INTERNATIONAL JOURNAL OF NURSING, HEALTHCARE AND HOSPITAL ADMINISTRATION **VOL. 1 NO. 1**
E-ISSN: 3116-5974 P-ISSN: 3116-5966
https://doi.org/10.66206/eduheart.ijnhha.39

Palliative Care Needs, Quality of Life, and Death Acceptance among Elderly Individuals with Chronic Illnesses in Pangasinan: A Descriptive-Correlational Study

Marites C. Atuelan, RN[1], Dr. Brando V. Solis, RN[2], Dr. Crecencio C. Quinto[3]
matet_m@icloud.com[1], solis.brando.v@lyceum.edu.ph[2], quinto.cresencio.c@lyceum.edu.ph[3]
Lyceum Northwestern University[1,2,3]

Abstract

This descriptive-correlational study examined palliative care needs, quality of life, and death acceptance among elderly individuals with chronic illnesses in Pangasinan, Philippines. Thirty-eight respondents aged 60 years and above from Orchid Carehome, Inc. and the Dagupan City Office of Senior Citizens Affairs participated through purposive sampling. Data were obtained using a structured questionnaire adapted from validated quality-of-life and death-attitude instruments and supplemented with items on illness-related, social, spiritual, and communication factors. Frequency, percentage, weighted mean, Pearson correlation, and regression analyses were used. Findings showed a moderate overall quality of life, with stronger social and environmental functioning but lower physical and psychological scores, indicating ongoing palliative needs for symptom control, mobility support, emotional care, spiritual support, and health information. Death acceptance was high, with faith comfort, acknowledgment of death as natural, and perceived spiritual peace receiving the highest scores. Quality of life was significantly and positively associated with death acceptance ($r = 0.46$, $p = 0.004$). Regression results showed that spiritual involvement and duration of illness significantly predicted death acceptance. The findings support holistic geriatric-palliative care integrating rehabilitation, psychosocial counseling, family engagement, spiritual care, and advance care planning for chronically ill Filipino elders in community and institutional settings, especially in provincial healthcare contexts.

Keywords: *Palliative care needs; quality of life; death acceptance; elderly individuals; chronic illness; spiritual care; social support; advance care planning*

Introduction

Population aging and chronic illness have intensified the need for geriatric and palliative care systems that address not only disease control but also comfort, dignity, psychosocial stability, and end-of-life readiness. Palliative care is internationally framed as an approach that improves the quality of life of patients and families facing serious illness by preventing and relieving suffering through assessment and treatment of physical, psychosocial, and spiritual problems; major reviews further emphasize communication, symptom management, shared decision-making, and family support as core components of serious-illness care (Kelley & Morrison, 2015; Kavalieratos et al., 2016).

Quality of life is a multidimensional construct involving physical health, psychological well-being, social relationships, and environmental conditions. The WHOQOL framework defines quality of life as an individual's perception of position in life in relation to goals, standards, expectations, and cultural values, making it suitable for elderly populations whose illness

experiences are shaped by family, religion, care access, and living arrangement (The WHOQOL Group, 1998; Skevington et al., 2004).

Chronic illness and multimorbidity frequently reduce health-related quality of life by increasing functional limitations, treatment burden, dependency, and psychological distress. Evidence from multimorbidity research shows that long-term conditions create complex healthcare needs, while studies among older adults with multimorbidity show that health-related quality of life is shaped by physical function, emotional well-being, and support systems (Barnett et al., 2012; Klompstra et al., 2019).

Death acceptance is another crucial dimension of elderly care. It refers to the cognitive, emotional, and existential readiness to acknowledge death as natural, inevitable, and meaningful. For elderly individuals with chronic illness, death acceptance may be influenced by duration of illness, symptom burden, spiritual beliefs, family support, communication with healthcare providers, and advance-care planning. This study therefore examined palliative care needs, quality of life, and death acceptance among elderly individuals with chronic illnesses in Pangasinan.

