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# Evaluation of Perspectives Among Elderly Patients and Their Relatives in Palliative Care Centers of Istanbul

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## ABSTRACT

In Turkey, there is a dearth of research on palliative care, particularly concerning the elderly population. This study aims to evaluate the perspectives of elderly patients and their relatives regarding palliative care centers. The findings are expected to offer guidance for palliative care centers, specifically those catering to the elderly, and contribute to the enhancement of palliative care practices. The research utilized a questionnaire-based methodology, comprising inquiries pertaining to demographic information and the evaluation of perspectives regarding palliative care centers. These aspects encompassed patient care and treatment, communication with patients' relatives, perceptions, familial interest, emotional impact on relatives, the palliative care unit's waiting environment, and decision-making processes. A Palliative Care Satisfaction Scale, comprising seven sub-dimensions, was employed for assessment. The research population encompassed elderly patients receiving palliative care in Istanbul and their relatives, with the sample drawn from both public and private sectors. Data collection occurred during 2020-2021, with a total of 333 participants, including elderly patients and their relatives, being included in the study. The analysis revealed a positive palliative care satisfaction rate of

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78.75%. The highest mean value, at 3.52 (88%), was associated with the dimension concerning the care of patients' relatives, followed by patient care and treatment at 3.30 (82.5%), perception at 3.26 (81.5%), provision of information to patients' relatives at 3.19 (79.75%), emotional impact on patients' relatives at 3.00 (75%), and the decision-making process at 2.94 (73.5%), with the lowest score attributed to the palliative care waiting environment. The findings underscore the importance of improving the waiting environments in palliative care centers and involving patients and their relatives more actively in decision-making processes.

**Keywords:** Elderly, Palliative, Palliative Care

## INTRODUCTION

As per the World Health Organization (WHO), individuals aged 60 and above are categorized as elderly. Demographic data suggest a consistent increase in this elderly population, with this trend anticipated to persist (Wagiman et al., 2016). Healthy aging is defined as the process of developing and sustaining functional and physical capacities that contribute to well-being in old age. Functional capacity is a combination of an individual's internal capacity, related environmental characteristics, and interactions between the individual and these characteristics (Tavares et al., 2017). Challenges experienced by elderly patients can significantly impact their quality of life and overall satisfaction (Kurt et al., 2010).

The delivery of care services occurs through two primary ways. The first of these is formal care provided by private and public institutions. The second is informal care provided by family members, neighbors, close relatives or friends. Palliative care and home care services are at the forefront of formal care services. In the past, it was thought that palliative care should be applied to patients in the last phase of the diseases, but today, the opinion that it should be carried out together with therapeutic approaches since the diagnosis of life-threatening diseases has prevailed (Ezgici et al., 2019).

Palliative care is interdisciplinary care (medicine, nursing, social work, religion, and other specialties as appropriate) that focuses on improving the quality of life of people of all ages living with any serious illness. Palliative care provides patients with additional support by treating pain, other symptoms,

psychological and mental distress, utilizing advanced communication skills to identify care goals and assisting treatments in a personalized way, and providing sophisticated care coordination. Palliative care is provided either for the disease or in accordance with curative treatments (Campion, 2015).

In this study, the perspectives of elderly patients and their relatives on palliative care centers in Turkey were evaluated. It is thought that this study will be a guide for palliative care centers especially for the elderly and will be beneficial in terms of the effectiveness of palliative care practices.

## **CONCEPTUAL FRAMEWORK**

### **Care Service and Elderly Care**

In general, the concept of care can be expressed as providing support and assistance to people who are unable to independently perform daily life activities. Since the need for supervision and care of the elderly persists throughout their lives, it brings a long-term caregiving into focus and is primarily undertaken by family members and relatives free of charge. Nevertheless, it is also provided by professionals specializing in long-term elderly care for a certain fee (Oğlak, 2017).

As age increases, functional abilities gradually decrease. From a completely independent life to simple activities, dependence on others begins. Aging varies from person to person, often influenced by factors such as physical and mental illnesses. Dependency on others arises when daily activity skills become inadequate. Along with the decreasing abilities, the care needs of the elderly are also increasing. These needs are not only related to health, they also need friendship, security, social belonging and many other things (Kar, 2015).

Elderly care is mostly tried to be solved with the family in developing countries. However, to achieve the desired effectiveness in elderly care, family-based care at home should also be professionally organized and supported. From this point of view, in order to ensure that the care and treatment of the elderly in their homes or other care institutions can be at the desired level, it is necessary to create the social infrastructure and the trained manpower and make future plans (Doğanay and Güven, 2019).

Different care options are on the agenda to solve the care-related problems of the elderly who need support and care in Turkey. Nursing homes, nursing

homes, elderly apartments, elderly villages, etc. In addition to institutional elderly care, home-based care services have gained prominence in recent years. With home care services, it is aimed to strengthen and support the relations of people with their environment in cases such as old age and chronic diseases, enabling them to continue living freely in their surroundings, meet expectations and wishes, increase social functionality and reduce the costs of institutional care services (Tamer, 2017).

