Quality of Life for Our Patients:
How Media Images and Messages Influence Their Perceptions

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2007 Trish Greene Memorial Quality-of-Life Lecture

Media messages and images shape patients’ perceptions about quality of life (QOL) through various “old” media—literature, film, television, and music—and so-called “new” media—the Internet, e-mail, blogs, and cell phones. In this article, the author provides a brief overview of QOL from the academic perspectives of nursing, psychology, behavioral medicine, multicultural studies, and consumer marketing. Selected theories about mass communication are discussed, as well as new technologies and their impact on QOL in our society. Examples of media messages about QOL and the QOL experience reported by patients with cancer include an excerpt from the Canadian Broadcasting Corporation radio interview with author Carol Shields, the 60 Minutes television interview focusing on Elizabeth Edwards (wife of presidential candidate John Edwards), and an excerpt from the 1994 film The Shawshank Redemption. Nurses are challenged to think about how they and their patients develop their perceptions about QOL through the media.

The idea for this—the 14th Annual ONS Trish Greene Memorial Quality-of-Life (QOL) Lecture—came from a few inspirations. One was a recurring scene shared by most of you in your practices each day. Our chemotherapy patients come in for treatment, plop themselves down in our vinyl treatment chairs, and bide their time during their treatments by watching a nearby television or burying themselves in a book, newspaper, or magazine. Some of our more “hip” patients bring in their laptops to make use of their time in the chair. Over the years, I have been curious about the concept of QOL for our patients and what learned points of view—other than nursing—are saying about it. I, like you, want to help my patients make the most of their QOL—whether it is for a brief time or for what we hope are many rich and productive years that follow their time in treatment with us.

Quality of Life: Input From Many Disciplines

Many different disciplines continue to try to make sense of QOL—what it looks like, how to assess it, how to make it better. So I’ll start by giving a overview of how nursing, as well as other disciplines, have contributed to our understanding of QOL and how those concepts may influence how patients perceive their own QOL.

How many times have you had a discussion with a patient about QOL and shared a story or idea—something you saw or heard, something you have experienced, something you agreed to disagree about? So much of the input for those discussions comes from what I am calling the media—communication and content that saturate our lives and also bring us to new understandings and perspectives on QOL.

At a Glance

- Understanding of quality-of-life (QOL) issues with our patients is a collaborative effort supported by research from nursing, psychology, behavioral medicine, multicultural studies, consumer marketing, and mass communication.
- Because of our unique relationship with patients, clinical nurses can support interventions that help patients define, clarify, inform, and support their perceptions of QOL.
- The media—through literature, film, music, television, art, and content delivered by new technologies—transmit information about QOL to our patients. Their use of these technologies also affects their perceptions of QOL.

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and insights. The classic forms of media, which I hope are still part of your lives, include books, plays, movies, poetry, art, and music. The new media include the Internet and all its glory: e-mail, Google™, online shopping, MySpace, streaming video, blogging, DVDs, MP3 players, iPhones, and cell phones. (And for you early adopters, the new media forms that I just listed are not so new anymore.)

Even our most conventional patients cannot escape the influence of the media on their lives. Thus, this lecture was born. My own perspective is on display in what I have chosen to include here. I hope my choices prompt you to think about what messages you pick up from the media and what they tell you about your own version of QOL and those of your patients.

My primary clinical exposure is with patients with head and neck cancer, so I am keenly aware when QOL is compromised because of disease and treatment. For my patients, those compromises can require difficult adjustments when talking, seeing, hearing, tasting, and smelling. For purposes of this lecture, my focus is on middle-class American society. I say this knowing that our society has many variables—culture, race, income, geography, family and workplace dynamics, age, and interests.

