Cancer - A Sociological Study - With Special Reference To Malnad Cancer Hospital Shivamogga, Karnataka State

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Introduction

Cancer is a complex genetic disease that is caused primarily by environmental factors. The cancer-causing agents (carcinogens) can be present in food and water, in the air, and in chemicals and sunlight that people are exposed to. Since epithelial cells cover the skin, line the respiratory and alimentary tracts, and metabolize ingested carcinogens, it is not surprising that over 90% of cancers occur in epithelia. The causes of serious ill-health in the world are changing. Infection as a major cause is giving way to no communicable diseases such as cardiovascular disease and cancer. In 1996 there were 10 million new cancer cases worldwide and six million deaths attributed to cancer. In 2020 there are predicted to be 20 million new cases and 12 million deaths. Part of the reasons for this is that life expectancy is steadily rising and most cancers are more common in an ageing population. More significantly, a globalization of unhealthy lifestyles, particularly cigarette smoking and the adoption of many features of the modern Western diet (high fat, low fibre content) will increase cancer incidence. Tobacco use and diet each account for about 30% of new cancer cases, with infection associated with a further 15%; thus, much of cancer is

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preventable. No individual can guarantee not to contract the disease, but it is so strongly linked to diet and lifestyle that there are plenty of positive steps that can be taken to reduce the chances: eat more fruit and vegetables, reduce the intake of red meat and definitely do not smoke. Carcinogens interact with the individual's constitution, both inherited and acquired, determining vulnerability to cancer induction.

This vulnerability is based on how an individual deals with the carcinogens, ideally eliminating them in a harmless form before they do any genetic damage or being able to repair that damage. The science of classical epidemiology has identified populations at high cancer risk (e.g. users of tobacco products). However, many lifelong smokers do not get cancer, perhaps because of the way they handle potential carcinogens metabolically, and the relatively new science of molecular epidemiology attempts to identify high-risk individuals within populations, such as smokers. Many issues concerning diet and cancer are controversial (e.g. fat intake and breast cancer). This may be because only certain polyunsaturated fatty acids generate damaging free radicals; furthermore, the intake level of antioxidant vitamins that can scavenge these harmful radicals is a confounding factor. Reducing infection, particularly in the poorer countries, will lead to reductions in cancer incidence. Infectious agents associated with increased cancer risk include hepatitis B virus (liver), certain subtypes of human papillomavirus (cervix), the bacterium Helicobacter pylori (stomach) and human immunodefi-ciency virus (many sites). The management of patients with cancer is costly, but there is the daunting prospect that 70% of tomorrow's patients are likely to live in countries that between them have only 5% of global resources. Huge steps in improving the prognosis of patients with cancer are almost immediately achievable with present-

day technology and sufficient financial resource, and all essentially relate to early detection. Cancer does not develop overnight, instead often evolving over many years with detectable premalignant lesions presaging the development of full-blown malignancy.

Malignant tumours not only invade surrounding tissue, but are able to colonize other, often vital, organs, a process known as metastasis. Widespread metastatic disease is usually a harbinger of imminent patient death. Thus, immediate referral to the oncologist after detection of any suspicious lump or symptom is paramount; in many parts of the world with poor health education patients present with very advanced disease. In the same vein, cancer screening programmes are designed to detect not only early asymptomatic malignant tumours but also premalignant lesions. Even in the richer countries, such programmes are a significant financial burden, and the more cost-effective programmes target the higher-risk groups denoted by age (e.g. cervical screening, mammography and colonoscopy) or occupation (e.g. blood in the urine of dye workers for bladder cancer)

Causes of cancer

Most cancers are related to environmental, lifestyle, or behavioral exposures. The term "environmental", as used by cancer researchers, refers to everything outside the body that interacts with humans. In this sense, the environment is not limited to the biophysical environment (e.g. exposure to factors such as air pollution or sunlight, encountered outdoors or indoors, at home or in the workplace), but also includes lifestyle, economic and behavioral factors. Common environmental factors that contribute to cancer death include tobacco (according to one estimate, accounting for 25–30% of deaths), diet and obesity (30–35%), infections (15–

20%), radiation (both ionizing and non-ionizing, up to 10%), stress lack of physical activity, and environmental pollutants.

