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.35

Quality of Life, Death Acceptance, and Associated Sociodemographic and Illness-Related Factors among Elderly Patients with Chronic Illnesses: A Descriptive-Correlational Study

Eugenio P. Domalanta, Jr, RN[1], Dr. Brando V. Solis, RN[2], Dr. Crecencio C. Quinto[3]
domalantaeugenio@gmail.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 quality of life, death acceptance, and associated sociodemographic and illness-related factors among elderly patients with chronic illnesses in Pangasinan, Philippines. Thirty-eight older adults aged 60 years and above from Orchid Carehome, Inc., and the Dagupan City Office of Senior Citizens Affairs participated through purposive sampling. Data were collected using structured and validated questionnaires that covered demographic characteristics, chronic illness profile, quality-of-life domains, death acceptance, social support, spirituality, and communication experiences. Weighted mean, Pearson correlation, and multiple regression were used for analysis. Results showed that respondents had moderate overall quality of life (M = 3.34), with higher ratings in social relationships and environment than in physical and psychological domains. Death acceptance was generally favorable (M = 3.69). Quality of life was positively and significantly associated with death acceptance (r = 0.46, p = 0.004), indicating that better perceived well-being corresponded with greater readiness to acknowledge mortality. Regression analysis showed that duration of illness (β = 0.30, p = .038) and religious/spiritual involvement (β = 0.48, p = .002) significantly predicted death acceptance, explaining 39% of the variance. Findings underscore the importance of integrated geriatric, spiritual, psychosocial, and palliative care interventions for chronically ill elderly patients within local community settings.

Keywords: *Quality of life, Death acceptance, Chronic illness, Elderly patients; Spirituality, Social support, Gerontology, Palliative care*

Introduction

Population aging and the increasing prevalence of chronic illnesses have intensified scholarly and clinical attention on the lived experiences of older adults. Quality of life is commonly understood as a multidimensional perception of one's position in life in relation to personal goals, expectations, values, health, social relationships, and environment (WHOQOL Group, 1998; Skevington et al., 2004). The WHOQOL-BREF framework is particularly useful in gerontological and nursing research because it examines physical health, psychological well-being, social relationships, and environmental conditions as interconnected domains of well-being.

Among elderly patients, chronic illnesses such as hypertension, diabetes mellitus, cardiovascular disease, respiratory disease, and musculoskeletal disorders affect mobility, independence, treatment adherence, emotional stability, family roles, and access to care.

Previous studies have shown that multimorbidity, frailty, limitations in activities of daily living, loneliness, and high symptom burden are associated with poorer health-related quality of life among older adults (Barnett et al., 2012; Bally et al., 2024; Klompstra et al., 2019). These findings support the need to examine quality of life not merely as a clinical outcome but as a holistic indicator of functional, emotional, social, and environmental well-being.

Death acceptance is another important but often underexamined dimension of elderly care. Death attitudes may include fear of death, death avoidance, neutral acceptance, approach acceptance, and escape acceptance (Wong et al., 2015). In later life, especially among patients with long-term illnesses, death acceptance may be shaped by illness duration, personal meaning, religious belief, previous exposure to death, family communication, and quality of healthcare support. Literature on death attitudes further suggests that religion and spirituality may influence how individuals interpret mortality and cope with end-of-life realities (Dezutter et al., 2009; He & Li, 2022).

In the Philippine context, elderly patients often depend on family-centered caregiving, religious coping, and community-based health services. However, local evidence regarding the relationship between quality of life and acceptance of death remains limited. This study therefore examined the perceived quality of life, level of death acceptance, influencing factors, and the relationship between quality of life and death acceptance among elderly patients with chronic illnesses in Pangasinan.

Methodology

This study employed a descriptive-correlational research design. This design was appropriate because the study described the demographic profile, quality of life, death acceptance, and related factors among elderly patients without manipulating variables, and also examined the statistical relationship between quality of life and death acceptance. Observational studies of this nature are commonly strengthened by clear reporting of participants, variables, measurement tools, and statistical procedures, consistent with the STROBE guidance for observational research (von Elm et al., 2007).

The respondents were thirty-eight elderly patients aged 60 years and above who had been diagnosed with at least one chronic illness. They were drawn from Orchid Carehome, Inc., and the Dagupan City Office of Senior Citizens Affairs. Purposive sampling was used because the study required respondents who were elderly, chronically ill, and able to provide information on quality of life and acceptance of death. The uploaded thesis states that the respondents were selected from institutional and community-based senior-citizen settings and that structured questionnaires were the primary data-gathering tool.

The research instrument consisted of sections on demographic profile, type and duration of chronic illness, living arrangement, perceived quality of life, factors influencing quality of life, level of death acceptance, and factors influencing death acceptance. The quality-of-life component was aligned with the WHOQOL domains, while death-acceptance items reflected peaceful acceptance, neutral acknowledgment, emotional readiness, and spiritual comfort. Data were analyzed using frequencies, percentages, weighted mean, Pearson product-moment correlation, and multiple regression.