But first, I’ll start with some background to provide a context for these inputs from the media. Many disciplines have contributed to our knowledge and understanding about our experience of QOL. The human experience is complex—a prism that filters constantly, changing stimuli from certain distinct perspectives. In researching and preparing this lecture, I realized that I could not jump into a discussion about media and its effects on our patients’ perceptions without touching on the myriad array of QOL influences that are the foundation for our perceptions.

Let’s consider these many disciplines—nursing, psychology, behavioral medicine, multicultural studies, consumer marketing, and mass communications—and what each tells us about QOL in our society. The imagery of a prism shows how our patients are on the receiving end of many inputs, filtered through their own experience and translated into their own perceptions about QOL (see Figure 1).

From our nursing colleagues, we know that QOL is defined in broad categories. Ferrans, one of the first nursing researchers to publish articles about QOL, provided categories and definitions about QOL based on literature reviews (Ferrans, 1990, 1996, 2005). Based on those categories, QOL can be perceived as:

- A normal life or the ability to lead a normal life
- Happiness: a balance between positive and negative feelings, with positive feelings being more pronounced
- Satisfaction or a long-term cognitive assessment of positive feelings about one’s life condition
- Achievement of personal goals
- Social utility: the ability to make contributions to society (i.e., by being a grandparent, teacher, or citizen; making contributions through employment; or being useful in society)
- Natural capacity: actual or potential physical or mental capabilities, such as the potential for human relationships.

Over the years, several nursing-led studies have emphasized that QOL is whatever it is to the individual. It is multidimensional in nature and a dynamic process (King, 2006; King, Hinds, Dow, Schum, & Lee, 2002). It also changes throughout the patient’s experience (Ferrans, 1990, 2005; Ferrell, Dow, Leigh, Ly, & Gulasekaram, 1995; Ferrell et al., 1992; King et al.). An accepted conceptual model of QOL, developed by Ferrell et al. in 1992, categorizes QOL into four domains of well-being: physical and symptoms, psychological, social, and spiritual (see Figure 2). In 1995, Ferrell et al. contributed to our understanding of QOL with their seminal study of bone marrow transplantation survivors. They identified factors that influence the patient’s experience of QOL: the patient’s status related to active disease, the patient’s gender (especially related to the importance of religious and spiritual activity), the patient having positive changes and/or having a purpose in life, and the presence of a spouse, parent, or children living at home.

From their research, Ferrell et al. (1995) used a physical subscale to identify fatigue and aches and pains as negatively affecting physical well-being. From Miaskowski et al. (2006), we have learned that subgroups of patients with cancer have different symptom experiences and QOL outcomes. The functional symptoms that can affect QOL for patients in treatment include fatigue, depression, sleep disturbance, and pain. Miaskowski et al. suggested that younger patients can be at greater risk for more severe levels of symptoms.

Of special sustaining interest to nurses is the importance of relationships in patients’ perceptions of QOL (King et al., 2002). At the core of oncology nursing practice is the human response that our patients have to illness, which is affected not only by the cancer but by interpersonal, family, social, cultural, and work relationships (Cantrell, 2007; Stanton, Revenon, & Tennen, 2007). Moreover, based on extensive nursing research, nurses

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**Figure 1. Disciplines Offering Input About Quality of Life**

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rely on their relationship with patients as the mainstay to assess their patients’ QOL (King, 2006; King et al.).

At last count, more than 500 tools were available to assess and evaluate QOL (King, 2006; Ropka & Padilla, 2007). These measurement strategies and tools have clinical limitations; they could be shorter, more flexible, and more relevant to a clinical setting (Ropka & Padilla). Some researchers suggest that QOL could be better evaluated by using meaning-based models, emphasizing patterns and consistent models of inquiry; hope; coping methods; and the treatment experience from subjective and holistic perspectives (Bloom, Kang, Petersen, & Stewart, 2007; Cantrell, 2007; Chi, 2007; Jim, Purnell, Richardson, Golden-Kreutz, & Andersen, 2006; Lane, 1987).

