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The Sick Role of Senior Citizen Cancer Patients in Sri Lanka: A Sociological Perspective

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Abstract

As the fastest-aging nation in South Asia, Sri Lanka faces significant challenges in addressing the welfare of senior cancer patients, who make up over 60% of cancer cases and are often diagnosed at advanced stages due to insufficient screening services. The theory of Sick Role explains the rights and obligations of patients. This study examines the sick role of senior cancer patients and how demographic factors impact the sick role of them within Sri Lanka's state healthcare system. Using a mixed-methods approach, including twenty interviews, ten case studies, and a survey of 262 patients from the National Institute of Cancer and oncology clinics across five districts, the research explores the sick role from an 'emic' perspective and analyses data with NVivo software. Findings reveal that factors such as education, employment status, and living conditions influence the sick role, while gender shows no significant effect. A majority of patients (72.9%) are disengaged from normal duties and rely predominantly on the biomedical model of care (78.8%). Most patients (88%) maintain a positive attitude toward the legitimate authority of healthcare workers showing goodwill towards state healthcare system, and rely on family support for caregiving. Although many seniors accept their sick role due to old age facilitating self-acceptance, a small proportion resist this role due to internal or external factors. The study highlights the importance of understanding these dynamics to improve the welfare and support systems for senior cancer patients in Sri Lanka.

Keywords: Cancer, Elderly, Senior citizen, Sick role, Sri Lanka

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INTRODUCTION

The risk of cancer increases with age, and the growing senior citizen population is altering the population pyramid globally. Cancer is defined as 'a group of diseases characterized by the uncontrolled growth and spread of abnormal cells in the body.' (American Cancer Society, 2020). Cancer as a non-communicable disease (NCD) corresponds to the level of economic development in a particular society (Luzzati et al., 2018). By 2023, 1 billion people (12.3% of the world's population) was 60 years of age or older. The WHO and the International Agency for Research on Cancer (IARC) estimate that seniors have a high cancer prevalence, with about 60% of cancer diagnoses and 70% of cancer deaths occurring in those 65 and older.

Developed countries report proportionately higher level of cancer occurrences. About 41% of all Americans can expect to be diagnosed as a cancer patient at a certain point of their life (Adler & Page, 2008). As developed countries show more or less similar socio- demographic profiles, any country follows those models of development may expect the same challenges. Parallel to the level of economic expansion, the cancer is increasingly becoming a top rank health risk in Sri Lanka. Indoor morbidity and mortality statistics of Sri Lanka ratify that more of neoplasms are reported from population 50-69 years (49.5% of reported cases) and for over 70 (13.6%). This suggests that senior citizen population can be notified as a group prone to heightened risk. Added to this chaotic potential, occurrences of neoplasms in Sri Lanka show a steady growth. Changing patterns of food consumption, exposure to multitude of toxic chemicals and altered lifestyle may be behind this consistently increasing NCD.

Table 1. *Morbidity and Mortality of Neoplasms in Sri Lanka (For 100,000 People)*

	2008	2010	2012	2014	2016	2018
Morbidities	359.2	403.2	470.9	540	640.4	729.4
Mortalities	17.2	21.5	22.2	24.0	24.3	26.7

Source: Ministry of Health, 2018.

This data suggests the occurrences of neoplasms show a steady increase within a short time span. Within the reference period, neoplasms related morbidity and mortality ratios have increased by 49.2% and 64.4% respectively in Sri Lanka. Total number of reported cancers over the years through the National cancer registry have increased more than 4 times from 1985 to 2014.There is a 10% increase in new patient registrations between 2017 and 2018.

Senior citizenry in Sri Lanka doubled within the census years of 1981 and 2011. About12.4 % of senior citizen population by the Census year 2012 was projected to be 24.8% by the year

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2041. The aging index read as 14.5 in the year 1946 has increased 49.1 in the year 2012 (Ministry of Policy Planning and Economic Affairs, 2015). Sri Lankan society is at a critical demographic turn reporting the highest median age in the South Asian region by 2000 and 2050. The median age of a Sri Lankan (21.4 years) by the census year 1981 has increased up to 30 years by the last national census 2011. Age sixty and above population of 9.8% in 2000 will increase to 21.5% in 2030 (Siddhisena, 2005). Graying of population may not be a problem if they live a healthy, productive old age. Added to the burden of less managed labour markets corresponding to the population dynamics, NCD like cancer can drain resources inside the family particularly in low income settings (World Health Organization, 2022). Studying the sick role behaviour of senior citizen cancer patients becomes pertinent optimizing the health care practices.