### **Palliative Care**

Palliative care is a relatively new specialty that has evolved over the past two decades. The initial aim of this specialty was to provide end-of-life care for advanced cancer patients and their families. It developed as a result of growing public concern and dissatisfaction with the care of dying patients in the 1960s and 1970s. The focus of this specialization is to relieve pain, control symptoms and improve the quality of care for patients, their families and the healthcare system. It includes not only the physical aspect but also the psychological, social and spiritual dimensions. It offers a support system to help patients live as actively as possible until death. Additionally, it provides a support system to help caregivers and families cope with the patient's illness and grief (Al-Mahrezi and Al-Mandhari, 2016).

The concept of care lies at the heart of the philosophical principles underpinning palliative care and serves as the guiding framework for professionals working in this field, irrespective of the patient's environment. In the context of caring for individuals afflicted by incurable, progressive, and life-threatening diseases, special emphasis must also be placed on the patient's families. Palliative care adopts a holistic approach that encompasses both the individual and their family, a perspective endorsed by the World Health Organization (Silva et al., 2018).

Palliative care represents an approach aimed at enhancing the quality of life of patients and their families facing problems related to life-threatening diseases. It includes the early diagnosis, accurate assessment, and treatment of pain and other associated problems, with a focus on both the prevention and alleviation of pain and relieve patients. Palliative care extends to the prevention and mitigation of any physical, psychological, social or spiritual suffering

experienced by those with life-limiting health problems (WHO, 2016). Palliative care (WHO, 2018);

- It requires early diagnosis and evaluation and treatment of problems.
- It improves the quality of life, promotes comfort and can also have a positive impact on the course of the disease.
- It provides support both for the patient and family throughout the illness.
- It is concerned with preventing, diagnosing early, and treating serious or life-limiting health problems.
- It can be administered concurrently with other treatments aimed at prolonging life.
- It can be applied to individuals living with long-term physical, psychological, social or mental challenges resulting from serious or life-threatening diseases or their treatments.
- It offers support to bereaved family members when necessary, following the patient's death.
- It offers any necessary treatments to ensure sufficient comfort for the patient.
- It is delivered by health care professionals at various levels of palliative care training and skill at various levels.
- It encourages the active participation from communities and community members.

In 2017, there were 252 palliative care centers in Turkey, 238 of which are within the Ministry of Health and 14 of which are within universities, with a total of 2.942 beds. In 2018, the number of palliative care centers increased to 294, with 3.730 beds. As of March 2019, the number of palliative care centers had reached 365, and the number of beds had risen to 4.855 (Akçakaya, 2020).

### **Aim of Palliative Care**

Palliative care is defined as an approach for the early diagnosis, evaluation and treatment of physical and psycho-social and mental problems to alleviate or prevent the problems and pain associated with life-threatening diseases. The main purpose of palliative care is to provide a quality of life, relief of patients' pain and other symptoms, psychological and social support, nutritional support and education needs of the patient. However, the main purpose is to

improve the quality of life for patients and their families (Turan et al., 2017).

In addition to treatments targeting the underlying disease, modern palliative care can be provided from the moment of diagnosis, and palliative care may be necessary. However, treatments targeting the control of the disease may be necessary in addition to palliative care until the time of death (Hawley, 2017).

With palliative care, patients and their relatives can be psychologically prepared for death. The main goals of palliative care are to prevent, relieve, reduce or alleviate the symptoms caused by the disease without relying solely on treatment. In addition to these goals, it is aimed at improving the quality of life for the patient and providing support for the patient's relatives. Palliative care is not solely provided in the final stages of life. It is a form of care that begins with the initial diagnosis of the patient, continues with the purpose of treatment until death, and supports the family and members in the mourning process after death. The general aims of palliative care are as follows (Kızıltuğ, 2019);

- Palliative care sees death as a natural process and affirms life.
- Palliative care helps relieve pain and other distressing symptoms.
- Palliative care does not aim to hasten or delay death.
- Palliative care addresses the spiritual and psychological aspects of patient care.
- Palliative care provides support for patients to live as actively as possible until the moment of death.
- Palliative care provides support for the families of patients to cope with the problems during their illness and at the end of their life.
- Palliative care offers a team approach to meet the needs of patients and their families.
- Palliative care can have a positive impact on the course of the disease and contributes to increase the quality of life of patients.
- Palliative care can be initiated early in conjunction with other treatments such as radiotherapy and chemotherapy to extend life, depending on the course of the disease.

## **METHODOLOGY**

### **Purpose of Research**

Palliative care in Turkey is an issue that is not emphasized enough, except for a few palliative care centers that serve mostly for cancer patients. In Turkey, there haven't been many studies on palliative care and its centers especially for the elderly. The purpose of the research is to evaluate the perspectives of elderly patients and their relatives on palliative care centers in Istanbul. It is believed that this study will be a guide for palliative care centers especially for the elderly and will be beneficial in improving the effectiveness of palliative care practices. Enhancing the effectiveness of palliative care centers is crucial for assessing satisfaction, identifying any deficiencies, and taking necessary precautions.