We know that as nurses, our communication skills help to support our patients’ social interests, hope, and involvement in everyday life (Cantrell, 2007; Chi, 2007). The challenge of clinical nurses is to optimize that relationship with patients so that appropriate interventions can follow. These interventions can include linking patients to information and resources to help them better cope, being present with patients in discussions, helping patients and families identify what makes QOL better or worse, and using information we solicit about patients’ perceptions to individualize their plan of care (King, 2006).

As to nursing and communication, we know that storytelling and hearing stories are part of our therapeutic tool kit. From Heiney’s seminal Mara Mogensen Flaherty Memorial Lecture- ship in 1995, we are reminded that we bring four types of therapeutic benefit to patients with storytelling: cognitive, affective, interpersonal, and personal growth. According to Heiney, “The story introduces the known, bringing comfort and security with a twist for learning and growth. ‘Life tales’ offer models for problem solving and coping” (p. 900).

**Psychology and Behavioral Medicine**

We know from our colleagues in psychology that a patient’s self-defined assessment of QOL is subjective, involving the feelings of well-being, happiness (an emotional response), life satisfaction (a cognitive response), and perceived QOL (Sirgy, 2002). A level of adaptation and coping influences the level and distinction of QOL. For example, three components of subjective well-being have the distinctions of (a) cognitive versus affective, (b) positive versus negative affect (i.e., joy, pride, affection, sadness, depression, guilt, anxiety, anger, and shame), and (c) short-term versus long-term (Sirgy).

Psychology concepts related to QOL are explored in Cantrell’s (2007) study of health-related QOL in childhood cancer. In her study, we learned that children and adolescents with cancer view QOL as being healthy and getting on with life. Their perception of psychosocial well-being influences physical functioning. Cognitive predictive coping—such as being optimistic and maintaining a positive perspective about the course of illness—has a strong relationship with QOL.

Cantrell (2007) suggested that personality traits (i.e., one who is less neurotic, one who is more conscientious) also contribute to QOL perceptions. Thus, personality may significantly influence a child’s perception of QOL beyond a negative life event such as surviving cancer. Cantrell reported that the survivor’s coping with his or her illness influenced the ability to reach long-term social goals. Cantrell’s research suggests that happy, well-adjusted patients are more likely to successfully complete treatment regimen and ultimately have better survival outcomes.

Our colleagues in behavioral medicine continue to look at various interventions to lift up our patients and provide them with a better QOL. The premise of behavioral medicine is that a total approach to care involves the patient’s mind, body, and spirit. For example, some people learn to use relaxation as a way to reduce stress during chemotherapy, thereby affecting their perception of their QOL (National Cancer Institute, 2005). We know from a Cochrane review about QOL interventions that various behavioral medicine approaches have been attempted (Fellowes, Barnes, & Wilkinson, 2004). Among studied behavioral medicine strategies include complementary and alternative medicine therapies, such as acupuncture, to help with the side effects of treatment. Special diets as a treatment for cancer have also been studied. There is some evidence that nurse follow-up programs and nurse interventions to manage breathlessness may produce beneficial effects that improve QOL (Sola, Thompson, Subirana, Lopez, & Pascual, 2004). Psychotherapeutic
studies indicate that counseling may help patients cope more effectively with emotional symptoms, but the evidence is not conclusive (Sola et al.). Fellowes et al. looked at the effectiveness of aromatherapy and massage on anxiety, thus improving QOL. Some short-term benefits on psychological well-being have been shown, but their effect on anxiety has limited evidence. Yet evidence is scarce in documenting consistent improved QOL outcomes.

