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Evaluation of Palliative Care Awareness Among Hospitalized Patients and Their Relatives in Türkiye

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Abstract

Background: Today, with the advances in medical knowledge and technology, chronic diseases have increased worldwide in parallel with the prolonging life expectancy and the aging of the population. This has increased the need for palliative care in the delivery of medical services. This study aimed to evaluate the palliative care awareness and level of knowledge of inpatients receiving health services in a university hospital and their relatives in Türkiye.

Methods: This cross-sectional study was carried out with 360 patients and their relatives who volunteered to participate in the research. The study data were collected in face-to-face interviews using an individual introduction form and palliative care information and opinion form.

Results: Most individuals (84.4%, N = 304) participating in the study had never heard of palliative care before. In participants who had a relative with a chronic disease now/in the past, the rate of those who knew and could explain palliative care was significantly higher than those who had never heard of palliative care (p = 0.013).

Conclusions: Palliative care awareness care is low among the population, most of which consists of individuals with chronic diseases and their relatives, who are hospitalized to receive health care.

Keywords: awareness, chronic disease, knowledge, nursing, palliative care

INTRODUCTION

Today, advances in medical knowledge and technology have made life easier and have extended life expectancy by providing important developments in the early diagnosis and treatment of diseases. Chronic diseases have increased worldwide alongside this prolonged life expectancy and an aging population, increasing the need for palliative care in the delivery of medical services.[1,2] The World Health Organization (WHO) reported that approximately 56.8 million people, including 25.7 million in the last year of life, need palliative care annually, and most of whom live in low- and middle-income countries; of those, 38.5% have cardiovascular disease, 34% have cancer, 10.3% have chronic lung disease, 5.7% have AIDS, and 4.6% have diabetes.[3] In 2014, the WHO and the Worldwide Palliative Care Alliance prepared the Global Atlas of Palliative Care. The necessity of palliative care was also reported for many diseases, such as renal failure, chronic liver disease, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological diseases such as Alzheimer's and other types of dementia, congenital anomalies, and drug-resistant tuberculosis.[4] Although palliative care service is provided in such a wide range, only 14% of people worldwide have access even though they need it.[3]

Although the need for palliative care services is increasing globally, access to these services varies significantly by region and income level. Countries in Europe, the Asia-Pacific, and North America generally benefit from high levels of government support and integration of palliative care into their health systems. In contrast, many Central and Eastern European countries offer only localized palliative care services. On the other hand, low- and middle-income countries face many challenges in developing and delivering palliative care services. It is known that 80% of palliative care needs are in low-and middle-income countries and that there is a lack of access to palliative care in many areas, including pain management.[5] This global picture is also reflected in our country. From the 2000s onwards, the need for PCs in Türkiye began to be recognized the Ministry of Health adopted Pallia-Turk to establish a nationwide PC program in 2010 as one of the most important building blocks of the 2010-2015 National Cancer Control Program.[6] Türkiye is home to about 85,6 million people and has an annual growth rate of 3,4‰.[7] Life expectancy for both sexes is 77.3 years.[8] Based on the Global Cancer Observatory 2022 data, the estimated

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number of annual cancer cases in Türkiye is 240.013.[9] In addition, 407,300 (218,600 men and 188,700 women) out of 455,000 deaths in Türkiye in 2016 were as a result of noncommunicable diseases (NCDs). It is expected that 86% of total deaths.[10] Considering the burden of cancer and other NCDs and the increase in life expectancy at birth, the real need for palliative care is high and will grow further in the near future.

Despite increasing awareness and progress in developing palliative care services, access to these services remains limited for a large portion of the population.[6] Limited access to palliative care services is associated with several interrelated barriers. These include an underdeveloped health system, low education levels, poor socio-economic conditions, insufficient healthcare workforce, a lack of specialized palliative care training, and restricted access to essential medications such as opioids.[5] These barriers are closely related and mutually reinforcing. Under-resourced health systems present significant barriers to the delivery of palliative care education programs and the retention of qualified health professionals.[11] The lack of trained palliative care teams, particularly in low- and middle-income countries, negatively impacts the continuity and quality of services.[12] Likewise, low socioeconomic status and education levels result in low health literacy and limited knowledge of palliative care in society.[13] Low health literacy makes it difficult for individuals to understand what palliative care services are and to apply for these services.[12] In parallel, stringent regulations and weak supply chains make access to opioids for pain relief even more difficult, especially in under-resourced settings. A lack of infrastructure to safely store, distribute and monitor opioids prevents the drugs from being delivered to patients effectively and safely.[14] Especially in resource-limited settings, these interrelated factors create a vicious cycle that severely limits the expansion of palliative care.[15]