### **Research Method**

This research is a quantitative in nature, and it aimed to assess the perspectives of elderly patients and their relatives on palliative care centers in Istanbul. A questionnaire was utilized as a quantitative data collection tool in the research. The research questions are as follows;

- 1) Does the perspective towards palliative care centers differ according to gender?
- 2) Does the perspective towards palliative care centers differ based on whether one is a patient or a patient's relative?
- 3) Does the point of view towards palliative care centers differ according to the frequency of visits?
- 4) Does the perspective towards palliative care centers differ from having previous knowledge of palliative care?
- 5) Does the point of view towards palliative care centers differ according to whether there is a relative in the palliative care center or not?
- 6) Does the perspective towards palliative care centers differ according to place of residence?
- 7) Does the point of view towards palliative care centers differ according to education level?
- 8) Does the perspective towards palliative care centers differ according to income level?

9) Does the perspective towards palliative care centers differ according to the reason for choosing the palliative care center?

### **Research Population and Sample**

The population of the research consists of elderly patients and their relatives who receive service from the palliative care center in Istanbul. Considering the cost and time constraints, it was decided to use the sampling method since it is very difficult to apply the questionnaire to the whole population. The sample consists of service recipients from the public and private sectors. In Turkey, palliative care services are provided within the Ministry of Health in 396 health institutions in 81 provinces with a total of 5,302 beds (Doğan and Demirtaş, 2020).

According to 2020 data, there are 595 palliative beds in public hospitals in Istanbul. The population of the study consists of 600 patients and their relatives. When the acceptable margin of error was set at 5% and the confidence level was 95%, the recommended sample size was calculated to be 234. The research was carried out in 2020, and a total of 333 people were reached, including elderly patients and their relatives in Istanbul.

### **Data Collection Technique**

In the research, questions measuring demographic information and palliative care satisfaction scale were used. There are nine questions in the scale to obtain demographic information. In one question, they were asked whether they would recommend the palliative center. Palliative care, which consists of 7 sub-dimensions, including the care and treatment of the patient, informing the patient's relatives, perception, interest in the patient's relatives, the effect on the emotionality of the patient's relatives, the waiting environment of the palliative care unit, and the decision-making process regarding the evaluation of the perspectives of elderly patients and their relatives on palliative care centers. satisfaction scale.

Palliative care satisfaction scale: It was taken from the study titled "The evaluation of the service provided in the palliative care process by the relatives of the patients" by Mavi (2017). A 4-point Likert type scale was used. According to this; It was assessed using a scale of Poor (1), Fair (2), Good (3),



Very Good (4) points. There are 30 questions in total in the palliative care satisfaction scale. 4 questions (q19-q22-q28-q30) were excluded from the factor analysis. In this study, the scale consists of 26 questions in total. When all questions were answered very well, it was evaluated as 100% satisfaction out of 104 points.

All the scaler variables were analyzed for the normal distribution and were found to be normally distributed. Thus, parametric tests were used in this study.

## RESULTS

**Table 1:** Findings related to demographic information

		n	%
<b>Gender</b>	Woman	184	55.3
	Male	149	44.7
<b>Patient/Patient Relatives</b>	Patient	69	20.7
	The relatives of the patient	264	79.3
<b>Interview Frequency</b>	Continually	56	16.8
	More than once a week	93	27.9
	Once a week	136	40.8
	Once a month	33	9.9
	Once a year	15	4.5
<b>Palliative Care Information</b>	Yes	135	40.5
	No	198	59.5
<b>Relative Previously in Palliative Care</b>	Yes	88	26.4
	No	245	73.6
<b>Place of Residence</b>	In the city where the hospital is located	305	91.6
	Out of town	28	8.4
<b>Education level</b>	Primary school graduates	49	14.7
	High school graduates	75	22.5
	University graduates	133	39.9
	Master's degree graduates	62	18.6
	Doctorate graduates	14	4.2

<b>Income Level</b>	2.000 TL and less	9	2.7
	Between 2.001-3.000 TL	49	14.7
	Between 3.001-5.000 TL	107	32.1
	Between 5.001-10.000 TL	106	31.8
	10.001 TL and above	62	18.6
<b>Reason for Choosing Palliative Care Center</b>	Unsuitable home	24	7.2
	For better care	150	45.0
	Under doctor's guidance	105	31.5
	Familiar advice	35	10.5
	Other	19	5.7

Among participants %55.7 (184) are women, 79.3% (264) are relatives of the patients and the rest are patients, 14.7% (49) are primary school graduates, 22.5% (75) high school graduates, 39.9% (133) university graduates, 18.6% (62) master's degree graduates and 4.2% (14) doctorate graduates. When we looked at the socioeconomic levels of the group, 17.4% (58) of participants have lower income than 3.000 TL, 32.1% (107) between 3.001-5.000 TL, 31.8% (106) between 5.001-10.000 TL and 18.6% (62) over 10.000 TL (Table 1).