Multicultural Studies

As to multicultural influences and the current pace of population growth and diversity, ethnic minority populations will make up the majority of the U.S. population by 2030 (U.S. Census Bureau, 2000). We know from several studies about what is meaningful for cancer survivors that one cultural experience may be far different from another (Ashing-Giwa & Kagawa-Singer, 2006; Findley, 2007). In clinical practice, it is clear we need to seek to comprehend and practice cultural competence—understanding the nuances of diverse ethnic groups by taking into account their sensibilities, customs, traditions, experiences, way of life, and social interactions (Ashing-Giwa & Kagawa-Singer; Bloom et al., 2007). Yet multicultural and multiethnic studies about QOL sensibilities are still limited in number.

One of the few examples of QOL research with a multicultural focus is a 1991 study by Chaturvedi of Indian patients with cancer and their family members. The study cited peace of mind, spiritual satisfaction, satisfaction with religious acts, and happiness with family as the most important issues related to QOL.

In a 1998 study, Juarez, Ferrell, and Borneman studied perceptions of QOL in Hispanic patients with cancer. Their findings suggested that QOL was equated with being happy, maintaining an active lifestyle, and interacting with family. The Hispanic patients studied valued the role of the family and their faith in God. Pain, although seemingly a deterrent to perceptions of good QOL, was to be endured because it is a component of life that helps the patient—in his or her eyes—reach heaven.

Consumer Marketing

In the United States, our marketing colleagues have effectively permeated our society with messages about what the ancient Greeks called “the good life.” In the time of the Greeks, what constituted the good life was debated among philosophers, political scientists, and sociologists. The wide-ranging discussions were about the balance between liberty and equality (Phillips, 2006). Since World War II, QOL as a focus in consumer marketing has become especially popular (Phillips). Many other discipline experts, such as social theorists and economists, have also been involved in setting the agenda about marketing messages.

For example, in the United States, war meant production and jobs. With jobs came money. With money came the possibility of consumption of goods and services that many middle-class and working American consumers had been denied during the Great Depression. During the war years, there were times of shortages and sacrifice for the cause, which propelled an expanding economy (Young, 2005). These pro-American messages from the war years included imagery and messages about neighborliness and familiarity, American know-how, goods and services that would enhance a distinctly American view about QOL, and America’s vision for tomorrow (Young).

These messages were first orchestrated by a prescribed campaign from the Office of Facts and Figures, created by President Roosevelt, and the early corporate entities that blossomed into industry-branding executives, advertising agencies, and public relations firms (Young).

American life during World War II was accompanied by increased wealth, scarcity of goods, increased industrial productivity, and a better-defined American way of life for Americans to fight for. From this environment emerged messages that told us to make purchases to stay healthy and make current products last longer, be bigger, and be better. What many of the middle class realized from this time was a steady transformation to all-electric homes with more and more appliances and the ability to set a table with a variety of plentiful foods, which was not possible in pre-war years (Young, 2005). Thus, abundant products and services that made life easier—and some would say better—became closer to what most people wanted most of the time. A marketing perspective—partnered with advertising—was happy to oblige. Advertising was not intended to be altruistic but created consumer needs . . . and endless opportunities to spend. And if you believe that those messages are from a time long ago, remember the consumer marketing messages that were targeted at us after the September 11, 2001, terrorist attack on New York and Washington, DC. To strengthen the U.S. economy—and show the world our intent and the superiority of our way of life—we were reminded to consume and spend to keep the economy going: Fly the skies, buy with abandon at your local grocery store, and show the world that we have choice, freedom, competition, and endless possibilities. The message was that by returning to our mass consumption roots, we could show the world that our American way of life was supported, cherished, and protected (Young).

So we have a society that worships the enhancement of QOL with messages that give credence to (remember the Greeks) the good life: higher pay, longer holidays, more satisfaction in our working lives, time to pursue enjoyable and satisfying leisure pursuits, emotional fulfillment in our relationships, and the prospect of having a long, healthy, and happy life. Moreover, we could have this life while living within a safe, caring, and supportive local community (Phillips, 2006).