If not to acute malignancies, cancers can rather be noted as chronic illness needs long term treatment. Above data show mortalities in a single year are numerically only around 5% of reported morbidities due to neoplasms. This reveals that more of cancer patients have long term treatment. Mere increase in life expectancy does not mean the absence of chronic illness. Escalating life expectancy causes a series of old age welfare issues. Life expectancy of Sri Lankan males by the year 2020 was 73.4 years and 80.1 years was the value for females (World Bank, 2021). This backdrop further suggests that senior citizen people who live with cancer too live extended years receiving long term treatments. More of hospital deaths due to cancer and about 65.8% of cancers were reported from age group 50 and over. More of the patients survived a longer period of time with cancer are reported from the same age group. Statistics show that about 59% of cancer patients survived more than 1 year (National Cancer Institute, 2010). With advanced medical intervention many types of cancers today may be considered as chronic illnesses need long term treatment and care. Some cancer types cause irreversible pathological alterations, residual disability which require such long-term care.

Advancements in technology for early cancer detection and treatment have improved life expectancy for patients. However, in the UK, rising mortality rates among senior cancer patients indicate that they are often undertreated (Adler and Page, 2008). Despite the advantages of a free healthcare system, these patients face culturally specific challenges. The experiences of Sri Lankan senior citizen cancer patients are particularly under-researched, especially regarding their interactions with healthcare personnel, coping mechanisms post-diagnosis, and relationships with family and social support networks. There is a need for further investigation into these areas to better understand their realities.

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Senior citizens are a vulnerable group for contingencies such as income insecurity, dependency and age induced decline of physical and cognitive functions. Being a cancer patient may increase those vulnerabilities as the sickness can affect them physically and psychologically. Vulnerability of any kind has cultural implications. The belief and values of a certain cultural backdrop may influence the perception, meanings and the resultant behaviour towards an illness. Hence, cultural traits are increasingly being recognized as significant determinants of cancer prevention, control and to deal with psychological and behavioural issues following cancer diagnosis and treatment (Daher, 2012). The sick role behaviour can be impacted by a specific cultural setting and its demographic factors. On these grounds, the general objective of this research is to examine the sick role behaviour of senior citizen cancer patients in Sri Lanka.

The first specific objective of the study was to examine the profile of senior citizen cancer patients searching demographic factors that can be related with the sick role behaviour. This study took effort to capture the meaning derived by senior citizen cancer patients through the adoption of sick role. Health care worker- patient relationship of the senior cancer patients were noted as it is obviously a facet of sick role behaviour. Meantime the study focused on issues and problems patients encountered in coping with the sick role. Indisputably, the family remains the foremost welfare mechanism and the mainstay for Sri Lankan senior citizens. The study investigates the family intervention in sick role acquisition and coping. The study involved measuring attitude of senior citizen cancer patients towards top, middle and lower-level health care workers with the hope of understanding the factors constitute their attitude towards health care workers making an impact on sick role in return. Issues and problems encountered in the pursuit of technically competent medical care, the way they rationalize their behaviour socially negotiating the sick role was focused.

LITERATURE REVIEW

Especially in the Sri Lankan context, being a cancer patient apparently tempts individuals towards an inward orientation as the illness is socially stigmatised. Being a cancer patient causes a change in individual identity and individuals show a continuous re-adjustment to the new identity (Mathieson and Stam, 1995) and these situational adjustments to the existing reality can be considered a separate model for analysis. Sudden changes and the re-negotiation of identity is stressful even for an average healthy individual. Most studies of cancer patients follow the 'medical model' in which such experience is captured in clinical terms measuring patients' emotional reactions to cancer. Research

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on senior citizen cancer patients in the 'medical model' can be problematic, as the approach can overemphasise their physical or mental illness, leaving few options beyond medical interventions.

Long term illness at old age appear to disengage senior citizens from social interaction. The previous research on the health status of Sri Lankan senior citizens suggests multiple realities. Relative economic deprivation of senior citizens and the resultant marginalization in the health care related opportunity structure, resultant abuse of senior patients both inside and outside the family, status of 'elders' as 'passive patients' with less expanded consumer rights instead 'an expert patient' in the western sense, harmful inefficiencies of bureaucratic negligence and its putative effects on the senior citizens, right to health care as senior citizens at the mercy of administration , lack of realistic projections of health care needs and corruption are identified as the main bottle necks in the passage to an efficient health care system for senior citizens. Added to above, senior citizen patients appear to be less knowledgeable regarding their illnesses (Welgama and De Silva, 2017). A significant proportion of cancer patients had inaccurate information regarding the stage of disease and its management (De Silva et al, 2008). Despite the vulnerabilities of old age, a senior citizen cancer patients may go through many difficulties being in the above stressed backdrops.