It is nearly impossible to prove what caused a cancer in any individual, because most cancers have multiple possible causes. For example, if a person who uses tobacco heavily develops lung cancer, then it was probably caused by the tobacco use, but since everyone has a small chance of developing lung cancer as a result of air pollution or radiation, then there is a small chance that the cancer developed because of air pollution or radiation. Cancer is generally not contagious in humans, though it can be caused by oncoviruses and cancer bacteria.

Over 30% of cancers are potentially avoidable by reducing key risk factors, of which much the significant is tobacco use, which is the cause of about 22% of cancer deaths. Another 10% is due to obesity, a poor diet, lack of physical activity, and drinking alcohol. Other factors include certain infections, exposure to ionizing radiation, and environmental pollutants. In the developing world nearly 20% of cancers are due to infections such as hepatitis B, hepatitis C, and human papillomavirus. These factors act, at least partly, by changing the genes of a cell. Typically many such genetic changes are required before cancer develops. Approximately 5–10% of cancers are due to genetic defects inherited from a person's parents.

The focus of the present study is on the Socio-Economic, aspects which effect or influence on the cancer disease and the reasons of causing various problems related to cancer. For the better understanding of the present study, it would be necessary to grasp the information regarding the cancer disease imposing major obstacles to the process of the development of mankind. The rising incidences of cancer are compounded by the massive challenges of modern medical science. Because of illiteracy and

poor out-reach of medical services; people are more often than not ignorant about their disease. Infact there is over whelming evidences to indicate a wide gap between the medical services and disturbing trends in social reality. The governmental apparatus and society do not appear to have come to terms with the implications of this study area.

Ø Significance of the Study

unique strength of the sociological perspective is the focus on underlying social structural mechanisms of phenomena that ostensibly occur at the individual level. Sociologists have long conceptualized medicine as a social institution, highlighting the influence of macro factors on help-seeking and the practice of health care in everyday life .The institution of medicine is characterized by a powerful set of social norms, rules, values, and practices that provides a blueprint for the behaviour of individuals and organizations (e.g., physicians, patients, hospitals, HMOs, etc.), and systematically structures the relationships between them. Sociologists have contributed much to our understanding of the ways that culturally and historically shaped institutional forces constrain the behaviour of health care providers and consumers, reproducing health care inequalities across social groups.

For the past 50 years, medical sociologists have made significant contributions in improving our understanding of the nature and impact of the organizations that constitute our health care system.

Increasing cancer cases against human society is an ever-increasing problem. This problem has been growing more and more acute in India during the recent years. This study aims at understanding the cancer problems and the changing medical treatment would highlight their existing belief and prospective contribution to the society. The present study looks closely at their family history, occurrence of the problem, problems and

constraints faced by them at various stages of their family and private life. This study intends to cover "Malnad Cancer Hospital" of Shivamogga district where the hospital is established and situated and the information will be collected by the patients of cancer disease and the family members with different problems.

This research study was provided a detailed analysis of the problems of cancer in Shimoga district. These problems have been analyzed from their live with their family members. The study has adopted a Sociological perspective in understanding these problems in the wider context.

Ø Objectives of the Study

Keeping all this in mind for the purpose of the study the following objectives are formed:

- Ø To sociologically analyze whether there is possibility of Genitival (Hereditary) influence on an individual
- Ø To study the socio-economic and educational profile of the respondents.
- Ø To examine the level of confidence and courage in a patient of cancer.
- Ø To analyze the various types of cancer in human being with the supporting literature.
- Ø To explore the efficacy of the treatment methods of the doctors and the care takers of the patients.

Ø Concceptualization and Definitions of Terms Used

Cancer:

Cancer is not just one disease, but a large group of almost 100 diseases. Its two main characteristics are uncontrolled growth of the cellsin the human body and the ability of these cells to migrate from the original site and spread to distant sites. If the spread is not controlled, cancer can result in death.

