

Short Communication

## What Can Complex Abdominal Wall Hernia Surgeons Learn About Quality of Life From Ancient Greek Philosophers?

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### Abstract

Ancient philosophers were the first to explore the concept of quality of life. Their conceptual views although complemented, challenged or replaced by other schools of thought such as Positivism, still underpin many modern thoughts pertaining to quality of life. QoL and its measurement are vital in healthcare. Often it is a perceived deterioration in QoL

that prompts a surgical consult. Here we outline some Greek philosophical thoughts about quality of life and highlight implications for the complex abdominal wall hernia surgeon.

**Keywords:** Quality of life; Hernia; Philosophy

## Introduction

Quality of life (QoL) and its measurement have gained increasing traction in surgery and more widely [1]. Increased interest in QoL generally shows that there is widespread interest in the big questions like: “*what is quality of life?*” and “*what does QoL mean to you?*” Surgeons have a long history of pursuing improved QoL for patients and, indeed, it is often a reduction in quality of life that prompts patients to seek a surgical consult [2]. The element of QoL related to health is colloquially called Health Related Quality of Life (HRQoL). Some consider this to be a useful indicator of health-related outcomes [3]. Equally, The Royal College of Surgeons England have called for service providers of numerous operations to routinely collect measures of HRQoL pre and post-operatively [4]. As such, it is important for surgeons to have an awareness of QoL, what it is and what the tools are measuring for their patients.

Ultimately, QoL is a concept [5]. Concepts are important in healthcare and qualitative research because they provide a framework to help doctors understand how and where they can target or enhance their knowledge to eventually reduce distress [6]. They provide one form of world view [6]. However, often concepts are based on a variety of assumptions, often entrenched over some time and these are not always transparent. HRQoL tools such as the commonly used Short Form-36 are based on this concept [7]. Philosophers critically evaluate concepts such as QoL [8]. It is important to evaluate such concepts because these philosophical views on QoL form the foundation of modern thinking on the topic and underpin QoL instruments [9]. Therefore, we turn to philosophical thoughts concerning QoL and later highlight their implications for the hernia surgeon.

## Quality of life according to Greek philosophers

Greek philosophers were interested in the topic of QoL. They presided over its meaning and devoted much time thinking about how best to live. The term “Quality of Life” is a relatively modern lexicon appearing in literature during the 20<sup>th</sup> century [10]. However, ideas pertaining to “QoL” appear as early as 322BC. The prominent Greek Philosopher, Aristotle (384-322BC) used the word “*ευδαιμονία*” (*eudaimonia*), which holds two different translations – “well-being” or “happiness” [11]. Aristotle believed that happiness was directly related to goal-orientated activities [12]. There are two points to consider here. Firstly, *eudaimonia* is not the state of a person but of an activity. This implies that happiness is a certain type of active lifestyle/experience. Secondly, it implies that happiness is an activity that a person has to work for and can work towards achieving. What, then, is the activity that one should pursue in order to live a good life? According to Aristotle in his magnum opus *Nicomachean Ethics*, all entities have a specific function. For example, the function of an axe is to cut wood. This same principle may be applied to man. Aristotle argues that it is the purpose of every object to exercise its function [12]. For example, it is important that an axe is used to cut wood rather than remain inactive. Equally, it is important that a person exercises his/her function than remain docile.

After Aristotle’s death philosophical thought fractured into different groups - the Sceptics, Cynics, Epicureans, Cyrenaics and Stoics [13]. The Sceptics and the Cynics believed that one could avoid frustration in life by not believing in anything. The most extreme sceptic was Pyrrho (360-270BC). He believed that unhappiness stemmed from not getting

what one wanted but ultimately, we cannot be certain of anything. If we cannot be certain of anything then how can one be sure that one thing would be better for us or make us happier than another [13].

Epicurus (341-270 BC) is the founder of the Epicureanism. He argues that whilst Hedonism and pleasure are important in obtaining a good life, overindulgence in pleasures is not necessary in order to attain it [13]. Rather, it may prevent it in some circumstances. Therefore, his primary principle is not to seek pleasure but rather to avoid pain. The Cyrenaics believed that the best life was one filled with the most pleasure, particularly bodily pleasures i.e. sexual gratification, wine and food [13]. They believe that bodily pleasures are the most intense form of pleasure and that in order to live a good life one must maximise their exposure to this. Epicurus disagreed. He argued that bodily pleasures, whilst the most intense and should be enjoyed, are only short-lived and often followed by pain of a longer duration e.g. inebriation on wine resulting in a painful hangover. Paradoxically, to avoid pain one must cultivate discipline [13]. According to Epicurus, a simple life equates to a good life and it is one that avoids pain incurred by overindulgence in pleasures [13].

Stoicism (Zeno of Citium, 334-262BC) proposes that one should only worry about events that are in one's control [14]. Extreme stoics suggest removing emotion altogether and accept fate with indifference. Such troublesome emotions may cloud judgement. Such thinking would avoid unhappiness when events happen that are out of our control. Another Stoic, Seneca (1BC-65AD) highlights the brevity of life and that life, long or short, should be wholesome [15].

## **What is Quality of life?**

Over time the Ancient Greek views briefly outlined above were challenged by other schools of thought. The one which has the most impact on healthcare is Positivism [16]. This philosophical system only recognises that which may be scientifically verified. This extends to the concept of QoL.

Quality of life (QoL) is a nebulous topic with a plethora of definitions. In the words of Voruganti, *"quality of life is easy to understand, but hard to define"*[17]. One definition is that QoL is *"a multi-level and amorphous concept which reflects both macro societal and socio-demographic influences and also micro concerns, such as individuals' experiences, circumstances, health, social well-being, values, perceptions, and psychology"*[18].