Only 56 (16.8%) of patients and their relatives are in close contact with each other. 93 persons (27.9%) see each other more than once a week, 136 (40.8%) once a week, 33 (9.9%) once a month and 15 (4.5%) once a year. The ratio of the people who had knowledge about palliative care centers previously was 40.5% (135), 26.4% (88) had a relative previously hospitalized in a palliative care center, 91.6% (305) live in the city where the hospital is located. Due to the limits of the home conditions 2% (24) prefer the palliative care center. A 45% (150) prefer a palliative care center for better care, 31.5% (105) as the result of the doctor's advice, 10.5% (35) on the recommendation of an acquaintance and 5.7% (19) for other various reasons (Table 1). In total, a 46.1% (287) of the group declares that they would recommend/strongly recommend palliative care units to their relatives and friends, 11.1% (37) are undecided and 2.7% (9) do not recommend/strongly do not recommend. Observed differences were compared by t-test and analysis of variance.

**Table 2:** Results of analysis for observed differences in responses by gender

Factors	Gender	n	Mean	S.D.	t	p
Care and treatment of patients	Woman	184	3.26	0.58	-1.334	0.183
	Man	149	3.34	0.58		
Giving information to the patient's relatives	Woman	184	3.17	0.55	-.538	0.596
	Man	149	3.21	0.63		
Perception	Woman	184	3.27	0.63	0.380	0.704
	Man	149	3.24	0.67		
Caring for the patient's relatives	Woman	184	3.48	0.56	-1.323	0.187
	Man	149	3.56	0.58		
Affect to emotion situation of patient's relatives	Woman	184	2.93	0.62	-2.010	0.049*
	Man	149	3.08	0.71		
Palliative care waiting environment	Woman	184	2.86	0.79	-1.947	0.052
	Man	149	3.04	0.82		
Decision making process	Woman	184	2.87	0.64	-2.160	0.035*
	Man	149	3.03	0.75		
General satisfaction	Woman	184	3.11	0.47	-1.643	0.108
	Man	149	3.20	0.56		

Only affect to emotion situation of patient's relatives and decision-making process item results were found significantly different by gender as male results had higher scores for both items ( $p < 0.05$ ) (Table 2). Accordingly, it appears that men are more satisfied with the attention shown to their feelings than women and feel more included in decision-making processes.

**Table 3:** Results of analysis for observed differences by patient group

Factors	Patient Patient's relatives	n	Mean	S.D.	t	p
Care and treatment of patients	Patient	69	3.36	0.58	1.016	0.311
	Patient's relatives	264	3.28	0.58		
Giving information to the patient's relatives	Patient	69	3.13	0.61	-1.000	0.318
	Patient's relatives	264	3.21	0.58		
Perception	Patient	69	3.05	0.73	-2.928	0.004*
	Patient's relatives	264	3.31	0.62		
Caring for the patient's relatives	Patient	69	3.62	0.52	1.669	0.096
	Patient's relatives	264	3.49	0.58		
Affect to emotion situation of patient's relatives	Patient	69	3.07	0.60	0.968	0.334
	Patient's relatives	264	2.98	0.68		
Palliative care waiting environment	Patient	69	2.84	0.73	-1.195	0.233
	Patient's relatives	264	2.97	0.83		
Decision making process	Patient	69	2.68	0.66	-3.630	<0.001*
	Patient's relatives	264	3.01	0.68		
General satisfaction	Patient	69	3.10	0.50	-.921	0.347
	Patient's relatives	264	3.16	0.52		

Only affect to decision-making processes item result were found significantly different between the perception and the status of being a patient/patient relative ( $p < 0.05$ ) (Table 3). Accordingly, it is seen that patient relatives are able to perceive issues related to the condition of the disease better than the patients and feel that they are more included in the decision-making processes.

**Table 4:** Results of analysis for observed differences according to knowledge about palliative care

Factors	Having Knowledge	n	Mean	S.D.	t	p
Care and treatment of patients	Yes	135	3.24	0.63	-1.433	0.164
	No	198	3.33	0.55		
Giving information to the patient's relatives	Yes	135	3.25	0.62	1.435	0.160
	No	198	3.15	0.56		
Perception	Yes	135	3.32	0.66	1.490	0.137
	No	198	3.21	0.64		
Caring for the patient's relatives	Yes	135	3.48	0.60	-.943	0.356
	No	198	3.54	0.54		
Affect to emotion situation of patient's relatives	Yes	135	3.06	0.67	1.335	0.183
	No	198	2.96	0.66		
Palliative care waiting environment	Yes	135	3.02	0.85	1.585	0.114
	No	198	2.88	0.77		
Decision making process	Yes	135	3.13	0.65	4.115	0.001*
	No	198	2.82	0.69		
General satisfaction	Yes	135	3.20	0.56	1.497	0.147
	No	198	3.11	0.48		

Only affect to decision-making processes item result were found significantly different between whether to have prior knowledge of the palliative care center ( $p < 0.05$ ) (Table 4). Accordingly, it seems that those who have previously had information about the palliative care center feel that they are more included in the decision-making processes than those who do not.