Surveys continually evaluate QOL in the marketing realm by measuring our response to goods and services, seeking and finding the ultimate “whatever” in our ability to live active and
full lives. Our lives should be abundant, wouldn’t you agree? Plus, are we happily “with someone”? Do we experience the joys of marriage? Togetherness? How are we doing with our search for youth, our disappointment with aging, and dealing with stress (Gallup, Inc., 2008; Pew Research Center, 2006; Young, 2005)? Consumer-focused QOL indicators also translate into the agendas that guide how we live in our communities. In 1989, the population of the city of Jacksonville, FL (850,000 in 2005), developed a list of indicators that the city’s leaders could use to measure and improve QOL for its citizens (see Figure 3). The city’s QOL progress report has been published annually since then and is the basis for decisions to improve QOL in the community and how their community is faring (Warner, 2006). These indicators also contribute to the environment of how our patients’ perceive their QOL.

**Mass Communication and the New Media Technologies**

So now we’ll discuss some background about influences from the mass media and how they affect our patients’—and our own—perceptions of QOL.

As a review, the field of mass communication has its own theories. Mass communication is when a source uses a medium to communicate with a larger audience. Mass society theory was best shown in practice in the novel 1984 by George Orwell (1949), which suggested that no message is without a larger, sinister presence creating it and targeting it. . . the so-called “big brother” who rules the business of society (Baran & Davis, 2006). When big brother is involved, the media is the source of corruption—brainwashing defenseless, average people with propaganda and creating paranoia about our enemies. It manipulates messages that, in the end, are debasing and that pander to popular culture (Baran & Davis). Our obsession with celebrity in the media could be argued as a manifestation of mass society theory.

The effects of the media and its messages have been exhaustively researched, yet mass society theory has been found to be just one popular theory. Depending on the audience hearing and seeing the message as well as the message itself, other theories have emerged that explain mass communication within our society. Two of those theories are social responsibility theory and limited effects theory.

Social responsibility theory provides a more optimistic rationale as to how media affects society (Baran & Davis, 2006). It suggests that media connects people to people, thus the media is a major and powerful source of information, a source of truth telling, accuracy, objectivity, and balance. The media reflects the diversity of the society it serves and is accountable to. This idealistic theory has its obvious weaknesses. It is overly optimistic about the media’s part in taking responsibility for unclear or biased messages that it champions. It also underestimates the power of the profit motive and competition in our society (Baran & Davis).

Limited effects theory proposes that the mass media reinforces existing social trends and strengthens the status quo (Baran & Davis, 2006). It contends that in the long run, the media has minimal or limited effect on individuals because they are more influenced by their friends, family, coworkers, and social groups. The limited effects theory gives the power of influence to the values held by the people, especially those related to politics and religion. It contends that the mass media is powerless to overcome an individual’s strong inherent beliefs. This theory proposes that any messages from the media that are internalized are, at best, isolated and modest in their scope (Baran & Davis).

One of the most sustaining mass communication theories is still frequently discussed in our culture, and it appears was prophetic. In 1964, Marshall McLuhan, a Canadian academic, published his book *Understanding the Media: The Extensions of Man*. The book’s main premise suggests that the content that the media provides us is not as powerful as the medium that sends the message. The choice of the medium that sends the message can be the message itself.

As we sit here in 2008, the tenets proposed by McLuhan (1964) are all around us as the so-called new technologies have taken over so many parts of our daily lives. They also have contributed mightily to how we operationalize QOL. Figure 4 shows some of the technologies that have been introduced in the past few decades, starting with the remote control in 1956 to the iPhone in 2007. In the past 20 years alone, the number of media innovations that affect our American culture—and global marketplace and society—are especially ground-breaking. These new forms of media—the World Wide Web, e-mail, cell phones, text messages, and MySpace pages, to name a few—have transformed our individual experience of how society functions.

McLuhan (1964) was one of the first to coin the phrase “the global village.” This village is a new form of social organization.