Despite criticisms of Talcott Parsons' sick role theory in chronic illness studies, it retains some relevance in understanding illness-related behaviours (Byrd, 2013). The sick role encompasses social expectations regarding the attitudes and behaviours of individuals who are ill. Parsons (1951) identifies four key aspects: patients are exempt from standard social roles and not held responsible for their recovery, provided they acknowledge their illness as undesirable and seek competent medical help while following medical advice. The sick role functions as an institutionalised role but carries a deviant status, as individuals accept their symptoms and diagnoses within the recognized medical framework. However, the interpretation of the sick role can vary significantly across different social and cultural contexts, influenced by prevailing attitudes toward illness (Emke, 2002). This variability is particularly notable in how ageist perspectives shape the experiences of older adults across cultures.

Exemption from social roles and role disengagement are significant realities in old age. Cumming and Henry (1961) posited that as individuals age, both they and society gradually withdraw from each other, disrupting the equilibrium that existed during middle age. This disengagement is framed as a universal and inevitable process that can be beneficial, allowing society to prepare for the eventual loss of older

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individuals by facilitating the transition of roles. In Sri Lanka, senior citizens are often revered particularly within Buddhist and Hindu traditions, and their withdrawal from social roles is somewhat culturally accepted. However, when these individuals become cancer patients, they may adhere even more strongly to the sick role, reinforcing their disengagement from societal roles. This dynamic highlight how cultural attitudes influence the experiences of aging and illness.

Embracing symbolic interactionism as a theoretical framework allows for a focus on the micro-level interactions of cancer patients. This perspective views patients not merely as passive recipients of care, but as active agents with the intention to engage with healthcare providers (Alonzo, 1993). The effectiveness of treatment often hinges on the patient's willingness to accept, adhere to, or reject medical interventions, highlighting the importance of compliance. Active patient involvement in healthcare can lead to numerous positive outcomes. Additionally, the interactionist perspective is particularly valuable in understanding the cultural differences that influence healthcare experiences within a multicultural society (Schaefer & Lamm, 1998). In the light of this perspective the study may focus the knowledge gap prevails explaining the experience of senior citizen cancer patients being sensitive to the significant demographics. Dimensions such as health care staff- patient relationship, the individual adjustment to the new status as a cancer patient, issues and problems encountered making adaptations into the sick role are elaborated.

RESEARCH METHODOLOGY

Materials and Methods

This mixed-methods study involved two distinct phases to explore the sick role of senior citizen cancer patients. The first phase employed a qualitative approach, focusing on an "emic" perspective to capture the culture-specific experiences of these patients. Qualitative research is seen as particularly suitable for contexts that require understanding the "plurality of life worlds" (Flick, 2002), and the researchers avoided a purely quantitative approach, which could overlook the complexity of cultural factors. Qualitative methods are rooted in interpretivist traditions such as phenomenology, ethnography, and symbolic interactionism, making them ideal for addressing how the social world is interpreted and experienced. The flexibility, sensitivity to context, and ability to gather rich, in-depth data for holistic analysis were key reasons for this approach (Mason, 2002). Unstructured interviews were used to generate a large volume of undirected data from the senior patients, ensuring a free flow of personal insights. In the final stage, a structured questionnaire was administered to enhance the validity, reliability, and generalisability

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of the research through quantitative analysis.

Cancer patients are more or less equally reported from all districts of Sri Lanka. A Questionnaire was employed to collect data from a cluster sampling (n= 262) representing residential and patients attending the oncological clinics at National Institute of Cancer in *Maharagama and* clinics in four general hospitals located in four districts of Galle(*Karapitiya* Teaching Hospital), Kandy(Kandy Teaching Hospital), *Ratnapura (Ratnapura* Teaching Hospital) and *Anuradhapura* (*Anuradhapura* Teaching Hospital) which were randomly selected from a list of government hospitals had oncological units excluding Jaffna and Batticaloa hospitals due to language barrier. Cluster sampling was an option against the stratified sampling which would have been financially less viable due to wide dispersal of locations. Questionnaires were administered to in-house patients and those attending the clinics of each oncology ward. About 30 in-depth interviews were conducted with selected senior citizen cancer patients. 10 out of 30 interviews were developed into full case studies that can bring vital qualitative inputs. Senior citizen patients as the respondents, interviewees and cases were selected on non-random basis due to serious ethical constraints encountered. As noted earlier, non-representation of hospitals in the North and Eastern provinces of Sri Lanka due to language barrier, non-random selection of respondents for questionnaire and interviews were two main limitations of this research. Rapport building and discussions with questionnaire respondents and interviewees were challenging due to the researchers' commitment to strict adherence to ethical standards. Such difficulties varied depending on the cancer site, stage of the cancer and the personality type of the patient.