**Table 5:** Results of analysis for observed differences according to relatives previously hospitalized in palliative care

Factors	Previously Inpatient Relative	n	Mean	S.D.	t	p
Care and treatment of patients	Yes	88	3.32	0.65	0.354	0.743
	No	245	3.29	0.55		
Giving information to the patient's relatives	Yes	88	3.27	0.66	1.582	0.115
	No	245	3.16	0.56		
Perception	Yes	88	3.34	0.67	1.395	0.164
	No	245	3.23	0.64		
Caring for the patient's relatives	Yes	88	3.54	0.60	0.466	0.641
	No	245	3.51	0.55		
Affect to emotion situation of patient's relatives	Yes	88	3.12	0.72	2.002	0.061
	No	245	2.95	0.64		
Palliative care waiting environment	Yes	88	3.04	0.91	1.363	0.210
	No	245	2.90	0.77		
Decision making process	Yes	88	3.18	0.72	3.845	0.001*
	No	245	2.86	0.66		
General satisfaction	Yes	88	3.25	0.60	2.116	0.035*
	No	245	3.11	0.47		

Only affect to decision-making processes item result were found significantly different between general satisfaction and whether there is a relative in the palliative care center before ( $p < 0.05$ ) (Table 5). Accordingly, those who had relatives previously hospitalized in a palliative care center felt more included in the decision-making process and their general satisfaction was higher than those who did not.

**Table 6:** Results of analysis for observed differences by place of stay

Factors	Place of Stay	n	Mean	S.D.	t	p
Care and treatment of patients	In the City of the Hospital	305	3.32	0.56	2.117	0.035*
	Out of Town	28	3.07	0.76		
Giving information to the patient's relatives	In the City of the Hospital	305	3.20	0.57	1.613	0.108
	Out of Town	28	3.02	0.72		
Perception	In the City of the Hospital	305	3.29	0.62	3.046	0.030*
	Out of Town	28	2.90	0.88		
Caring for the patient's relatives	In the City of the Hospital	305	3.54	0.54	2.997	0.038*
	Out of Town	28	3.21	0.79		
Affect to emotion situation of patient's relatives	In the City of the Hospital	305	3.01	0.65	1.206	0.229
	Out of Town	28	2.85	0.83		
Palliative care waiting environment	In the City of the Hospital	305	2.95	0.81	0.838	0.403
	Out of Town	28	2.82	0.81		
Decision making process	In the City of the Hospital	305	2.94	0.69	0.150	0.881
	Out of Town	28	2.92	0.70		
General satisfaction	In the City of the Hospital	305	3.17	0.49	1.941	0.053
	Out of Town	28	2.97	0.70		

Only affect to care and treatment and perception item result were found significantly different of patient's explanation between care and treatment, perception and care for the patient's relatives and the place of residence ( $p < 0.05$ ) (Table 6). Accordingly, it is seen that those living in the city where the hospital is located think that the care and treatment of patients is better than those living outside the city where the hospital is located, they can better perceive the issues related to the condition of the disease, and they are more satisfied with the attention shown to them.

**Table 7:** Results of analysis for observed differences according to incidence

Factors	Mean	Source of Variance	Mean Square	F	p	Significant Difference
<b>Care and treatment of patients</b>	3.13	Between groups	0.669	1.975	0.098	-
	3.36	Within Groups	0.339			
	3.35	Total				
	3.20					
	3.30					
<b>Giving information to the patient's relatives</b>	3.25	Between groups	0.292	0.829	0.507	-
	3.24	Within Groups	0.352			
	3.12	Total				
	3.22					
	3.22					
<b>Perception</b>	3.35	Between groups	0.234	0.541	0.705	-
	3.27	Within Groups	0.432			
	3.24	Total				
	3.20					
	3.13					
<b>Caring for the patient's relatives</b>	3.40	Between groups	0.855	2.661	0.033*	2-4>1 3>4
	3.62	Within Groups	0.321			
	3.55	Total				
	3.33					
	3.40					
<b>Affect to emotion situation of patient's relatives</b>	3.11	Between groups	0.619	1.388	0.238	-
	3.02	Within Groups	0.446			
	2.91	Total				
	3.04					
	3.18					
<b>Palliative care waiting environment</b>	2.93	Between groups	1.377	2.118	0.078	-
	3.03	Within Groups	0.650			
	2.81	Total				
	3.10					
	3.26					



<b>Decision making process</b>	3.14	Between groups	2.106	4.522	0.001*	1>3
	2.97	Within Groups	0.466			
	2.77	Total				
	3.06					
	3.28					
<b>General satisfaction</b>	3.18	Between groups	0.214	0.793	0.530	-
	3.20	Within Groups	0.269			
	3.09	Total				
	3.15					
	3.24					
<b>1: Continually 2: More than once a week 3: Once a week 4: Once a Month 5: Once a Year</b>						

Only affect to decision-making processes item result were found significantly different between the care and decision-making process of the patient's relatives and the frequency of the interview ( $p < 0.05$ ) (Table 7). Accordingly, those who meet more than once a week and once a month are more satisfied with the attention shown to them than those who meet constantly, and those who meet once a week are more satisfied with the attention shown to them than those who meet once a month. It seems that those who meet regularly feel more included in the decision-making process than those who meet once a week.