Results and Discussion

The demographic profile showed that most respondents were in the 65–74 age range, were female and widowed, had elementary or high school educational attainment, and commonly lived with family members. Hypertension was the most frequent chronic illness, followed by diabetes mellitus. Most respondents had lived with chronic illness for one to five years, although a substantial portion had an illness duration of six years or longer. This profile reflects the typical burden of cardiometabolic disease among older adults and reinforces the need for chronic disease management, health literacy support, and family-assisted care planning.

The overall quality of life of the respondents was moderate (M = 3.34). The social relationships domain was rated high (M = 3.58), and the environmental domain was also rated high (M = 3.40), while the physical health and psychological well-being domains were rated moderate. This suggests that the respondents maintained relatively favorable family, social, and environmental support, but continued to experience limitations related to energy, pain, mobility, emotional strain, and dependence on medication. This pattern is consistent with studies showing that physical limitations, multimorbidity, frailty, and ADL restrictions reduce quality of life among older adults (Bally et al., 2024; Klompstra et al., 2019).

The level of death acceptance was generally favorable, with an overall mean of 3.69, interpreted as "Agree." The highest-rated indicator was finding comfort in faith when thinking about death (M = 4.10), followed by acknowledging death as a natural part of life (M = 3.95) and believing that death brings spiritual peace (M = 3.85). These findings indicate that elderly patients with chronic illnesses tend to frame death through spiritual, existential, and culturally meaningful interpretations. This supports previous findings that religion and spirituality can shape death attitudes and provide meaning-based coping resources in end-of-life contexts (Dezutter et al., 2009; Balboni et al., 2007).

Factors influencing quality of life had an overall mean of 3.43, interpreted as high. Family support and involvement (M = 3.80), social relationships and interaction (M = 3.70), institutional or caregiving support (M = 3.60), and medication adherence and treatment availability (M = 3.55) emerged as major contributors. Regression results further showed that social support significantly predicted better quality of life ($\beta = 0.45$, $p = .003$), while longer illness duration ($\beta = –0.28$, $p = .041$) and number of illnesses ($\beta = –0.32$, $p = .030$) significantly predicted lower quality of life. The model explained 42% of the variance in quality of life.

Factors influencing death acceptance had an overall mean of 3.58, interpreted as high. The strongest factor was spirituality or religious involvement (M = 4.05), followed by social support from family (M = 3.80), quality of communication with healthcare providers (M = 3.70), advance-care planning discussions (M = 3.65), and exposure to previous deaths of loved ones (M = 3.60). Regression analysis showed that duration of illness ($\beta = 0.30$, $p = .038$) and religious/spiritual involvement ($\beta = 0.48$, $p = .002$) significantly predicted death acceptance, while age and social support were not statistically significant predictors. The model explained 39% of the variance in death acceptance.

A significant positive relationship was found between quality of life and acceptance of death ($r = 0.46$, $p = 0.004$). This means that elderly patients who reported better perceived well-being also showed greater readiness to acknowledge and integrate mortality. The finding

suggests that acceptance of death is not separate from daily well-being; rather, it is strengthened by physical comfort, emotional stability, social connectedness, functional capacity, and spiritual meaning.

Conclusion

The study concludes that elderly patients with chronic illnesses had a moderate overall quality of life and a generally favorable level of acceptance of death. Social support, treatment access, caregiving support, and environmental safety contributed to quality of life, while spirituality, family support, healthcare communication, and advance care planning shaped acceptance of death. Regression findings showed that quality of life was negatively affected by longer illness duration and multiple illnesses but positively influenced by social support. Death acceptance was significantly predicted by duration of illness and religious/spiritual involvement. The significant positive correlation between quality of life and acceptance of death suggests that improving the well-being of elderly patients may also foster healthier, more peaceful end-of-life perspectives. Therefore, geriatric and community health programs should integrate chronic disease management, psychosocial counseling, family engagement, spiritual care, and palliative communication to promote dignity, comfort, and meaning among chronically ill older adults.

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

Bally, E. L. S., Korenhof, S. A., Ye, L., van Grieken, A., Tan, S. S., Mattace-Raso, F., Procaccini, E., Alhambra-Borrás, T., & Raat, H. (2024). Factors associated with health-related quality of life among community-dwelling older adults: The APPCARE study. *Scientific Reports, 14*, 14351. https://doi.org/10.1038/s41598-024-64539-x

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

Dezutter, J., Soenens, B., Luyckx, K., Bruyneel, S., Vansteenkiste, M., Duriez, B., & Hutsebaut, D. (2009). The role of religion in death attitudes: Distinguishing between religious belief and style of processing religious contents. *Death Studies, 33*(1), 73–92. https://doi.org/10.1080/07481180802494289

He, Y., & Li, T. (2022). Death attitudes and death anxiety among medical interns after the 2020 outbreak of the novel coronavirus. *Frontiers in Psychology*, *13*, 698546. https://doi.org/10.3389/fpsyg.2022.698546

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*, 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

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