to lie within the realm of what the individual perceives to be possible. This enables people who have different life circumstances to maintain a reasonable quality of life.”

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including physical, emotional, social, and cognitive functions and, importantly, disease symptoms and side effects of treatment.” (Bottomley. A., 2002, Leplege A, 1997) 

Non-communicable diseases including cancer are already emerging as major public health problems in India. Treatments of these diseases require particular infrastructure and specialized human resource. The increasing burden of cancer is much evident and it is important to be addressed as a major public health issue in a highly populated country like India. 

Breast and cervical cancer are the two most important cancer types and account for one-third of all cases diagnosed in women of the developing world (Kurkure A P and Yeole BB &. 2006). The incidence of breast cancer is rising and is the most common cancer among urban women (Chopra R. India: the socio-economic & cultural considerations of breast cancer management, The Global Summit Consensus Conference on Breast Cancer, 2003, US). Presently 75,000 new cases occur in Indian women every year (Delhi Breast Unit, Apollo Clinic).

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33 Bottomley. A. (2002) described the meanings of HRQOL carried in different studies as – a) ability to perform as well as various levels of satisfaction (p. 49), b) subjective evaluation of the good and satisfactory character of life as a whole (p. 50), c) the gap between the patient’s expectations and achievements (p. 51), d) the functional effect of an illness and its consequent subjective effects on the patient (p. 52), e) overall satisfaction with life and perceptions on personal well-being (p. 53), f) perception of their position in life in the context of the culture and value systems (p. 54)

34 Varghese. C, depicted 50 years of cancer prevention and control in India by connecting the dots-magnitude of the issue, cancer epidemiology, diet, risk factors, prevention and treatment and prevention strategies, palliative care, registry network, human resource generation as well as participation of international agencies.

35 Breast cancer is the most common malignancy type diagnosed in women in developed countries and the second most common type diagnosed in developing countries. Breast cancer has been described as an alarmingly health problem in India (Yeole BB, Kurkure AP (2003) (p. 51 – 56.).

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Most cancer patients now undergo a combination of effective, but traumatic treatments such as the surgery, radiotherapy, chemotherapy, and hormone therapies. Although these treatments are enough capable to cure some cancers, and to extend the life span of patients, they usually cause a wide range of physical as well as psychosocial problems. Different strategies are used to assess the psychosocial morbidity of the cancer patients including the QOL assessments; satisfaction with care, needs assessment and so on. Cancer patients’ activities such as work and social activities, management of daily routine and household activities, family and other relationships are reported as impaired by the diagnosis and subsequent cancer treatment. In addition, studies regarding the psychological dimension of cancer have brought evidence for clinically significant levels of anxiety and depression in cancer patients (Bonevski, B, Sanson-Fisher, R, 2000).

Although both cancer specialists and patients may admit physical and psychosocial problems as an unavoidable part of the disease and its treatment, these problems have a considerable influence on cancer patients’ compliance with their treatment and with results. So, it is important for cancer specialists to be conscious about the prevalence of these issues among their cancer patients and to act their best to prevent and address them where it is feasible.

Supportive care facilitates people who have difficult life conditions to maintain a sound QOL (Janssen, 2003). Supportive care can be defined as:

“the provision of the necessary services as defined by those living with or affected by cancer to meet their physical, informational, practical, emotional, psychological, social, and spiritual needs during the pre-diagnostic, diagnostic,
treatment, and follow-up phases, encompassing issues of survivorship, palliation, and bereavement. (Fitch, 2000)"

Being a woman, varieties of roles have to be performed in family, society, work place and in her personal life. Fear and health complications of such an illness create impact on their quality of life and proper supportive care is essential to enhance it. The evidence supporting the provision of psychosocial care to women with breast cancer is clear. The challenge for the social work profession is to ensure that women can obtain appropriate help when needed. Social support has been identified as a key factor in women's coping to breast cancer (Reynolds, 2006), Bloom, Stewart, Johnston, Banks, & Fobair (2001). Social support can be provided by family and friends, health care professionals, or support groups. Studies have shown that psychological distress of cancer patients considerably reduces when they share feelings with a treatment team member or a counsellor. Studies reveal, women with breast cancer who were provided with an opportunity to discuss their feelings with a treatment team member or a counsellor had less psychosocial distress than women not provided with this opportunity (Sanson-Fisher, R, et al, 2000). Social work profession is in a key position to educate women and other health care professionals on the importance of supportive care for women diagnosed with breast cancer. This study points out the domains of supportive care needs of women with BC, needs to be addressed as well as towards the predecessors which directly or indirectly determines their quality of life.
3.3. CONCEPTUAL FRAMEWORK

A conceptual framework provides a theoretical lens to form the nature of research questions to be proposed and the methods to be used (Glesne (1999), Miles and Huberman (1994). HRQoL and SCN are the two major concepts on which this study is based on. Though several theories have come up to explain QOL, Betty Ferrel’s (1993) model of HRQOL for breast cancer has been taken as the frame to study HRQOL and Fitch’s (2008) supportive care framework for cancer care has been used for studying SCN.