**Table 8:** Results of analysis for observed differences by education level

Factors	Mean	Source of Variance	Sum of Squares	Df	Mean Square	F	p	Significant Difference
<b>Care and treatment of patients</b>	3.48	Between groups	3.644	4	0.911	2.714	0.030*	1>3-4
	3.34	Within Groups	110.085	328	0.336			
	3.21	Total	113.729	332				
	3.23							
	3.52							
<b>Giving information to the patient's relatives</b>	3.18	Between groups	0.578	4	0.144	0.408	0.803	-
	3.18	Within Groups	116.130	328	0.354			
	3.16	Total	116.708	332				
	3.22							
	3.37							
<b>Perception</b>	2.99	Between groups	4.574	4	1.143	2.719	0.030*	2-3-4-5>1
	3.32	Within Groups	137.919	328	0.420			
	3.32	Total	142.492	332				
	3.23							
	3.38							
<b>Caring for the patient's relatives</b>	3.62	Between groups	2.201	4	0.550	1.693	0.151	-
	3.55	Within Groups	106.651	328	0.325			
	3.42	Total	108.853	332				
	3.58							
	3.60							
<b>Affect to emotion situation of patient's relatives</b>	3.03	Between groups	2.781	4	0.695	1.562	0.184	-
	2.90	Within Groups	145.976	328	0.445			
	2.96	Total	148.757	332				
	3.11							
	3.27							
<b>Palliative care waiting environment</b>	2.82	Between groups	10.607	4	2.652	4.179	0.003*	4>1-2-3
	2.76	Within Groups	208.116	328	0.634			
	2.92	Total	218.722	332				
	3.28							
	3.07							

<b>Decision making process</b>	2.60	Between groups	14.213	4	3.553	7.929	<0.001*	3>1 4-5>1-2
	2.77	Within Groups	146.992	328	0.448			
	3.02	Total	161.205	332				
	3.17							
	3.35							
<b>General satisfaction</b>	3.10	Between groups	1.354	4	0.338	1.263	0.284	-
	3.11	Within Groups	87.876	328	0.268			
	3.13	Total	89.229	332				
	3.23							
	3.37							
<b>1: Primary school graduates 2: High school graduates 3: University graduates 4: Master's degree graduates 5: Doctorate graduates</b>								

Only affect to decision-making processes item result were found significantly different university graduates feel more included in compared to primary school graduates, and master's graduate and doctorate graduates compared to primary and high school graduates ( $p < 0.05$ ) (Table 8). Accordingly, it is seen that those who are primary school graduates think that care and treatment of patients is provided better than those who have university and master's degree graduates. It is seen that those whose education level is higher than primary school graduates can perceive the issues related to the disease status better than primary school graduates. It is seen that master's degree graduates view the palliative care waiting environment better than primary school, high school and university graduates. It is seen that university graduates feel more included in decision-making processes than primary school graduates, and master's and doctorate graduates feel more involved in decision-making processes than primary school graduates and high school graduates.

**Table 9:** Results of analysis for observed differences by income level

Factors	Mean	Source of Variance	Sum of Squares	Df	Mean Square	F	p	Significant Difference
Care and treatment of patients	3.44	Between groups	1.636	4	0.409	1.197	0.312	-
	3.39	Within Groups	112.094	328	0.342			
	3.29	Total	113.729	332				
	3.21							
	3.36							
Giving information to the patient's relatives	3.04	Between groups	1.824	4	0.456	1.302	0.269	-
	3.10	Within Groups	114.883	328	0.350			
	3.20	Total	116.708	332				
	3.15							
	3.32							
Perception	2.81	Between groups	6.221	4	1.555	3.743	0.005*	3-4-5>1-2
	3.00	Within Groups	136.272	328	0.415			
	3.31	Total	142.492	332				
	3.33							
	3.30							
Caring for the patient's relatives	3.50	Between groups	0.842	4	0.210	0.639	0.635	-
	3.56	Within Groups	108.011	328	0.329			
	3.46	Total	108.853	332				
	3.50							
	3.60							
Affect to emotion situation of patient's relatives	3.04	Between groups	6.834	4	1.708	3.948	0.004*	5>1-2-3-4
	2.84	Within Groups	141.923	328	0.433			
	2.90	Total	148.757	332				
	3.01							
	3.27							
Palliative care waiting environment	2.88	Between groups	16.425	4	4.106	6.658	<0.001*	4>2 5>2-3-4
	2.66	Within Groups	202.298	328	0.617			
	2.79	Total	218.722	332				
	2.99							
	3.34							
Decision making process	2.58	Between groups	26.693	4	6.673	16.273	<0.001*	3>2 4>1-2 5>1-2-3-4
	2.40	Within Groups	134.512	328	0.410			
	2.91	Total	161.205	332				
	3.02							
	3.35							