Table 2. *Summary Characteristics of Participants (n=262)*

	n	%
Sex		
Male	115	43.9
Female	147	56.1
Age (Mean 67.5, Range 60-85 years)		
60 -69	178	67.9
70- 79	73	27.9
80+	11	4.2
Cancer site		
Colon	19	7.3
Oral cancer	30	11.5
Breast	51	19.5
Lung	14	5.3
Brain	4	1.5
Thyroid	13	5
Gullet	28	10.7
Liver	1	.4
Womb	18	6.9
Bone	6	2.3
Blood	12	4.6
Skin	3	1.1
Abdomen	34	13
Bladder	4	1.4
Limbs	1	.4
Other	24	9.2
Total	262	100

Despite the deductive reasoning directed verifying the findings aligning them with existing theory, the best approach will be 'the systematic discovery of the theory from the data'

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(Glaser & Strauss 1968). All interviews were recorded and transcribed. Data from interviews and case studies were analysed using qualitative data analysis software (NVivo). Researcher has identified five demographic factors namely, gender, civil status, education, employment, and living sector as independent variables to investigate the impact on sick role behaviour of cancer patients. Quantitative data analysis was conducted using SPSS data analysis software to identify the impact of above independent variables on dependent variable of sick role behaviour. Suitable inferential statistical analysis such as multiple regression and Coefficient Correlation were adopted in the analysis.

Ethical Consideration

This research involved primary and secondary data. Informed consent of the respondent was taken, and the appropriate permission was ensured for the use of data. Confidentiality of the respondents is maintained to ensure the privacy of their communications. Collection of data was strictly limited to methods of interviews, case studies and questionnaire. The personal identity of the patient here was immaterial, and cases were recorded under an identification number and pseudo names. The researcher was aware that cancer patients can be physically, and psychologically disturbed and utmost care was extended to make sure they are not disturbed either physically or psychologically in the process of data collection. Respondents' right to stop answering or pausing his or her availability was highly respected. Researcher and trained enumerators were careful about any particular question or lead by the researcher not to disturb the patient or other health care workers. The usage of any secondary data from any source were acknowledged with appropriate references. The original proposal of the study was approved by the Ethical Clearance Committee of Sabaragamuwa University of Sri Lanka. The principal investigator used his experience as a psychological counsellor carrying out interviews and questionnaire filling sessions in such a way the dialogues reduce the anxieties of the patients. Enumerators involved in the research were further trained for this purpose.

Initial contact of patients occurred in clinics and wards at conducive times not disturbing the daily work or schedules. Research investigators/ enumerators were bound to follow all advice and regulations set by the hospital administration. The investigation was strictly restricted to verbal realm. All subjects were informed of the purpose of research at the initial contact. Storage of collected data and information were strictly in the possession of principal investigator and he is responsible for the safe disposal of data and information. Subjects were informed with the contact details of the principal investigator at the inception of the

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research and made aware of his availability at any phase of the research.

RESULTS AND DISCUSSION

Demographics and Sick Role Behaviour

Talcott Parsons' *sick role theory* (1951) views illness as a socially constructed phenomenon in which the sick individual has specific rights (exemption from normal roles) and obligations (seeking treatment). Socio-cultural and demographic factors influence how individuals fulfil the sick role, with variations depending on whether the illness is chronic or acute (Kassebaum & Baumann, 1965). This is particularly relevant in culturally distinct contexts like Sri Lanka, where older individuals hold a higher social status compared to Western ideals of old age. A study explored how demographics such as gender, civil status, education, employment, and living environment affect the sick role behaviour of senior citizen cancer patients in Sri Lanka. Categorical variables like gender and civil status were transformed into dummy variables for regression analysis, while age and the dependent variable (sick role behaviour) were treated as continuous variables, highlighting the significance of demographic impacts on sick role behaviour in this cultural backdrop.

Impact of Gender on Sick Role Behaviour

Gender was categorized as Male and Female with the values of 1 and 2. In this study, this variable was transformed to be the dummy variable with the values of 0 & 1.

Table 3. *ANOVA*

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.000	1	.000	.001	.977[b]
	Residual	34.757	260	.134		
	Total	34.758	261			

a. Dependent Variable: Sick Role Behaviour
b. Predictors: (Constant), Gender dummy

The analysis reveals that gender does not significantly impact sick role behaviour among senior citizen cancer patients, as indicated by a p-value of 0.977 at a 95% confidence level. This occurs despite notable gender disparities in morbidity and mortality rates (Ministry of Health, 2018). Women report more illness and disability but tend to live longer, a disparity attributed to both biological and social factors. In patriarchal societies, men may have better access to privileges, and 'society reinforces and rewards men's poor health habits' (Courtenay, 2000). Cultural gender patterns influence health and illness behaviours (Lane & Cibula, 2000), but in the case of senior citizen cancer patients, exemption from social roles

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and medical care-seeking behaviours does not appear to depend on gender. Witz (2000) cautions against essentialising emotional and physical traits as strictly masculine or feminine, despite the gendered expression of sick role behaviour.