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**Figure 3. Selected Community Indicators of Quality of Life**

*Note: Based on information from Warner, 2006.*

- Achieving educational excellence (high school graduation rate), school attendance, literacy (reading levels)
- Growing a vibrant economy (net employment, average annual wage, unemployment rate, children in poverty, new housing starts, housing affordability)
- Preserving the natural environment (air quality index, average water consumption, solid waste recycled, conservation land)
- Promoting social well-being and harmony (measurements of racism, foster children, births to teen mothers, births to mothers with a high school education, philanthropy given to campaigns, homeless rates, volunteerism)
- Enjoying arts, culture, and recreation (attendance at musicals, sports, selected events, library use, boat ramp use)
- Sustaining a healthy community (infant death rate, no health insurance, cancer deaths, lung cancer deaths, newly diagnosed AIDS or HIV, and sexually transmitted diseases report)
- Maintaining a responsive government (voter registration, percentage of voters who vote, diversity of elected officials, and households watching local evening news each day)
- Moving around efficiently (commute time < 25 minutes), average seats on airplanes, average bus ridership, average number of seats available on airline flights, destinations between community and other cities)
- Keeping community safe (reported violent and nonviolent crimes per 100,000 people, juvenile delinquents, rescue call response less than four minutes, child abuse reports, domestic violence reports, motor vehicle accidents per 1,000, and violent deaths per 10,000)
Figure 4. Technology Milestones: 1956–2007

1956: First wireless television remote
1969: Precursor to the Internet born (ARPAnet)
1971: First e-mail sent
1973: First cell phone call
1976: Sony Betamax introduced
  Apple personal computer (PC) introduced
1978: First commercial VCRs introduced
  First commercial cellular network (Chicago, IL)
1979: Voicemail patented
  ESPN launched
1981: IBM PC introduced
1982: First CD sold in Japan
  Internet-born transmission control protocol/Internet protocol established
1983: First commercially available cell phone in the United States
1984: CD technology introduced in automobiles.
1985: CD-ROM added as feature in PCs
1986: Nintendo introduces first video game system in the United States.
  First laptop PC marketed
1988: CDs outsell records in the United States.
1991: First Web server
1993: First PDA marketed
1995: E-Bay® founded
1996: DVD technology introduced
1997: First text message sent
1998: NetFlix established
1999: BlackBerry® introduced
  First TiVo® shipped
2001: iTunes and iPod released
2004: Facebook founded
  MySpace founded
2005: YouTube™ created
2007: iPhone introduced

Figure 4. Technology Milestones: 1956–2007

as technology links the world into one great social, political, and cultural system. Technology has become part of one’s daily routine. Figure 5 shows how extensively these new technologies have penetrated the American household. Inevitably, technology saturated in our daily lives can change how people think and how society is structured and maintained.

As Tom Friedman (2006) said in his landmark book, The World Is Flat: A Brief History of the Twenty-First Century, the technology revolution in which now we live extends our abilities to see, hear, and reach out to one another. These new technologies create an environment for new relationships, new messages, and new social roles (Friedman). He describes the never-ending cascade of “flat-world stories” that are part of our lives now. Technology has created a flat world with few boundaries, equalizing in how it allows new ways to create, collaborate, and compete. The personal computer allows anyone to create digital content, and the Internet allows ever-expanding ways to collaborate and to be interconnected. And all of that leads to more competition and rich and endless opportunities for multinational—or unnational—commerce (Friedman). The individual can now be the filmmaker—as evidenced by the popularity of YouTube™, streaming 200,000 videos per day (Liddtke, 2007). You can also be the reporter via blogging; 120,000 Web logs are created every day with more than 70 million blogs now online (Auletta, 2007). And you can be the photographer of choice by using your cell phone; an estimated three billion phones were expected to be in use worldwide at the end of 2007 (Wireless Intelligence, 2007).