Methodology

This study used a descriptive-correlational design. This design was appropriate because the study described the demographic characteristics, perceived palliative care needs, quality of life, and death acceptance of elderly respondents, and tested the relationship between quality of life and death acceptance without manipulating variables. Observational studies are strengthened when participant characteristics, measurement procedures, and statistical methods are clearly reported, consistent with STROBE guidance (von Elm et al., 2007).

The respondents were thirty-eight elderly individuals aged 60 years and above with at least one chronic illness. They were drawn from Orchid Carehome, Inc., and the Dagupan City Office of Senior Citizens Affairs. The study used purposive sampling to include respondents who could provide relevant data on chronic illness experience, palliative care needs, quality of life, and acceptance of death. The uploaded thesis identifies these two institutions as the sources of respondents and states that participants were elderly individuals diagnosed with chronic illness.

The research instrument was a structured questionnaire composed of sections on demographic profile, chronic illness profile, living arrangement, palliative care needs, quality of life, death acceptance, and factors influencing quality of life and death acceptance. Palliative care needs were examined across the physical, psychological, social, spiritual, and informational domains. Quality of life was aligned with WHOQOL domains, while death acceptance was assessed through items reflecting peaceful acceptance, emotional readiness, spiritual comfort, and openness to death-related discussion.

Data were analyzed using frequencies and percentages for the demographic profile; weighted means for palliative care needs, quality of life, death acceptance, and influencing factors; Pearson correlations for the relationship between quality of life and death acceptance; and regression analyses for predictors of quality of life and death acceptance.

Results and Discussion

Demographic Profile of Respondents

The respondents were mostly within the 65–74 age range, indicating that chronic illness and end-of-life reflection were already significant concerns among the younger-old and middle-old groups. Females comprised the majority of the sample, and many respondents were widowed. Educational attainment was generally low to moderate, with many having elementary or high school education. Hypertension was the most common chronic illness, followed by diabetes mellitus. Most respondents had experienced chronic illness for one to five years, while a substantial proportion had longer illness duration. More than half lived with family, while others lived in institutional care or alone.

This profile indicates a population with multiple geriatric vulnerabilities: chronic cardiometabolic conditions, probable health-literacy limitations, widowhood-related psychosocial risk, and varying levels of family or institutional support. These characteristics justify a palliative approach that goes beyond disease monitoring and includes symptom relief, emotional care, family engagement, spiritual care, and end-of-life communication.

Palliative Care Needs and Quality of Life

The respondents' overall quality of life was moderate, with an overall mean of 3.34. The physical health domain was moderate, particularly in energy for daily tasks, pain or discomfort during movement, and dependence on medication or medical aids. The psychological domain was also moderate, suggesting that respondents experienced manageable but persistent emotional strain. In contrast, social relationships were rated high, especially family support, interaction with others, and sense of belongingness. The environmental domain was also high, reflecting perceived safety, healthcare accessibility, and suitable living conditions.

These findings reveal important palliative care needs. The moderate physical score points to needs for pain management, mobility support, medication monitoring, and rehabilitation. The moderate psychological score suggests the need for counseling, life-review activities, anxiety reduction, and grief or fear-of-death support. High social scores indicate that family and community ties are protective resources, while the relatively favorable environmental score suggests that the carehome and OSCA contexts provide some level of safety and access. However, the moderate overall quality of life shows that physical and psychological burdens remain unresolved despite social and environmental support.

The findings are consistent with palliative care literature showing that early and integrated palliative interventions improve quality of life and mood, particularly when care addresses physical symptoms, emotional distress, and communication needs (Temel et al., 2010; Kavalieratos et al., 2016).

Level of Death Acceptance

The level of death acceptance was high, with a mean of 3.69. The highest-rated item was finding comfort in faith when thinking about death, followed by acknowledging death as a natural part of life and believing that death brings spiritual peace. Respondents also agreed that they were emotionally prepared to face death and were not afraid to talk about death.

However, some items related to not avoiding conversations about dying and to being prepared to die at any time were rated only moderately.