Impact of Civil Status on Sick Role Behaviour

Sick role behaviour, shaped by cultural values, may not depend on marital status among senior citizen cancer patients in Sri Lanka. Despite marriage being a strong institution (Caldwell, 1999), kinship networks often substitute for family support. Below case study supports the possibility that their sick role behaviour may not depend on the marital status.

> *I've been stuck in this ward for over a fortnight now. For sure, having a wife and kids is definitely a solid bit of support. Most folks here get visits almost daily if their lot don't live too far. I've clocked a couple of singletons, mind you. Even they get the odd visit from family. Rarely is anyone left alone. Doesn't matter if you're married or not… when it's cancer, everyone's just after a cure, isn't it? The treatments are free here, so you've no choice but to crack on and cooperate with the docs and nurses.* Male, 66 years.

Marital status is linked to the social relationships of chronically ill patients, with spouses often providing positive social control (August & Sorkin, 2010). While marital status can influence health behaviours, these effects may vary across time and cultures (Kim et al., 2018). In this study of 262 senior citizen cancer patients, 92% were married, while 7.3% were unmarried and 0.8% were separated. Additionally, 63.9% had at least three children, and only 8.5% were childless. Despite these statistics, the regression analysis showed that civil status (categorized as married, unmarried, and divorced/separated) did not significantly affect sick role behaviour. Dummy variables were used to assess the impact through multiple regression analysis, but no strong correlation between civil status and sick role behaviour was found.

Table 4. *ANOVA*

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	.047	2	.023	.174	.840[b]
Residual	34.711	259	.134		
Total	34.758	261			

a. Dependent Variable: Sick Role Behaviour

b. Predictors: (Constant), Married dummy, Unmarried dummy, Divorced dummy

According to the above table, significant value of this analysis is 0.840. Therefore, the researchers can conclude that there is no significant impact of Civil Status on Sick Role Behaviour under the 95% level of confidence.

Impact of Education on Sick Role Behaviour

Interview data suggests that education influences the sick role behaviour of senior cancer patients in two keyways. First, those with higher education levels maintain better relationships with healthcare workers, adhere more

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to medical procedures, and show greater trust in biomedical treatments over traditional practices. They also visit clinics regularly with fewer delays and follow medical advice more diligently. Second, educated seniors are observed to be more proactive in seeking treatment, rather than passively accepting their condition.

Education was categorized as Never Schooled, below Grade 8, below grade 10, A Level, Graduate, Postgraduate with the values of 1,2,3,4,5,6. The researcher developed dummy variables separately to conduct the multiple regression to understand the impact on Sick role behaviour.

Table 5. ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.770	6	.198	1.962	.045[b]
	Residual	33.988	255	.133		
	Total	34.758	261			

a. Dependent Variable: SRB

b. Predictors: (Constant), Never Schooled, below grade 8, below grade 10, A Level, Graduate and Postgraduate.

According to the above table, significant value of this analysis is 0.45. Therefore, the researchers can conclude that there is of significant impact of education on Sick Role Behaviour under the 95% level of confidence.

Table 6. *Coefficients*

Model	B	Sig.
1 (Constant)	3.297	.000
Never schooled	.230	.245
Below 8	.169	.363
Below 10	.207	.271
A Level	.224	.045
Graduate	.557	.047
Postgraduate	.453	.008

a. Dependent Variable: SRB

The coefficients table shows that education, particularly at A-level, graduate, and postgraduate levels, significantly impacts sick role behaviour at a 95% confidence level. Patients' adherence to treatment options is influenced by their educational background, affecting their understanding of illness. Qualitative data indicates that education mediates decisions regarding traditional or alternative treatments. Byrd (2013) confirms that limiting work as part of the sick role is statistically linked to education.

Narratives enable the researcher to see the personal world of illness (Mathieson and Stam, 1995). Narratives can be taken as deep reflections on one's own identity. The biographies investigated in case studies further explain the above observations. Despite the long waiting hours in the clinic (3 to 4 hour) a couple of senior patients were more indifferent to their experience.

Had thyroid cancer 25 years back, seems sorted now but I stick to the doc's advice. World's modern, treatments are much

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better. Me and my husband, both grads, met at the University ages ago. Noticed blood when I cough, but I reckon I'll handle it. Those Galaha herbal docs scare people with lies about radiation, but the docs here are proper decent. When you're clued up, you make better choices. Female, 70 years.