One of the most persistent barriers is the low level of public awareness about palliative care.[16] This may lead to reduced public demand for palliative care and inadequate advocacy efforts to expand services. The development of palliative care activities directly influences awareness, the scope of services offered, and the extent to which they are integrated into the health system.[3] In addition, cultural, religious, and sociodemographic factors shape how individuals perceive and engage with palliative care.[17] In the 2014 Global Atlas of Palliative Care, it was stated that public palliative care awareness is at an acceptable level only in those countries where hospice and/or palliative care activities are widely integrated into the general health system, such as the USA, UK, Italy, Sweden, Japan, Germany, and Australia.[4] The public is aware of palliative care in countries with well-established national guidelines and programs (New Zealand and Australia) and countries that have started palliative care activities earlier.[18,19]

However, the public's palliative care awareness is more limited in countries where the concept of palliative care is relatively new (India, Saudi Arabia).[20,21] In our country, populations in studies conducted on palliative care awareness are limited to cancer patients,[22] individuals receiving palliative care,[23]and health professional groups.[24,25] In light of the global and national challenges surrounding access to palliative care, this study aims to explore the level of palliative care awareness among patients receiving inpatient healthcare services for various reasons, as well as their relatives. This study seeks to understand knowledge, perceptions and attitudes towards palliative care and to identify factors that influence this awareness.

METHODS

Ethics committee approval for this study was obtained from the Eskişehir Osmangazi University Non-interventional Clinical Research Ethics Committee on September 21, 2021 with the approval number 08. Written permission was also obtained from the relevant university hospital before data collection. Participants' verbal and written informed consent was obtained in accordance with the Declaration of Helsinki, and they were assured that the collected data would be used for scientific purposes and published. Participants were informed that participation in the study was voluntary. The benefits to society of the results obtained from their participation in the study were explained. Information was provided as to whether non-participation in the study would negatively affect the treatment and care processes.

This cross-sectional study aimed to evaluate the palliative care awareness and level of knowledge of inpatients receiving health services in Eskişehir Osmangazi University Health Practice and Research Hospital and their relatives in Türkiye. A total of 360 participants were included in the study, consisting of inpatients receiving health services and their relatives who accompanied them during hospitalization. Both patients and their accompanying relatives were required to be 18 years of age or older and voluntarily agree to participate in the study. Illiterate individuals were excluded from the study. In the study, no calculation was made when determining the sample number, and the complete count method was used to include all patients and their relatives who satisfied the inclusion criteria in the sample between January and December 2022.

The study data were collected in face-to-face interviews using an Individual Introduction Form and a Palliative Care Information and Opinion Form in patients' room. In the pilot application of the study, completed to evaluate the clarity of the forms and ease of filling, 5 patients who received health services in the same hospital and their relatives who were asked to fill out the questionnaires were excluded from the study.

Individual Introduction Form was developed by the researchers and consists of 17 questions regarding socio-demographic characteristics (age, gender, marital status, education level, job, income status), disease status (presence and type of chronic disease, the state of being in the end stage of the disease, care status and duration, persons receiving support in care), and the caregiving process (status of caregiving for relatives and duration, Status of receiving support during the caregiving process).[26,27]

Palliative Care Knowledge and Opinion Form was developed by the researchers in line with the relevant literature[22,26,28–30] to determine the palliative care awareness of individuals in this study. It consists of 24 questions in total. The appropriateness of each statement in the form was evaluated by eight experts (4 academics and 4 nurses who work in the field of palliative care). The opinions of eight experts were obtained to evaluate the questions, and the content validity index was calculated. The experts' answers to the Palliative Care Knowledge and Opinion Form were evaluated using the content validity formula. The Content Validity Index (CVI) of this form was calculated as 0,88. As the CVI value was greater than 0.80, this indicated that the questionnaire was statistically valid.[31]

Data were analyzed in the IBM SPSS 25 package program. Summary values of quantitative variables were given as mean ± standard deviation or median and quartiles (Q1–Q3). Qualitative variables were presented as frequency and percentage. The fitness of quantitative variables to the normal distribution was evaluated with the Shapiro-Wilk test. Age values of independent groups were compared with the Kruskal-Wallis test. The pairwise group comparisons were performed with Dunn's test. The relationship between qualitative variables was examined with the Pearson chi-square and the Pearson Exact chi-square tests. A $p < 0.05$ was considered significant.