Betty Ferrel’s (1993) model of HRQOL for breast cancer

HRQOL in this study is build upon the four-domain model of QOL for BC patients formulated by Betty Ferrel in 1993. This holistic model talks about the four domains—physical, psychological, social, and spiritual which are the areas of a patient likely to be affected by the illness—breast cancer.

Present study examines the issues and factors concerned to each domain which influence the total HRQOL of women with BC, afterwards seek the similar and diverse factors specifically matters to its socio cultural context.

Fitch’s (2008) supportive care framework

Supportive care framework for cancer care described by Fitch (2008) has employed to understand SCN in this particular research as it addresses the non medical needs of the patients as well. Fitch (2000) defines supportive cancer care as-
“...the provision of the necessary services as defined by those living with or affected by cancer to meet their physical, social, emotional, informational, psychological, spiritual and practical needs during the pre-diagnostic, diagnostic, treatment and follow-up phases of cancer care, encompassing issues of survivorship, palliation and bereavement (p. 41).”

Figure.3.1. Specific quality of life model for breast cancer survivors

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36 Adapted with permission from Betty Ferrell & Marcia Grant, Quality of Life Conceptual Model applied to Cancer Survivors, City of Hope Beckman Research Institute
The Diagnosis of cancer might impact the usual modes with which an individual meets his/her physical, psychological, social, and spiritual needs (Fitch, 2000; Fitch, 2008). Variation and diversity in the nature of experiencing these needs can explicitly be noticeable, as over the time it differs from person to person as well as for the same person during her course of illness. SCN is also unique as the distinctive individual factors like socio demographic and cultural context she belongs to and preferences and decisions she needs to make. Fitch (2008) insists SCN must be assessed, designed, matched and delivered according to the context of the recipient’s unique situation. During this course of illness, almost all require different supportive care services to meet their SCN. Precisely, this framework proposes that every hospital or care system should define their own design, structure, strategies and procedures for implementing supportive cancer care
services which is suitable to the socio cultural context and existing resources of the particular area as well as to the exact target group.

3.4. RESEARCH QUESTIONS

Attempts to address the following four research questions guided this study-

1. How are socio-demographic, medical and treatment factors of the women with BC associated with the different domains of HRQOL?
2. How are the various domains of well-being associated with HRQOL of the Women with BC?
3. What are the key issues and concerns of women with BC associated to various types of their SCN?
4. How the women with BC view the availability of existing supportive care provisions in terms of information needs and health care system delivery and their expectations regarding better supportive care availability?

3.5. OBJECTIVES

1. To study the socio-demographic and case profile of women with breast cancer.
2. To assess physical functioning and well being of the women breast cancer patients
3. To analyze psychological and social functioning and well being of the women breast cancer patients.
4. To study the spiritual well being of the women breast cancer patients and the role limitations due to their illness
5. To assess the supportive care needs of the respondents related to their physical, psychological, social and spiritual functioning.

6. To understand the patient care and health care system support needs of the women breast cancer patients.

3.6. OPERATIONAL DEFINITIONS

3.6.1. Health-related Quality of Life

In this study, Health-related Quality of Life means patient’s perception regarding factors related to well-being and functioning in their life affected by changes in health i.e., their illness- breast cancer.

3.6.2. Supportive Care needs

Supportive care needs denotes here as the perception (views and experience) of women with BC regarding their needs to meet their physical, social, emotional, informational, psychological, spiritual and practical needs during the diagnostic, treatment and follow-up phases of cancer care.

3.6.3. Woman

An adult female who has been diagnosed as breast cancer patient and undergoing treatment form a specialized hospital.
3.6.4. Breast Cancer

Breast cancer is diagnosed with self- and physician-examination of the breasts, mammography, ultrasound testing, and biopsy.