<b>General satisfaction</b>	3.04	Between groups	3.824	4	0.956	3.672	0.006*	5>2-3-4
	2.99	Within Groups	85.405	328	0.260			
	3.12	Total	89.229	332				
	3.15							
	3.34							
<b>1: Income level less than 2.000 TL</b> <b>2: Income level 2.001-3.000 TL</b> <b>3: Income level 3.001-5.000 TL</b> <b>4: Income level 5.001-10.000 TL</b> <b>5: Income level more than 10.000 TL</b>								

Among the nine items of the scale, responses for four of them showed significant difference ( $p < 0.05$ ). These four items were affected to emotional situation of patient's relatives, waiting environment in the palliative care unit, decision making process and general satisfaction. According to this;

It is seen that those with an income of 3.001 TL and above can perceive the issues related to the condition of the disease better than those with an income of 3.000 TL and below.

It seems that those with an income of 10.001 TL and above are more satisfied with the attention shown to their emotions than those with an income of 2.001-10.000 TL.

It is seen that those with an income of 5.001-10.000 TL see the palliative care unit waiting environment better than those with an income of 2.001-3.000 TL, and those with an income of 10.001 TL and above see the palliative care unit waiting environment better than those with an income of 2.001-10.000 TL.

Those with an income between 3.001-5.000 TL have a higher decision-making process than those with an income of 2.001-3.000 TL, those with an income between 5.001-10.000 TL have a higher decision-making process than those with an income of 3.000 TL and below, and those with an income of 10.001 TL and above have a higher decision-making process than those with an income of 10.000 TL and below. It seems that they feel more included.

Those with an income of 10.001 TL and above have higher general satisfaction levels with the palliative care center than those with an income of 2.001-10.000 TL.

**Table 10:** Results of analysis for observed differences according to the reason for choosing the palliative care center

Factors	Mean	Source of Variance	Sum of Squares	Df	Mean Square	F	p	Significant Difference
<b>Care and treatment of patients</b>	3.36	Between groups	1.602	4	0.401	1.172	0.323	-
	3.28	Within Groups	112.127	328	0.342			
	3.35	Total	113.729	332				
	3.29							
	3.05							
<b>Giving information to the patient's relatives</b>	3.26	Between groups	4.283	4	1.071	3.124	0.015*	2-4>3
	3.26	Within Groups	112.425	328	0.343			
	3.03	Total	116.708	332				
	3.32							
	3.20							
<b>Perception</b>	3.40	Between groups	2.442	4	0.611	1.430	0.224	-
	3.32	Within Groups	140.050	328	0.427			
	3.15	Total	142.492	332				
	3.24							
	3.17							
<b>Caring for the patient's relatives</b>	3.58	Between groups	1.168	4	0.292	0.890	0.470	-
	3.54	Within Groups	107.685	328	0.328			
	3.52	Total	108.853	332				
	3.51							
	3.28							
<b>Affect to emotion situation of patient's relatives</b>	3.9	Between groups	3.766	4	0.942	2.130	0.077	-
	3.07	Within Groups	144.991	328	0.442			
	2.84	Total	148.757	332				
	3.10							
	3.00							
<b>Palliative care waiting environment</b>	3.06	Between groups	22.914	4	5.728	9.596	<0.001*	1-2-4-5>3
	3.10	Within Groups	195.808	328	0.597			
	2.56	Total	218.722	332				
	3.27							
	3.05							

<b>Decision making process</b>	3.00	Between groups	27.166	4	6.791	16.619	<0.001*	1-2-4-5>3
	3.12	Within Groups	134.039	328	0.409			
	2.53	Total	161.205	332				
	3.27							
	3.13							
<b>General satisfaction</b>	3.23	Between groups	3.997	4	0.999	3.846	0.005*	1-2-4>3
	3.22	Within Groups	85.232	328	0.260			
	2.99	Total	89.229	332				
	3.27							
	3.11							
<b>1: Unsuitable home</b> <b>2: For better care</b> <b>3: Direction of the doctor</b> <b>4: Familiar advice</b> <b>5: Other</b>								

Only two affect waiting environment the decision-making process item result were found significantly different general satisfaction, and the reason for choosing the palliative center ( $p < 0.05$ ) (Table 10). According to this;

It is observed that those who prefer a palliative care center for better care and because of the advice of a friend think that they are better informed than those who prefer it with the guidance of a doctor.

It is seen that those who prefer the palliative care center due to unsuitable home, better care, advice from acquaintances and other reasons, see the waiting environment of the palliative care unit better than those who prefer it with the guidance of the doctor.