RESULTS

The mean age of the participants was 52.82 ± 16.66. Of the participants, 64.7% were female; 72.5% were married; 39.7% were primary school graduates; 38.9% were housewives; 68.3% had an income equal to expenses. More than half of the participants (53.3%) had a chronic disease, whereas 64.7% had a relative who had a chronic disease (Table 1).

Most individuals (84.4%, N = 304) participating in the study had never heard of palliative care before. For the participants who had knowledge of palliative care, the source of information about palliative care was health professionals (44.6%). Half of the participants knew the institution/institutions providing palliative care in the city they lived in, and the majority wanted to receive care in the home environment from family members or professional caregivers in the last period of their lives (66.1%) (Table 2).

According to the distribution of palliative care awareness by study groups and demographic characteristics, individuals who knew and explained palliative care were younger than those who had never heard of it ($p = 0.008$). There was a difference between palliative care awareness and the study groups. This difference was evident in participants who had a relative with a chronic disease now/in the past. In this group, the rate of those who knew and could explain palliative care was significantly higher than those who had never heard of palliative care ($p = 0.013$). Women ($p = 0.019$) and undergraduates ($p < 0.001$) had a higher level of knowledge of palliative care. Regarding income status, the rate of those whose income was more than their expenses had a higher level of knowledge of palliative care ($p = 0.005$) (Table 3).

TABLE 1. Demographic and chronic disease characteristics of the participants (N = 360)

Variables	N	%
Subjects		
Having a chronic disease	92	25.6
Having a relative with a chronic disease now/in the past	97	26.9
Having a chronic disease and a relative with a current/past chronic disease	112	31.1
No chronic disease	59	16.4
Gender		
Female	233	64.7
Male	127	35.3
Marital status		
Single	99	27.5
Married	261	72.5
Education status		
Literate	19	5.3
Primary school	143	39.7
Secondary school	38	10.6
High school	74	20.6
Graduate	86	23.9
Employment		
Housewife	140	38.9
Worker	32	8.9
Retired	67	18.6
Officer	47	13.1
Self-employment	74	20.6
Income status		
Less than expenses	83	23.1
Equal to expenses	246	68.3
More than expenses	31	8.6

TABLE 2. Distribution of the participants' knowledge and opinions about palliative care

Variables	N	%
Palliative care awareness (N = 360)		
I've never heard of palliative care before	304	84.4
I know a little about palliative care	37	10.3
I know what palliative care is, and I can explain it to someone	19	5.3
Information resource on Palliative Care (N = 56)		
TV/Radio	6	10.7
Book, Magazine, Newspaper	2	3.6
Social Media and/or Internet	6	10.7
Spouse/Friends/Family/Relatives	17	30.4
Health Professionals	25	44.6
The state of knowing the institution of providing palliative care service in the region of residence (N = 56)		
Yes	28	50.0
No	28	50.0
The most suitable care environment in the last period of life (N = 56)		
By family members at home	16	28.6
By professional caregivers at home	21	37.5
Nursing home	4	7.1
Hospital	15	26.8

TABLE 3. Distribution of palliative care awareness by study groups and demographic characteristics (N = 360)