3.7. RESEARCH METHODOLOGY

3.7.1. RESEARCH DESIGN

Present study is descriptive in nature and tries to reveal and analyze present situation and characteristics of particular group- women with breast cancer. This study has adopted Concurrent Triangulation mixed methodological research design where the researcher uses two different methods in an attempt to confirm, cross-validate, or corroborate findings within a single study (Cresswell, 2008). This design uses quantitative and qualitative methods as an alternative to the key issues in methodology - Clark V P, Creswell JW, (2008) in their book ‘The Mixed Method Reader’ explained that the role of philosophic foundations is important for all research (quantitative, qualitative and mixed methods) but, to counter the paradigm method link and to defend mixed method a different paradigm had to be used: pragmatism (Howe, 1988). "Instead of searching for meta physical truths, pragmatists consider truth to be ‘what works’” (Tashakkori A, Teddlie C, 2008). A major principle put forwarded by Howe’s concept of pragmatism was compatibility of quantitative and qualitative methods. As it says the compatibility of both the methods researchers could use these together for better understanding of the issue. “The pragmatic approach is to rely on a version of ‘abductive reasoning’ that moves back and forth between induction and deduction- first converting observations into theories and then those theories through action.” This approach also suggests ‘intersubjectivity’ to explain the relationship between the researcher and the research process and also represents the emphasis on process of communication and shared meaning. “Here there is problem with asserting both that there is a single “real world” andth that all individuals have their own unique interpretations of that world.” When talk about another key methodological issue the inference from data, the idea of ‘transferability’ of research results have to be borrowed as a solution. This approach to research makes research results either context-bound or generalizable; instead, investigating the factors that affect whether the knowledge gained can be transferred to other settings. These philosophical thoughts have influenced the researcher in choosing the research design of studying this particular issue.

37 Mixed methodological research debate:Pragmatic approach as an alternative to the key issues in methodology- Clark V P, Creswell JW, (2008) in their book ‘The Mixed Method Reader’ explained that the role of philosophic foundations is important for all research (quantitative, qualitative and mixed methods) but, to counter the paradigm method link and to defend mixed method a different paradigm had to be used: pragmatism (Howe, 1988). “Instead of searching for meta physical truths, pragmatists consider truth to be ‘what works’” (Tashakkori A, Teddlie C, 2008). A major principle put forwarded by Howe’s concept of pragmatism was compatibility of quantitative and qualitative methods. As it says the compatibility of both the methods researchers could use these together for better understanding of the issue. “The pragmatic approach is to rely on a version of ‘abductive reasoning’ that moves back and forth between induction and deduction- first converting observations into theories and then those theories through action.” This approach also suggests ‘intersubjectivity’ to explain the relationship between the researcher and the research process and also represents the emphasis on process of communication and shared meaning. “Here there is problem with asserting both that there is a single “real world” andth that all individuals have their own unique interpretations of that world.” When talk about another key methodological issue the inference from data, the idea of ‘transferability’ of research results have to be borrowed as a solution. This approach to research makes research results either context-bound or generalizable; instead, investigating the factors that affect whether the knowledge gained can be transferred to other settings. These philosophical thoughts have influenced the researcher in choosing the research design of studying this particular issue.
qualitative methods separately as a mean to balance the weaknesses inherent within one method with the strengths of the other method.\(^{38}\)

In this study, quantitative method is used to assess HRQOL of the women with BC. SCN is studied qualitatively by interviewing women with BC and analysed thematically. Information from interviews with treatment professionals were analysed and incorporated while developing the supportive care model. All sets of data have been collected separately and integrated at the stages of analysis, interpretation as well as writing.

**Figure 3.3. Concurrent Triangulation Mixed Methodological Research Design**

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\(^{38}\) Creswell JW and Clark V.P described “In this case, the quantitative data collection and the qualitative data collection are concurrent, happening during one phase of the research study. Ideally, the priority would be equal between the methods, but in practical application, the priority may be given to either quantitative or qualitative approach. This design usually integrates the results of the two methods during the interpretation phase. This interpretation either may note the convergence of the findings as a way to strengthen the knowledge claims of the study or must explain any lack of convergence that may result.”

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3.7.2. SAMPLING DESIGN

3.7.2. a. Sampling method

As this study has been conducted on a sensitive issue researcher had chosen *purposive sampling*[^39] to understand the response of the patients, as well as *expert sampling*[^40] has used to identify treatment professionals.