It is observed that those who prefer a palliative care center due to unsuitable home, better care, advice from acquaintances and other reasons feel that they are more included in the decision-making process than those who prefer it with the guidance of a doctor.

Those who choose a palliative care center due to unsuitable housing, better care and advice from acquaintances have higher general satisfaction levels with the palliative care center than those who choose it with the guidance of a doctor.

## DISCUSSIONS and CONCLUSIONS

Aging is a complex process of development and growth, which is an inevitable journey that starts with birth and ends with death. This process encompasses physiological, biological, sociological, psychological and chronological dimensions. As people age, starting in middle age, their bodily functions become increasingly susceptible to wear and tear, resulting in a decline in physical and mental capabilities. Palliative care is a model of care that primarily seeks to predict, prevent, diagnose and treat the symptoms experienced by those with a serious or life-threatening illness, and provide medical support to patients and their families. The goal of palliative care is to improve the quality of life for both patient and family, regardless of diagnosis. It can positively affect the course of the disease. Provides support for the patient and family throughout the illness. It includes the early diagnosis, correct evaluation and treatment of pain and other problems, as well as aiming to prevent pain and relieve patients. Palliative care includes the prevention and relief of any physical, psychological, social or spiritual suffering experienced by those with life-limiting health problems.

According to the research findings, satisfaction with palliative care stands at a positive 78.75%. The highest mean value of 3.52 (88%) belongs to the dimension of concern for the caring for the patient's relatives. The rest follows respectively as; 3.30 (82.5%) care and treatment of patients, 3.26 (81.5%) perception, 3.19 (79.75%) giving information to the patient's relatives 3.00 (75%) affect to emotion situation of patient's relatives 2.95 (73.75%) and the decision-making process was 2.94 (73.5%) and palliative care waiting environment. The highest average belongs to caring for the patient's relatives where the lowest average belongs to palliative care waiting environment category. In the study of Gdelođlu et. al. (2020), palliative care satisfaction ranking follows as; interest and giving information to the patient's relatives, affect to emotion situation of patient's relatives, care and treatment of patients, decision-making process, affect to emotion situation of patient's relatives, perception and waiting of environment and logistic support. The highest average belongs to interest and giving information to the patient's relatives and lowest average belongs to waiting of environment and logistic support. In the study of Mavi (2017), palliative care satisfaction rate of patient relatives was 85%. Palliative care satisfaction



order from highest to lowest in the study is as follows; decision making evaluation of perspectives among elderly patients and their relatives in palliative care centers of Istanbul process, care and treatment of patients, perception, giving information to the patient's relatives, affect to emotion situation of patient's relatives, waiting of environment and logistic support.

Improving the waiting environments of palliative care centers and involving both patients and their relatives in decision-making processes will further improve the positive perspective on palliative care centers. Analyzing the responses of research participants, we observe the following trends;

- The majority believe that they will definitely receive calls from home when there is a significant change in the condition of their patients. The second most common response is that employees are very kind and very understanding towards them, while the third most common response is that the skills and abilities of the doctors are very good.
- Participants indicate that they receive comprehensive information about their patients most frequently, with the second highest response being that the same information is provided to family members who are informed about the disease, and that the information given about their patients is understandable with the third highest rate.
- Respondents report that they occasionally need to attend to matters outside the palliative care unit the most, followed by occasionally sharing issues that distress them with the palliative care doctors. Furthermore, they occasionally participate in making decisions about their patients' treatment and care. It is evident that they sometimes feel involved in the decision-making process, have varying degrees of control over treatment and care, and occasionally have sufficient time to address concerns and problems during this process.
- It is seen that they definitely feel abandoned and alone in the waiting area with the highest rate, they always encounter a situation that disturbs them when they visit their patients with the second highest rate, and they never think they have control over the treatment and care of their patients with the third highest rate. To enhance the perception of palliative care centers positively, it is imperative to transform the waiting areas into environments that alleviate feelings of loneliness and abandonment, minimize disturbances

during visits, and empower patients to feel in control of their treatment. Additionally, assisting patients' relatives with tasks outside the palliative care unit, creating a supportive environment for them to discuss their concerns with palliative care doctors, and involving them more in decision-making processes will contribute to a more positive perception of palliative care centers. Allocating more time to address concerns and respond to problems during decision-making processes is also essential. Other suggestions for improving palliative care service delivery in institutions are as follows;

- Awareness should be raised regarding the creation of a palliative care environment.
- The need for changes in existing facilities, policies and procedures to support the goals of palliative care should be acknowledged.
- Be familiar with quality improvement tools that support excellence in palliative care.
- Every individual in need should be able to receive palliative care.
- The facility should be thoroughly evaluated and care and services provided to achieve or maintain the highest possible physical, mental and psychosocial well-being in accordance with the care plan.
- The management of the facility should adopt the philosophy of palliative care, and the purpose of maintenance should be integrated into the daily practices and operational philosophy of the facility.

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