The new technologies put the power of choice and control back with the individual, rather than messages sifted through an oligarchy of media powers. That said, those who own our standard media technologies are in the hands of a few. In the 1980s, 50 major corporations owned the various types of media—satellite, cable, phone line, mobile devices, digital radio, and newspapers. Now, only six multibillion-dollar corporations own the worldwide reach of the media empire, in part, because of 2005 legislation in the United States that allowed television networks, Hollywood studios, and cable outlets to merge. Time Warner (which owns TNT and TBS) is the largest corporation, followed by Disney (which owns ESPN and ABC), News Corporation, Viacom (which owns MTV and Nickelodeon), Bertelsmann, and Vivendi Universal (Bucy, Gantz, & Wang, 2007).

Still, despite the “wow” factor of the new media technologies, the message that they carry is what affects all of us . . . and our patients. As Brad Bird, director of the Disney films Ratatouille and The Incredibles, said, “People in Hollywood, the press always fixates on the technology because it’s easier to quantify. The truth of the matter is the technology has never been the answer. The same answers to making a good movie are the answers that were around 80 years ago. . . . Technology is simply the tool. What they’re [Pixar] really all about is classic storytelling” (Coyle, 2007). So no matter the medium, the messages—in this case QOL messages—come through to our patients as good stories.

Examples: Quality-of-Life Perceptions From the Media

When first preparing this lecture, I intended to focus on examples from literature, film, music, and theater. I quickly realized that I needed to expand my examples to sources involving new technology and show how collaborative these examples are in any discussion about QOL. So here are four examples about the concept of QOL, which have combined several of the schools of thought just reviewed as well as combinations of various media.

The first is from a radio interview of a novelist, who at the time was also battling breast cancer. A 2000 clip from the Canadian Broadcasting Corporation radio program “Writers and Company” featured Carol Shields, the award-winning novelist of Larry’s Party, Dressing Up for the Carnival, and Unless. Shields spoke to program host Eleanor Wachtel about her diagnosis and illness, how she coped, and how she viewed her illness as a writer (Canadian Broadcasting Corporation, 2008). (To access the clip online, go to http://archives.cbc.ca/acces/400d.asp?id=1-68-407-2327-11.) Unfortunately, Shields
died of her illness in 2003, but she has left us her wisdom as a writer, as well as a woman fighting cancer.

The next example is an excerpt from the March 2007 60 Minutes interview with Elizabeth and John Edwards the weekend after it was announced that Mrs. Edwards’s breast cancer had recurred (CBS Interactive, Inc., 2007). (Elizabeth Edwards is the wife of Presidential Candidate John Edwards.) After the interview aired, there was much discussion about the Edwards, their motives in sitting down for the interview, and the interviewing skills of Katie Couric. During the following three days after the interview, the 60 Minutes blog posted more than 1,000 comments about the interview. During the interview, Elizabeth Edwards responded to questions about her recurring illness with the following comments.

You know, you really have two choices here. I mean, either you push forward with the things that you were doing yesterday or you start dying. That seems to be your only two choices. If I had given up everything that my life was about—first of all, I’d let cancer win before it needed to. You know, maybe eventually it will win. But I’d let it win before I needed to. And I’d just basically start dying. I don’t want to do that. I want to live. And I want to do the work that I want next year to look like last year . . . and the year after that and the year after that. And the only way to do that is to say, ‘I’m going to keep on with my life.”

I think that it is our intention to deny cancer any control over us. Cancer took a lot away from us a few years ago. It took a year of my life and a lot of John’s. I didn’t want it to take this away—not just from me but from those people who depend on our having the kind of President he would be. I don’t want to deprive the country of having my husband lead us. That would be my legacy, wouldn’t it? That I’d taken out this fine man from the possibility of giving a great service. I mean, I don’t want that to be my legacy.