**Table. 3.1. Sampling design of the study**

<table>
<thead>
<tr>
<th>Universe</th>
<th>Sample set</th>
<th>Sampling Technique</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amala institute of Medical Sciences,</td>
<td>Women with breast cancer</td>
<td>Purposive Sampling</td>
<td>60</td>
</tr>
<tr>
<td>Thrissur</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCC, Trivandrum</td>
<td>Women with breast cancer</td>
<td>Purposive Sampling</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Women with breast cancer</strong></td>
<td></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>

**Inclusion criteria:**

Women with BC -

- who had completed at least one month after cancer diagnosis
- who were willing to provide filled informed consent

[^39]: Max Well (1997) defined purposive sampling as “selecting units based on specific purposes answering a research study’s questions, in which particular sample units are deliberately selected for the important information they can provide with and it cannot be gotten as well from other choices.” (p. 77)

[^40]: Lisa M. G. (2008) described, in expert sampling the researcher looks for individuals who have particular expertise that is most likely to be able to advance the researcher’s interests and potentially capable of opening new ideas. (p. 697)
• who were physically and mentally able to talk to the researcher at the time of interview

3.7.3. Tools of data collection

The tools used for primary data collection were - *socio demographic and case profile*, **standardized assessment tools**- *FACT-B* (Functional Assessment of Cancer Therapy–Breast Malayalam version IV to assess quality of life), *FACT- Sp* (spirituality subscale) *interview schedule* (to understand supportive care needs) and *interview guide* (to gather information from treatment professionals).

Table. 3.2. Instrumentation

<table>
<thead>
<tr>
<th>Data set</th>
<th>Tool used</th>
<th>Purpose</th>
<th>Major themes discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women with BC (Quantitative data)</td>
<td>Functional Assessment of Cancer Therapy - Breast</td>
<td>To assess Health Related Quality of Life (FACT-B) &amp; FACT-Sp sub scale</td>
<td>Physical QoL, Psychological QoL, Social QoL, Spiritual QoL, Additional concerns related to Ca-breast</td>
</tr>
<tr>
<td>Women with BC (Qualitative data)</td>
<td>Interview schedule</td>
<td>Socio demographic&amp; case profile</td>
<td>Socio demographic factors, Case history</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supportive care needs</td>
<td>physical, psychological, social/ family, psychological and spiritual SCN, Informational needs</td>
</tr>
<tr>
<td>Data from treatment professionals</td>
<td>Interview guide</td>
<td>Supportive care needs</td>
<td>Factors facilitate SCN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Factors/ strategies/ methods impact QoL of patients, What they can do for better care Barriers (system/ process), Suggestions- Govt, Mgt, Support groups, NGOs</td>
</tr>
</tbody>
</table>

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3.7.4 AREA OF THE STUDY

The study conducted in patients who receive treatment from Cancer specialty hospitals of Kerala.

3.7.5. UNIVERSE

Woman, diagnosed as breast cancer patients who receive treatment from any of the cancer specialty hospitals of Kerala constitutes the universe.

3.7.6. DATA COLLECTION, ANALYSIS AND INTERPRETATION

The researcher prepared the tool, interview schedule I and II and translated to Malayalam. Pretesting of tools had been conducted in October, 2011 with 20 women with breast cancer in Kerala and made necessary changes in the tools. Another tool used, FACT B has been translated and validated by Pandey et al, (2004). Subsequently researcher has done the procedures to get the approval of Institutional Review Board (IRB) and Ethical committee- (September- October, 2012) and collected the data from November 2012 to March, 2013.

3.7.8. Ethical considerations while collecting the data

Approval for the study was obtained from the Institute of Review Board and the ethics committee of the hospitals concerned. The researcher tried best to ensure adherence to the standards of research ethics and the Ethical Principles for Medical Research Involving Human Subjects (World Medical Association’s Declaration of Helsinki 2004). The process and procedures by which this study ensured ethical standards are mentioned below.
Figure 3.4. Ethical considerations

- Maintained the anonymity of the respondents and confidentiality: Anywhere in this study, researcher did not mention or share any identifying features of the respondents such as name, hospital identification number, address.

- Approval of Institute of Review Board and Ethical Committees of the respective hospitals: Synopsis of the study, tools of data collection, information sheet and informed consent have been prepared and translated and presented before the two committees and received the approval certificate.

- Information sheets have been provided for the respondents: information sheets have been prepared in the languages English and Malayalam which were in simple language and easily comprehensible about the study details, purpose, benefits/ consequences, services available in the hospital for the particular illness, contact numbers if they have any doubt and so on.

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• Informed consent (English/ Malayalam) obtained from respondents: Interviews have been conducted only with the respondents who were willing to provide the filled and signed informed consent to conduct the interview (Appendix 8).

• Memorandum of Understanding (MoU) has been signed between JMI and Regional Cancer Center, Trivandrum to conduct the study (Appendix 9).

3.7.9 Process of data collection

Hospital A–Amala Institute of Medical Sciences, Thrissur

Researcher got the approval from the hospital authorities and the medical social workers of surgery and oncology helped her to get the patient files. The files were reviewed by the researcher and then selected the respondents according to the inclusion criteria and met them in wards and rooms. Then researcher herself interviewed the respondents and collected the data. Before collecting the data, information sheet was provided and the informed consent was obtained from each respondent. Data from the treatment professionals were collected by the researcher by interviewing them.