Cancer, by definition, is a disease of the genes. A gene is a small part of DNA, which is the master molecule of the cell. Genes make "proteins", which are the ultimate workhorses of the cells. It is these proteins that allow our bodies to carry out all the many processes that permit us to breathe, think, move, etc.

Ø The Study Universe

The Present study **"Cancer a Sociological Study" - With Special- Reference to Malnad Cancer Hospital Shivamogga District"**

Focuses the cancer disease in various spheres in the Sivamogga District as it consists cancer hospital for the purpose of research the researcher has taken only malnad cancer hospital . So Shivamogga District is one among the important districts of Karnataka. As the researcher is intended to connect the study briefly with knowing about Karnataka as follows.

A region inhabited predominantly by Kannada speaking people set the origin of the name 'Karnataka'. Karnataka is situated between 11°31' and 18°45' north latitudes and 74°12'and 78°40' east longitudes and lies in the west-central part of peninsular India. The length from the north to south is around 700 km and 400 km east to west. Karnataka state is surrounded by Maharashtra on the north, Goa by the north-west, Tamilnadu to the south-west, Andhra Pradesh to the south, Kerala to the south- west and Arabian sea to the west.

Around 5.35 percent of the geographical area of the country are covered by Karnataka State, which accounts to about 192204 sq.km. Mysore District has a geographical area of 6269 sq.km. and it is 5685 and 10291 sq. kms for Chamrajnagar and Uttar Kannada districts. According to 2001 census, total Population of Karnataka is 52733958 (26856343 males and 25877615 females) as against 4481 million in 1991, 3704 million in 1981 and 2929 million in 1971. Population for Mysore,

Chamrajnagar and uttar Kannada is 2624911, 964275 AND 1353299. The density of population as per 2001 census is 275 persons per square km for Karnataka state and it is 383,189 and 132 for Mysore, Chamrajnagar and Uttar Kannada districts respectively. The sex ratio happens to be 964 female per 1000 male for Karnataka state for mysore, Chamrajnagar and UttarKannada districts it is 965,968 and 970 respectively. Large portion of Karnataka lies between 450 and 900 meters above the mean sea-level. In some places it exceeds 1800 metres as mullaiyanagiri peak which is 1913 meters in Baba-Budan(ChandradronaParvata) ranges followed by Kuduremukha which stands at 1892 meters.

The Physiographic divisions of Karnataka may be unfolded into two broad divisions: the Coastal Plains and the Western Ghats for the Coastal Region and the Malnad and the Maidan for the Karnataka Plateau. The Maidan is further subdivided into the Northern and the Southern Maidan. And a narrow belt between the Maidan and the Malnad is often referred to as the Semi-Malnad area.

Ø Shivamogga The Cradle of the Sahydddri Valley

Shivamogga District the jeweled crown of magnificent malnad; the perpetual paradise. The district Shivamogga is situated between 13’27’ and 14’39’ north latitude and between 74’38’ and 76’4’ east longitude, in about the mid-south-western part of the state. Its greatest length from east to west in 152.9 kilometer and from north to south 128.8 kilomwters.

It is bounded on the east by the Chitradurga district, on the south by Chikmagaluru district, on the west by the North and South Kanara districts and in the North by Dharwardistrict. The greater part of the district lies in the malnad, the easter portion lies in the plain region. The western portion with its tropical forests and mountain wide presents superbly enchanting

natural scenes. There are three ghats namely, the Agumbe Ghat in Thirthahallitaluk and Hulikal and Kollur Ghats in Hosnagartaluk. They provide outlets to the picturesque hill country down to south Kanara.

Verdant paddy fields, fed luxuriously by the rivers Tunga, Bhadra, Sharavati, Varda and Kumudavathi, sway and bow, welcoming you to this fertile land- the rice bowl of Karnataka. Amazingly beautiful waterfalls, hundreds of rapids, rivulets and cascades plunge from mountain tops to the depths of the valleys, thrilling spectacle of the world famous Jog falls roaring regally down the gorge.