This case highlights the patient's coping and resilience despite stressors. The patient uses their education to navigate treatment options and manage frustrations, maintaining hope while waiting in crowded cancer clinics. Their education also supports a positive outlook on health, avoiding cancer myths, and fostering a positive attitude toward themselves and healthcare workers, despite delays in an overburdened system.

Impact of Employment on Sick Role Behaviour

Employment influences lifestyle, and maladaptation at work can lead to stress and health issues. However, attributing illness solely to personal fault is mitigated by the theory of genetic predisposition. In the "new economy," individual responsibility in sickness is further reduced, as even high-paying jobs come with stress-related health risks. Marx's view that "we make our own health, but not under conditions of our choosing" (Emke, 2002) reflects this. In Sri Lanka, low-paying jobs like farming or construction also expose workers to harmful conditions beyond their control. Nonetheless, the type of employment seems to be less relevant shaping the sick role.

In this study, employment as a variable was categorised as farmer, unemployed, retired government servant, wage labourer, self-employed and private sector worker with the values of 1,2,3,4,5 and 6. The researchers developed dummy variables separately to conduct the multiple regression to understand the impact on sick role behaviour.

Table 7. *ANOVA*

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.906	6	.151	1.838	.049[b]
	Residual	33.851	255	.133		
	Total	34.758	261			

a. Dependent Variable: SRB
b. Predictors: (Constant), Private sector worker, Wage laborer, Retired Government Servant, Self-employed, Farmer, Unemployed

According to the above table, significant value of this analysis is 0.49. Therefore, researcher can conclude that there is no significant impact of Employment on Sick Role Behaviour under the 95% level of confidence.

Table 8. *Coefficients*

Model	B	Sig.
1 (Constant)	3.719	.000
Farmer	-.175	.201
Self-employed	.203	.162
Retired gvt servant	.237	.003
Wage laborer	-.242	.099
Unemployed	.282	.038
Private sector worker	.277	.043

a. Dependent Variable: SRB

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As per the above coefficients table, few employment categories including retired government servant, unemployed and private sector workers have a significant impact on sick role behaviour under the 95% level of confidence.

Patients seek private healthcare for its perceived efficiency, quality, and responsiveness (Preker et al., 2000), while Sri Lanka's state-run system is welfare oriented. Despite universal healthcare, wealthier individuals prefer private care, while chronically ill patients rely more on state services (Pallegedara & Grimm, 2017). The noted connections between sick role behaviour and employment types are realistic, as the study sample included senior cancer patients from state hospitals, showing similar sick role behaviours across employment categories.

> *Regular folks go to government hospitals. Who's got the cash to pay those crazy hospital bills? The doctors and staff there, work miracles with barely any resources. You can't expect all the fancy cleanliness or endless patience from them. They're swamped with too many patients to handle. On top of that, private hospitals are a rip-off, and the prices are out of control. I even know a case where they did an unnecessary surgery on a poor cancer patient just for the money. If your issue's serious, trust the government hospital. Even if you're dirt poor and dying, they won't give up on you.* Male, 72 years.

Senior citizen cancer patients largely rely on state healthcare, irrespective of the employment status. Retired government servants, with higher levels of education, tend to comply with treatment and view the government healthcare system as more reliable, especially for critical illnesses.

Impact of Living Sector on Sick Role Behaviour

Living sector was categorized as urban, semi urban and rural with the values of 1,2 and 3. The researcher developed dummy variables separately to conduct the multiple regression to understand the impact on sick role behaviour.

Table 9. *ANOVA*

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.131	3	.044	1.995	.042[b]
	Residual	34.627	258	.134		
	Total	34.758	261			

a. Dependent Variable: SRB

b. Predictors: (Constant), Rural, Urban, Semi-urban

Table 10. *Coefficients*

Model		B	Sig.
1	(Constant)	3.375	.000
	Urban	.174	.028
	Semi- urban	.107	.049
	Rural	.114	.593

a. Dependent Variable: SRB

According to the table 9, significant value of the analysis is 0.042. Therefore, the researchers can conclude that there is a significant impact of living sector on sick role behaviour under the 95% level of confidence.

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As per the table 10 indicate coefficients, urban and rural categories have a significant impact on sick role behaviour under the 95% level of confidence. This impact of living sector on the sick role can be justified with the qualitative information suggests the relationship between higher levels of education and sick role. Generally, the level of education in rural sector is low particularly on senior citizen generations.

Dimensions of Sick Role and Senior citizen Cancer Patients

Exemption from Usual Social Duties

Exemption from usual social duties is viewed as a right of patients in the sick role, legitimised by medical knowledge and physicians. Caregivers, in turn, are obligated to allow patients to rest and avoid physical or psychological strain, as the sick are deemed "not responsible for their condition" (Parsons, 1951). For senior cancer patients, this expectation can be intensified by societal pressure to disengage from responsibilities. The table below shows reported disengagement levels among senior cancer patients, which may result from self-realized exemption, doctors' authority, or social pressure from loved ones and society.