These results suggest that the elderly respondents exhibited meaningful, though incomplete, acceptance of death. Faith, spiritual meaning, and illness experience appeared to support acceptance, but lingering hesitation remained in relation to direct death discussion and readiness for imminent death. This pattern supports the importance of spiritual care, guided family conversation, and advance-care planning as part of palliative care. Spiritual support has been associated with better quality of life and end-of-life adjustment among seriously ill patients (Balboni et al., 2007).

Factors Influencing Quality of Life

The overall mean for factors influencing quality of life was high at 3.43. Family support and involvement received the highest rating, followed by social relationships and interaction, institutional or caregiving support, medication adherence and treatment availability, and environmental safety and comfort. Physical and financial factors, such as symptom severity, ability to perform daily activities, and capacity to purchase medication, were rated as moderate.

Regression analysis showed that the model explained 42% of the variance in quality of life. Longer illness duration significantly predicted lower quality of life, number of illnesses or multimorbidity also significantly predicted lower quality of life, and social support emerged as the strongest positive predictor. Age and living arrangement were not significant predictors.

These findings indicate that disease burden weakens quality of life, while social support protects it. In geriatric-palliative practice, this means that elderly patients with longer illness duration and multiple diagnoses should be prioritized for symptom control, rehabilitation, emotional assessment, and medication-support programs. At the same time, family conferences, caregiver education, community support groups, and institutional psychosocial programs should be strengthened because social support appears to buffer the negative effects of chronic illness.

Factors Influencing Death Acceptance

The overall mean for factors influencing death acceptance was high at 3.58. The most influential factor was spirituality or religious involvement, followed by social support from family, healthcare-provider communication, advance-care planning discussions, and previous exposure to deaths of loved ones. Moderately influential factors included duration of illness, symptom severity, chronic pain, emotional well-being, and living arrangement.

Regression analysis showed that the model explained 39% of the variance in death acceptance. Religious or spiritual involvement was the strongest significant predictor, followed by duration of illness. Age and social support were positively associated with death acceptance but did not reach statistical significance.

This finding suggests that death acceptance is shaped more strongly by internalized meaning systems and illness adaptation than by demographic factors alone. Spirituality may help older adults interpret death as a meaningful transition rather than a purely threatening event. Longer illness duration may also provide time for reflection, adjustment, and gradual acceptance of physical decline. Palliative care should therefore include spiritual assessment,

pastoral or faith-sensitive counseling, emotional processing, and structured advance-care conversations.

Relationship between Quality of Life and Death Acceptance

Pearson correlation showed a significant positive relationship between quality of life and death acceptance ($r = 0.46$, $p = 0.004$). This means that elderly individuals with better perceived well-being were more likely to accept death.

This relationship is clinically important. It suggests that acceptance of death is not isolated from daily well-being. Physical comfort, psychological stability, family support, environmental safety, and meaningful communication may strengthen an elderly person's readiness to confront mortality. Conversely, unmanaged pain, emotional distress, isolation, and uncertainty may weaken acceptance and increase fear. Thus, quality-of-life enhancement should be considered a pathway toward healthier end-of-life adjustment.

Conclusion

The study concludes that elderly individuals with chronic illnesses in Pangasinan experience moderate quality of life and high death acceptance. Their palliative care needs are most evident in the physical and psychological domains, particularly in relation to symptom burden, mobility limitations, emotional strain, and continuing dependence on medication and support. Social relationships and environmental conditions were relatively strong, indicating the protective role of family, community, and institutional care.

Quality of life was significantly influenced by illness duration, multimorbidity, and social support. Longer and multiple illnesses reduced quality of life, while social support strengthened it. Death acceptance was significantly influenced by spirituality and illness duration, showing that faith-based meaning and prolonged illness adaptation help elderly individuals accept mortality. The significant positive relationship between quality of life and acceptance of death confirms that improving elderly well-being may also promote more peaceful end-of-life perspectives.