Elizabeth Edwards joins a long list of patients with cancer and survivors in the news cycle, who regularly surface as role models for other patients and influence their perceptions about QOL. Among many examples are the retired athlete Lance Armstrong, Tony Snow (former press secretary in the Bush Administration), Rudy Giuliani, Jacqueline Smith, Olivia Newton John, and the first ladies Nancy Reagan and Betty Ford.

The next example—one that does not involve cancer or illness—combines several QOL concepts in the form of film, music, and storytelling. The 1994 film The Shawshank Redemption was based on the Stephen King novella Rita Hayworth and the Shawshank Redemption. The film starred Tim Robbins as Andy Dufresne and Morgan Freeman as “Red” Redding (Glotzer, Lester, & Darabont, 1994). These characters were inmates in the story’s Maine Shawshank Prison in the 1940s. The plot follows the friendship that develops between the main characters, as well as the power of hope, redemption, and the strength that comes with perseverance (themes that resonate with cancer survivors).

In a memorable scene from the movie, Andy Dufresne has just received a shipment of phonograph albums as part of a prison library he has created, after dealing with many years of bureaucracy and naysayers. He decides to share the experience of listening to the music with his fellow inmates, who find their own feelings of hope and meaning in music. The Shawshank Redemption has become so popular that it is consistently voted as one of the most popular movies of all time (American Film Institute, 2005). Many of the films on the American Film Institute’s list (www.afi.com/tvevents/100years/cheers.aspx) were also based on stories from classic literature.

The last example I will mention is survey results, which were completed during the summer of 2007. I’m ending with this because the survey foretells what is important to the next generation that is growing up in a new technology age.

In 2007, the Disney Mobile “Cell and Tell” survey (Cellular News, 2007) was conducted online by Harris Interactive. It asked 1,579 respondents aged 10–17 years who had cell phones about their cell phone usage. Survey results showed that cell phone usage among this age group jumped during the summer vacation days by more than one hour to a total of more than 3.75 hours per day (compared to usage on school days). Here are further results from the survey.

- 44% used text messages as their primary form of communication.
- 52% reported that they sent text messages from a movie theater.
- 28% sent messages from the dinner table.
- 26% sent text messages within 10 minutes of waking up.
- 96% communicated with their parents daily via cell phone.
- 20% connected with their parents at least five times a day.
- 33% said they would rather give up radio, video games, or trips to the mall than their cell phones.
- 20% said they would give up television for their cell phones.
- 25% said they would give up their MP3 players for their cell phones.

![Figure 5. Penetration of Consumer Technologies in American Households in 2006](image)
This memorial lecture is in honor of our oncology nurse colleague Patricia (Trish) Greene, RN, PhD, FAAN, who died in 1999 after a heroic battle against pancreatic cancer. She was a pioneer in our field. Dr. Greene made many contributions. She served as the first president of the Association of Pediatric Oncology Nurses. She joined the American Cancer Society (ACS) in 1981. In her 15 years with ACS, she helped develop the “Look Good, Feel Better” program and expanded the “Reach to Recovery” and “I Can Cope” programs. She was also the first nurse member of the Lane W. Adams Awards Committee of ACS, which annually honors outstanding clinical oncology nurses. In the Oncology Nursing Society (ONS), Dr. Greene was very active in the development of the ONS Research Committee and the Leadership Development Institute. At the time of her passing, Dr. Greene had served as senior vice president, patient services, at the Leukemia and Lymphoma Society. Dr. Greene’s legacy includes expanding patient and family services, establishing pain management as a foundation of cancer care, securing scholarships for oncology nurses and social workers, and recognizing and fostering excellence in multidisciplinary cancer care.

Conclusion

So what are your perceptions about QOL, based on what you see and hear in the media? What are your patients’ perceptions? I hope you will bring back to your practice a point of view that was stimulated by this information. Thank you again for the opportunity to present this lecture in honor of Dr. Trish Greene. Her commitment to QOL issues was steadfast. In her memory, may we better discover and support the concept of QOL for our patients.

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References


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