The impregnable forts and citadels here resound with echoes of the great dynasties-the Kadambas, Gangas, Chalukyas, Rashtrakutas, Keldi and Vijayanagar Kings, who ruled this land with vigor and valor in the days of yore.

This is a place to discover some exclusive architecture. The beautiful temples stand testimony to the rich architectural talent of the region. Ever stone echoes a song, every pillar resonates with poetry.

Blessed is this homeland of great poets and bards. Endowed with a rich cultural heritage, the district of Shivamogga is where art, literature and tradition intermingle, dispersing the grand sprit of Kannada far and wide.Shivamogga the wealth of flora and fauna, birds and beasts.

Shivamogga city is the administrative headquarters of the district. More or less it is centrally located in the district. Shivamogga city is about 280 kms away from Bangalore, capital of the Karnataka. The city is connected to other major cities in the state and also to other state capitals through state highways. It is also connected to the state capital Bangalore through broadguage railway. Shivamogga district occupies an important place in the State of Karnataka due to its social, cultural,

economic and physical specialties. According to 2011 census the total population of Shivamogga district is 16,42,545.

Ø Study Sample:

The present study aims at studying the "**"Cancer A Sociological Study" - With Special- Reference to Malnad Cancer Hospital Shivamogga District"** Thus, the study is carried out in cancer hospital of Shivamogga district where the malnad cancer hospital is established.

Structured interview schedule has been used in the hospital. The sample has been drawn from all the types of cancer patients. Respondents were interviewed by the researcher. The study sample has been selected through simple random sampling basis where a combination of various problems has been mixed; Equal preference will be given to all the respondents and their family members. In the proposed study the total sample size will be 20 (Twenty) respondents.

Ø Tools and Technique of Data Collection:

Both primary and secondary data is used in this study. To collect primary data, a rigorous field study was conducted malnad cancer hospital of Shivamogga district. The canvassed Questionnaire structured with both open and closed ends was pre-tested in the field before carrying out an empirical investigation. Personal interview method has been used to gather information from respondents using structured Questionnaire. While selecting the respondents special care has taken to identify different forms of problems related with cancer. The sample was selected at simple random basis some of the respondents were reluctant to the correct information fearing it being misused inspite of various efforts made by the researcher to convince them, Thus they were excluded from the list and had to select the next respondent

In addition to primary data, secondary data has been collected from the reports of various books, newspapers, Government and private publications, journals, Internet and other concerned authorities.

Ø Data Presentation

Researcher collected primary data using a structured interview schedule, which was canvassed to the respondents, by the researcher. Other than that informal discussions were carried out with special case in concern with NGO'S and concerned organizations, Institutional heads. Secondary data's are collected from books, journals, magazines, newspapers, government and private publications, official records etc. Such collected data was further processed and interpreted to draw inferences, which on the one hand fulfilled the objective of the study and on the other hand facilitated to prove or disprove the hypothesis laid. The data thus collected, have been codified and presented in tabular form. The information is presented through these tables representing various aspects of the study in absolute numbers as well as percentages, and which is interpreted to bring out the final dissertation.

Interview schedules were used to gather necessary information from the respondents as mentioned earlier, however, these schedules had both open and closed ended questions and largely contained closed ended questions with multiple options. While processing the data, the questions were coded and entered in the computer manually by the researcher thus to minimize the mistakes and errors. The complete data was unloaded into computer in the excel sheet in table from this coding helped the researcher in preparing with different variables. Other than the data analyzed and interpreted.

Ø Findings

Patients with cancer may be generally unfit for two main

reasons: the effects of the cancer; the effects of pre-existing or coexisting illness. Both mechanism imply that unfit patients will fare badly: either because they are debilitated by the extent of their cancer or because their co-existing medical problems mean that they are not fit to undergo adequate treatment for their cancer. Various objective measures of overall fitness have been used over the years.