Table 11. *Levels of disengagement from activities and senior citizen cancer patients (%)*

Activity	Engaged	Moderately engaged	Disengaged
Agricultural work	24.8	11.8	63.4
Income earning	19.8	7.5	72.9
Daily routine	27.5	9.5	63.0
Leisure	16.4	16.5	67.1
Overall exemption from social roles	19.8	7.5	72.9

Source: Field Survey,2018

Table 11 shows that most senior cancer patients are disengaged from daily activities, with 72.9% no longer involved in income-earning. Disengagement in other activities also exceeds 60%, reflecting an overall social role exemption rate of 72.9%.

Exempted Responsibility of Getting Well

The second right of the patient in the 'sick role' is exemption from the responsibility of getting well. This responsibility is transferred to the society, particularly left at the hands of health care staff, loved ones and significant others. Sri Lankan state-run free health care system is dedicated to assure the wellbeing of patients unconditionally. Senior citizen care is deemed to be mandatory according to the senior citizen policy of the country which becomes a right of senior citizens. Care for senior citizens has been made a compulsory obligation of the society. The table below provides evidence of the attitudes of senior citizen cancer patients towards the significant others who are responsible for the recovery from cancer.

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Table 12. *Attitude of senior citizen cancer patients towards care givers including health workers (%)*

Category of care giver	Low	Moderate	High
Family	4.7	12.6	82.7
Children	10.7	11.4	77.9
Doctors	0.8	5.0	94.2
Nurses	1.9	8.0	90.1
Attendants	3.7	8.1	88.2

Source: Field Survey,2018

Table 12 highlights that society offers significant support to cancer patients. From the patients' perspective, 94.2% report high levels of care from doctors, and over 75% hold positive views towards other caregivers, including nurses, attendants, and family members. Acceptance of illness, as the third aspect of the sick role, is explored in a study from Anuradhapura, Sri Lanka, where most cancer patients willingly accept their diagnosis and complications, regardless of their relatives' or doctors' opinions (Perera et al., 2013). However, some patients, particularly post-surgery, reject the sick role (Hallowell et al., 2015).

Sri Lankan senior cancer patients often resist less due to a lack of "expert patient" attitudes. Many come from working-class or lower-middle-class backgrounds, with limited health literacy, making them more likely to follow doctors' advice. In Sri Lanka, doctors hold high social status, making it rare for patients to challenge their authority. However, the study found a few instances of patients rejecting treatments in favuor of indigenous medicine. Survey data shows that 73.4% of senior cancer patients have a high level of self-acceptance, while 17.3% show moderate, and 9.3% low self-acceptance. Acceptance of illness depends not only on healthcare professionals but also on individual risk tolerance (Crossley, 1998). Age is strongly correlated with self-acceptance as a cancer patient(P=.000), though there is no gender difference. Some older patients still deny their status as cancer patients.

> *Sometimes their children ask not to tell it to the very old mother or father. They just ask us to do what is good for them. Some of these senile patients have a little comprehension in what hospital or what ward they are.* (Doctor – Male).

Interviews with some senior citizen patients were not possible as they had serious cognitive incapacities such as dementia and had little understanding of why they were in the hospital. Their own children, often the by-standers, rarely communicated the status of the illness to their parents.

> *She is my mother. Now she is 86 years. She doesn't believe she has cancer. Two weeks before she was diagnosed she had a bee sting close to the eye (Cancer site), and she believes a bee caused the problem. My mother is light hearted. She recalls the birthday of her grandson on coming May. I think it's better she doesn't bother.* (By- stander,53 years).

In cases of stage IV cancer, children often request doctors not to reveal the

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full diagnosis to patients, especially in Sri Lanka, where 58.3% of doctors directly inform patients of their condition, and 91.7% communicate to the family (Perera et al., 2013). Doctors sometimes prescribe pain relief drugs and send patients home to manage crowded wards, which also benefits families in rural areas by reducing the need for long-distance travel. Cultural factors influence how cancer is disclosed, with doctors in countries like Hungary, Italy, and Japan often using alternative terms like "tumor" or "growth" to avoid using the word "cancer" (Perera et al., 2013).

Senior cancer patients, particularly in Sri Lanka, often view their illness through a religious lens, accepting it as part of aging and being preoccupied with death. This can lead to a mindset that sees cancer as a death sentence, negatively impacting psychological recovery. Only 77.4% of patients expected to discuss their prognosis and death (Perera et al., 2013). Some patients appear to accept their experience of reality as 'living in a state of perpetual uncertainty' (Hallowell, et al. 2015). As qualitative interviews indicate, senior citizen cancer patients probably are relatively light hearted towards the recurrence of illness following treatments.