It is recommended that geriatric and palliative care programs in Pangasinan integrate symptom management, rehabilitation, psychosocial counseling, family participation, spiritual care, healthcare-provider communication, and advance-care planning. Such interventions can improve quality of life while strengthening dignity, preparedness, and acceptance among elderly individuals living with chronic illness.

AI DECLARATION STATEMENT

AI tools were used only for grammar refinement, formatting, and manuscript organization. The data, analysis, interpretation, and conclusions remain the sole responsibility of the author.

References

Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, M. E., Lathan, C. S., Peteet, J. R., & Prigerson, H. G. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology, 25*(5), 555–560. https://doi.org/10.1200/JCO.2006.07.9046

Barnett, K., Mercer, S. W., Norbury, M., Watt, G., Wyke, S., & Guthrie, B. (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: A cross-sectional study. *The Lancet, 380*(9836), 37–43. https://doi.org/10.1016/S0140-6736(12)60240-2

Brinkman-Stoppelenburg, A., Rietjens, J. A. C., & van der Heide, A. (2014). The effects of advance care planning on end-of-life care: A systematic review. *Palliative Medicine, 28*(8), 1000–1025. https://doi.org/10.1177/0269216314526272

Chochinov, H. M., Kristjanson, L. J., Breitbart, W., McClement, S., Hack, T. F., Hassard, T., & Harlos, M. (2011). Effect of dignity therapy on distress and end-of-life experience in terminally ill patients: A randomised controlled trial. *The Lancet Oncology, 12*(8), 753–762. https://doi.org/10.1016/S1470-2045(11)70153-X

Kavalieratos, D., Corbelli, J., Zhang, D., Dionne-Odom, J. N., Ernecoff, N. C., Hanmer, J., Hoydich, Z. P., Ikejiani, D. Z., Klein-Fedyshin, M., Zimmermann, C., Morton, S. C., Arnold, R. M., Heller, L., & Schenker, Y. (2016). Association between palliative care and patient and caregiver outcomes: A systematic review and meta-analysis. *JAMA, 316*(20), 2104–2114. https://doi.org/10.1001/jama.2016.16840

Kelley, A. S., & Morrison, R. S. (2015). Palliative care for the seriously ill. *The New England Journal of Medicine, 373*(8), 747–755. https://doi.org/10.1056/NEJMra1404684

Klompstra, L., Ekdahl, A. W., Krevers, B., Milberg, A., & Eckerblad, J. (2019). Factors related to health-related quality of life in older people with multimorbidity and high health care consumption over a two-year period. *BMC Geriatrics, 19*, Article 187. https://doi.org/10.1186/s12877-019-1194-z

Skevington, S. M., Lotfy, M., & O'Connell, K. A. (2004). The World Health Organization's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. *Quality of Life Research, 13*, 299–310. https://doi.org/10.1023/B:QURE.0000018486.91360.00

Temel, J. S., Greer, J. A., Muzikansky, A., Gallagher, E. R., Admane, S., Jackson, V. A., Dahlin, C. M., Blinderman, C. D., Jacobsen, J., Pirl, W. F., Billings, J. A., & Lynch, T. J. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. *The New England Journal of Medicine, 363*(8), 733–742. https://doi.org/10.1056/NEJMoa1000678

The WHOQOL Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine, 28*(3), 551–558. https://doi.org/10.1017/S0033291798006667

von Elm, E., Altman, D. G., Egger, M., Pocock, S. J., Gøtzsche, P. C., & Vandenbroucke, J. P., for the STROBE Initiative. (2007). The Strengthening the Reporting of Observational Studies in Epidemiology Statement: Guidelines for reporting observational studies. *PLoS Medicine, 4*(10), e296. https://doi.org/10.1371/journal.pmed.0040296

Wong, P. T. P., Reker, G. T., & Gesser, G. (2015). Death Attitude Profile—Revised: A multidimensional measure of attitudes toward death. In R. A. Neimeyer (Ed.), *Death anxiety handbook: Research, instrumentation, and application* (pp. 121–148). Routledge. https://doi.org/10.4324/9781315800813-8