The physical examination of the patient is an integral part of the clinical encounter. It provides reassuring human contact and reassurance at what, for many patients with cancer, can be a time of great distress. It reintroduces the simple human touch into a series of encounters that may appear to be driven by technology rather than empathy or courtesy.

- Before the doctor can make rational decisions about which treatments to deploy he need to know about the exact illness:
- Where the disease is, how much disease there is at each site and what the behaviour of the disease is likely to be:
- It allows the patients not only to select treatment that is appropriate, it also enables the patients to estimate the likely outcome and prognosis –information of crucial importance to patients and their families.
- The doctor should know how fit the patient is, how able are they to withstand potentially toxic treatments:
- This concerns performance status, co-morbidity, current drug therapy and assessment of risk factors for complications of treatment:
- What the patient's attitude is to their illness – are they keen to be managed actively or is their attitude somewhat more passive?
- This information is less easy to obtain and involves careful discussion with patients and, most importantly, giving them

an opportunity to express their views and preferences in an environment that does not make them feel rushed or pressured:

- Good communication between patients, their families and clinicians is, if cancer is to managed effectively, essential.
- Communication is not just about clinicians giving information to patients.
- Patients and their families can provide vital information that can affect the decisions that are made about how best to manage the disease
- If patients' views and opinions are not taken into account in the decision-making process then this violates the ethical principle of autonomy
- Patients are rarely present at meetings and this, for the reasons summarised above, may compromise the validity of decision-making
- If the best interests of patients are to be represented at meetings then firstly, someone needs to listen to them, and, secondly, that individual needs to be able to give an account of the patient's views and opinions to the meeting.

Ø Suggestions:

- Sociological health services research emphasizes the central role that structural arrangements and organizational dynamics play in shaping the quality, effectiveness, and outcomes of health services.
- Inequality between private and publicly available health services and facilities is growing. The resource environment associated with managed care is partially responsible, but rationing care does not inevitably lead to inequality.
- One of the most significant consequences of institutional change for everyday medical practice has been that most

physicians are now rewarded for providing fewer services at lower cost. This has caused concern among sociologists about the impact of third-party payers on equitable access and quality of care. Managed care increases the use of primary care, preventative medicine, and outpatient treatment, but it reduces hospitalizations, visits to specialists, and more intensive, costly procedures.

· Accordingly, the poor received free care from physicians and hospitals, and the population at large paid on a sliding scale according to their means.

· At the same time, health services expenditures began to increase rapidly, and concerns about cost containment began to overshadow the long-standing commitment to quality care and equity that had characterized the institution of medicine since its inception.

ØLImitation of the Study:

In this study the researcher was under the assumptions that as there were enough respondents. So which could be easily sorted for random sample, but it was wrong when the first round of selection and interview was over. Because most of the respondents did not know what exact have happened to them their family members have not informed them about their problem and few of them were not ready to disclose their problem. So that it was little difficult to find the respondents.

Ø Conclusion:

There is a structural problem with Daily Treatment meetings. The most important person, the person with the most at stake, is rarely present in the room. This raises the question: how can decisions made under such circumstances adequately serve a patient's best interests? Adequate communication is the key to the solution of this problem. Communication is not just about providing a patient with the information that clinicians

might think they need, it is also about a sensitive exploration of patients knowledge, hopes and expectations. It is about giving them the time and opportunity to ask the questions they want to ask, about letting them express their fears and concerns and allowing them to explore their attitudes to risk. We all differ in our attitudes to risk: some people are "risk averse", prepared to do anything (no matter how unpleasant or arduous) rather than run any risk whatsoever; others are more cavalier ("risk seeking") and will blithely take their chances in life. Some of us buy travel insurance, some of us never bother. Some of us go sky-diving; others would never even travel by aeroplane. It is difficult, within the context and format of the average Daily Treatment meeting, to incorporate these highly individual attitudes into the decision-making process. Which leads to the conclusion: an Daily Treatment meeting is not an exercise in decision-making, it is a forum for exploring and appraising options. These options are, at some later point, discussed carefully with the individual patient and then, and only then, can a decision be reached.

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