It is defined in terms of how people respond to changes in physical health, changes to mental health, social issues, occupationally, economic approaches and interpersonal relationships [19]. The World Health Organisation defines QoL as:

*'...individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment'* [20].

Such numerous definitions make measuring QoL very difficult and results in disagreement over its interpretation.

## How do we measure Health Related QoL (HRQoL)?

Despite the lack of a clear definition, researchers and doctors continue to measure QoL and HRQoL. Presently, there are >1000 reported quality of life tools [21]. These tools vary from quantitative to the qualitative. They aim to make objective something which is subjective [7]. Some scales aim to measure particular domains important to QoL e.g. the Short Form-36 [7]. Purely qualitative approaches utilise patient interview techniques or focus groups to capture what QoL aspects are important to an individual or particular group.

*“The ultimate goal of health care is to maintain or improve the quality of life of people”* [22]. HRQOL measures are one method used by healthcare professionals to determine this and are important health outcome indicators. There are three assumptions in measuring QoL [23]. These are:

1. *We know implicitly what we are measuring*
2. *We understand why we are measuring it*
3. *The way in which we are measuring it is valid* [23]

These assumptions are laced with problems. Regarding the first assumption, QoL and HRQOL have no clear, uniformly agreed definition. The lack of a clear definition might explain why there is no gold standard QoL measuring instrument [24]. This issue has implications for the other listed assumptions. If there is no clear definition for a seemingly circumscribed topic, then does that not imply that QoL is incompletely understood? Equally, if it is not understood, then how can one understand how to measure it? This may provide another explanation for

the use of a multitude of different HRQOL instruments within the literature and a lack of consensus. HRQOL is a concept that largely has a subjective basis concerning how the patient perceives their health and how it impacts upon their QoL. And yet HRQOL instruments are often based on expert opinion rather than the opinions of the patients themselves [25]. Again, the implication of this is that the instruments include items of relatively little importance to the patient and that subsequently may then tell researchers/health care professionals very little in terms of how patient pathology affects their QoL [26].

Lastly, the question of validity. In terms of HRQOL questionnaires there are different types of validity [25]. Firstly is face and content validity. This requires the content of the HRQOL instrument to be relevant to the specific patient group [27]. All too often measurement scales are solely based on expert opinion which is why patient interviews that unpick specific themes and domains are vital in ensuring instrument suitability [28]. Secondly is construct validity. This establishes whether the measurement instrument measures what it was intended to measure, in this case HRQOL [27]. Ancillary to this is the issue of numerically quantifying a subjective, qualitative patient feeling [25].

## Implications for the hernia surgeon

The philosophical arguments presented here bear importance for the hernia surgeon. Firstly, it is important not to be ignorant to the concept of QoL. Concepts are used throughout research, but they are embedded in man-made constructs some of which are ancient in nature, others which have been replaced, refined or complemented [5-8]. The QoL concept is utilised universally in healthcare and hernia surgeons will inevitably apply it to hernia patients [7]. Surgeons

may even be employing the concept unwittingly, unaware of the philosophical viewpoints with which they align. Increased surgeon awareness about QoL in general, it's origins, and surgical team reflexivity may improve outward patient care [29]. In the context of complex abdominal wall reconstruction this is two-fold. Firstly, for example, having an awareness of patient reflexive construction of their identity related to the cosmesis of their hernia and how that may affect other aspects of their life such as body image, self-esteem and mental health. Secondly, from a surgeon's perspective, acknowledging this and what may be realistically achieved in relation to this.

Secondly, hernia surgeons should remain critical about the QoL tools they use in practice. The nexus of this argument is that QoL is incredibly difficult to assess and measure [21]. Whilst generic QoL tools are useful and do have an important role in measuring QoL, perhaps they are not always the *right tool* to use in certain patient groups such as Complex Abdominal Wall Hernia (CAWH) patients. Using a tool because it is safe, validated and used by other research teams is not acceptable if the aforementioned tool is not capturing any new or useful information/change relating to how individuals feel specifically about their CAWH.

Beyond this, there is a role for qualitative research development in the field of complex abdominal wall hernia. Most QoL instruments are based on expert opinion rather than patient perspectives [25]. To our knowledge, no specific CAWH QoL instrument based on patient perspectives exists. This represents a deficit in research. As Fox-Rushby & Parker suggest, the first step to produce a patient specific questionnaire is to establish these domains by first interviewing the

relevant group, being mindful to capture these responses/themes [30].

The approaches discussed here represent advancement of the 'Personalised care' model used in surgical and oncology treatments [31,32]. 'Personalised care' is increasingly used by the regulators in UK such as Care Quality Commission (CQC) to assess the quality of care. The modern image of healthcare is one that focuses on personalised care. There is growing awareness of this and universally increased efforts to implement this individualised focus in treatments and interventions. It is time that personalised care is applied to QoL aspects at the individual level in surgical care, including CAWH patients.

In our unit, we are addressing this deficit in the field by undertaking qualitative methodology that will further our understanding of QoL in CAWH patients. It aims to address patient experience of their hernia utilising a "*grounded theory*" approach and is the first fundamental step in:

1. gathering *in-depth* and *meaningful* information about CAWH patient experience and,
2. in producing a QoL tool that is valid for this specific group.

Without a QoL tool grounded in patient's perspectives, the validity of all QoL research in CAWH patients is threatened and flawed.

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#### **Authors' contribution statement**

All authors contributed to the study conception and

Olivia Smith drafted the paper. All authors read and approved the final manuscript.

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