> *I have lived a long time. Whether the illness comes back or not, there should be a way to die when one is old. I have thought of my funeral arrangements too. I discourage my children when they keep too much hope and love me. If death comes to me today I am ready. More life with disease is more suffering (Female, 76 years).*

> *I am not afraid of disease. What is the purpose of being in fear? We mankind get sick. We have to die one day but we should try to live at least a day more. They said I have six months left. But I passed one year (Male, 68 year).*

These subjective experiences show the levels of self-acceptance as a cancer patient and responses are diverse.

Health Seeking Behaviour

Seeking "technically competent help" is considered an obligation for patients in the sick role. Table 13 explains some dimensions of health seeking behaviour.

Table 13. *Attitude of patients regarding one's own health seeking behaviour (%)*

Health seeking behaviour	Low	Moderate	high
Effort to get well	2.4	7.9	89.7
Seeking competent medical care	11.4	14.2	74.4
Use of western medicine	9.3	11.9	78.8
Use of Indigenous Medicine	60.3	12.4	27.3

Source: Field Survey, 2018

89.7% of patients made efforts to recover, with 78.8% using only Western medicine. Additionally, 74.4% sought competent medical care, while 60.3% avoided indigenous treatments. Despite the majority not opting for

alternative medicine, interviews suggest they would consider it if they found a trustworthy practitioner. Fear of exploitation by fake indigenous healers deters them seeking alternative medicines. Research indicates that while cancer patients prioritise biomedical therapies, they may consider alternative medicine for holistic well-being (Arthur et al., 2012). A Sri Lankan study found 67.4% of cancer patients used traditional or alternative medicine alongside biomedicine (Broom et al., 2010).

They say Sinhalese indigenous medicine removes the slough of the cancer. I take Sinhala medicine from Aānamaduwa. I had effective results from seeking both Western and Sinhalese medicine. When I took English medicine, I was unable to eat anything. After get Sinhala medical treatments I was strong and my appetite grew. Now I am following both medical treatments (Female, 64 years).

Senior citizen patients in Sri Lanka often have lower literacy and awareness of treatment options, leading them to rely heavily on doctors' opinions. Interviews with doctors reveal that many prefer government hospitals, believing them to be more trustworthy than private hospitals, which they perceive as pushing unnecessary procedures and costs. Doctors trained in the West emphasise the importance of explaining treatment options and prognosis to patients, but this practice is less common in Sri Lankan state hospitals unless specifically requested. Most senior patients expect doctors to make decisions on their behalf without extensive discussions.

If doctor asked to cut my neck, I would say 'yes sir please go ahead if you could cure me' (Laughing). (Male, 68 years).

Generally, cancer patients, but particularly senior citizen cancer patients might have benefited more if we had a proper follow up system supported by social workers. Some senior citizen cancer patients delay showing their urgent test reports skipping the clinic days not knowing the damage such delays can cause. (Doctor, 55 years).

The health-seeking behaviour of senior citizen cancer patients shows some potentially age- induced uniqueness. In Sri Lanka, cancer treatment options, particularly advanced therapies like high-accuracy radiotherapy, are limited, especially in state hospitals. Many senior cancer patients lack awareness of their rights and the dangers of delaying treatment. Their health-seeking behaviour often exhibits age-related patterns, with qualitative data suggesting that age and physical debilitation contribute to the rejection of certain treatments, such as colostomies and amputations. Fear of procedures like colostomy bags is common. Doctors note that senior citizen cancer patients are more likely to refuse surgeries. While these patients do seek medical care, they often have a limited understanding of

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the effectiveness and competence of available treatment options.

CONCLUSION

The study explores the sick role of senior citizen cancer patients in Sri Lanka, focusing on the relationship between their demographic profile and behaviour in this role. It highlights that while gender and marital status have no significant impact, education, employment, and living sector do influence the sick role of senior citizen cancer patients. Most patients disengage from social roles, often viewing this as self-imposed, and 88% hold positive attitudes toward healthcare workers in state hospitals. Many patients have high expectations from loved ones and trust the state healthcare system, though a small proportion reject the sick role for various reasons. Old age seems to ease acceptance of cancer, but patients often lack understanding of their treatment options.

The study recommends that boosting cancer awareness among Sri Lankan senior citizens may result in mitigating the stereotypes, behaviour and faulty practices lead cancer occurrences, late diagnosis and exposure to incompetent practitioners while enhancing their access to reliable information. Policymakers are encouraged to expand welfare for the growing number of senior citizen cancer patients, with tailored services to accommodate variations in sick role behaviour. Further research may explore avenues of helping the 'disengaged' senior patients.

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