Hospital B– Regional Cancer Center, Trivandrum

The Additional Professor, Division of Surgical Oncology had been assigned as the principal investigator for conducting the study in the particular hospital by the hospital authorities. Then researcher presented before IRB and ethical committee and got the approval document. The case files of the patients with breast cancer were provided manually and from the database. Women who met the inclusion criteria (Selected for each day from hospital database according to the date of appointment with the principal
investigator) were selected and others were excluded then interviewed by the researcher and collected the data. Researcher personally met the treatment professionals and handed the questionnaire and collected the data from them.

The collected quantitative data from 120 women with BC had been coded, tabulated, analyzed and interpreted using appropriate statistical techniques. The qualitative data collected from 30 women with BC is analysed thematically and presented in the chapter VI and findings are presented in the chapter VII. The analysis of interviews with treatment professional addressed the supportive care system needs; are analysed and incorporated for the development of hospital based supportive care model.

3.8 Report/ Chapterization

The final stage of research process is reporting. Chapters of this study are structured as follows-. 

I. Introduction: Chapter presents and establishes the major concepts- Clinical and social picture of Breast cancer on women’s life, HRQOL, SCN concerns of women with BC, the available support programmes in India and the scope of studying HRQOL and SCN of women with BC.

II. Review of literature: This chapter is an attempt to sum up the existing knowledge including theoretical as well as empirical contributions of various studies on the theme- women with breast cancer. It precisely talks about the discourse in breast cancer as a disease and as an illness experience with a focus on HRQOL and SCN on women. It is organised in a sequence where women with breast cancer is the
central theme, breast cancer experience as the disease and illness are discussed under the first sub theme. Women as a cancer patient; HRQOL and breast cancer (various domains) supportive care needs of women with BC (factors affecting SCNS) and common areas of need (incorporating informational needs and health care system delivery needs) are the subthemes discussed in the later sections. This chapter concluded by specifying potential gaps in understanding the women with breast cancer.

III. Research methodology: This chapter discussed the scope and significance of the study, research questions, objectives as well as the methodology of the study.

IV. Socio demographic and case profile: Discussed the socio demographic and disease related profile of the respondents. Age, mother tongue, district they belong to, religion, income category, type of family, education, occupation, current occupation, marital status and child status were the included socio demographic factors. Case profile consist of closed ended as well as open ended questions about presence of family history, History of the illness, initial hesitation to consult a doctor, treatment underwent and ongoing treatment of the respondents.

V. Health related quality of life: This chapter is major quantitative part of this study; attempting to examine the experience of women with BC in Kerala collected using the cancer specific QOL scale FACT- B and FACT- Sp; the spiritual well-being subscale. This chapter has discussed two research questions- firstly, the relationship between socio-demographic and disease related variables and HRQOL of women with BC. Secondly, the relationship in between the various domains of HRQOL such as physical, social, functional, emotional, spiritual and breast cancer specific
concerns; and how they are related with the overall quality of life of the women with BC have been discussed.

VI. Supportive care needs: Attempts to understand supportive care needs of women with BC who are under treatment of any cancer specialty hospitals of Kerala. This chapter is framed in a fashion which gives a picture on two questions on the SCN of women with BC- a) What are the key issues and concerns of women with BC associated to various types of their SCN? b) How the women with BC view the availability of existing supportive care provisions in terms of information needs and health care system delivery and their expectations regarding better supportive care availability? In order to understand these questions; the in-depth interviews with thirty women with BC were analysed qualitatively. To get the quantitative picture of certain issues, questions were asked to the 120 women with BC, and integrated to the categories of needs.

VII. Conclusion: Constitute major findings of the study have been discussed in chapter IV, V and VI. Based on the findings, a hospital based supportive care model is proposed as part of the suggestions. The chapter concludes by discussing a few other suggestions, limitations of the study and future research perspectives.

CHAPTER SUMMARY

This research study focuses on health-related quality of life and the supportive care needs of hospitalized women with breast cancer. This chapter discussed the scope and significance of the study, research questions, objectives as well as the methodology on which the present study has been visualized and proceeded with. It is hoped that this
research will deepen the understanding of the complicated experiences of women with cancer and its impact on their quality of life as well as to recognize the importance of understanding supportive care needs of women breast cancer patients to plan necessary modifications in supportive care strategies. Next chapter discusses the socio demographic and case profile of the women with BC.