Variables	I've never heard of palliative care before N (%)	I know a little about palliative care N (%)	I know what palliative care is, and I can explain it to someone N (%)	*p*
Sample groups				
Having a chronic disease	75 (24.7)	15 (40.5)	2 (10.5)	0.013*
Having a relative with a chronic disease now/in the past	75 (24.7)	12 (32.4)	10 (52.6)	
Having a chronic disease and a relative with a current/past chronic disease	99 (32.6)	7 (18.9)	6 (31.6)	
No chronic disease	55 (18.1)	3 (8.1)	1 (5.3)	
Gender				
Female	192 (63.2)	23 (62.2)	18 (94.7)	0.019*
Male	112 (36.8)	14 (37.8)	1 (5.3)	
Marital status				
Single	89 (29.3)	5 (13.5)	5 (26.3)	0.127
Married	215 (70.7)	32 (86.5)	14 (73.7)	
Education status				
Literate	18 (5.9)	1 (2.7)	0 (0)	<0.001*
Primary school	131 (43.1)	12 (32.4)	0 (0)	
Secondary school	35 (11.5)	2 (5.4)	1 (5.3)	
High school	64 (21.1)	5 (13.5)	5 (26.3)	
Graduate	56 (18.4)	17 (45.9)	13 (68.4)	
Job				
Housewife	125 (41.1)	11 (29.7)	4 (21.1)	<0.001*
Worker	29 (9.5)	3 (8.1)	0 (0)	
Retired	52 (17.1)	12 (32.4)	3 (15.8)	
Officer	29 (9.5)	7 (18.9)	11 (57.9)	
Self-employment	69 (22.7)	4 (10.8)	1 (5.3)	
Income status				
Less than expense	69 (22.7)	12 (32.4)	2 (10.5)	0.005*
Equal to expense	215 (70.7)	19 (51.4)	12 (63.2)	
More than expenses	20 (6.6)	6 (16.2)	5 (26.3)	

*$p < 0.05$

TABLE 4. The relationship between palliative care awareness and chronic disease characteristics (N = 360)

Variables	I've never heard of palliative care before	I know a little about palliative care	I know what palliative care is and I can explain it to someone	*p*
Having a chronic disease				
No	143 (47.0)	15 (40.5)	10 (52.6)	0.655
Yes	161 (53.0)	22 (59.5)	9 (47.4)	
Types of chronic diseases (N = 192)				
Diabetes	25 (34.7)	4 (50.0)	1 (14.3)	0.489
Heart disease	7 (9.7)	0 (0)	0 (0)	
Chronic renal failure	4 (5.6)	1 (12.5)	0 (0)	
Cancer	5 (6.9)	0 (0)	2 (28.6)	
COPD	2 (2.8)	0 (0)	0 (0)	
Hypertension	29 (40.3)	3 (37.5)	4 (57.1)	
Having a relative with a chronic disease				
No	112 (36.8)	12 (32.4)	3 (15.8)	0.164
Yes	192 (63.2)	25 (67.6)	16 (84.2)	
Types of chronic diseases in relatives currently or in the past (N = 233)**				
Diabetes	44 (47.3)a	0 (0)b	3 (30.0)a,b	0.032*
Heart disease	10 (10.8)	2 (18.2)	0 (0)	
Chronic renal failure	3 (3.2)	0 (0)	0 (0)	
Cancer	9 (9.7)	2 (18.2)	3 (30.0)	
COPD	3 (3.2)	1 (9.1)	2 (20.0)	
Hypertension	24 (72.9)	6 (54.5)	2 (20.0)	

*$p < 0.05$

TABLE 5. Distribution of Knowledge and Opinions on Palliative Care among participants who had some level of knowledge (N = 56)

Items	Agree N (%)	Disagree N (%)	No idea N (%)
Palliative care is the care provided to the patient in any part of the hospital.	21 (37.5)	26 (46.4)	9 (16.1)
Palliative care is the care provided to increase the comfort of people with terminal illness.	43 (76.8)	5 (8.9)	8 (14.3)
Palliative care is the care provided to increase the comfort of the relatives of patients with terminal illness.	29 (51.8)	20 (35.7)	7 (12.5)
Palliative care starts with the diagnosis of terminally ill patients and their relatives and ends in the mourning period.	25 (44.6)	19 (33.9)	12 (21.4)
Palliative care is the care provided to a terminally ill patient to prevent pain and suffering at the end of his/her life.	41 (73.2)	6 (10.7)	9 (16.1)
The aim of palliative care is to provide social and emotional support.	41 (73.2)	6 (10.7)	9 (16.1)
Palliative care improves the quality of life for the patient.	45 (80.4)	5 (8.9)	6 (10.7)
Palliative care is the medical service provided to every patient regardless of the type or disease course.	14 (25.0)	28 (50.0)	14 (25.0)
Accepting palliative care means foregoing life.	4 (7.1)	42 (75.0)	10 (17.9)
You forego other treatments when you choose palliative care.	5 (8.9)	40 (71.4)	11 (19.6)
The aim of palliative care is to prolong life.	25 (44.6)	18 (32.1)	13 (23.2)
The concept of palliative care recalls death to mind.	12 (21.4)	32 (57.1)	12 (21.4)
It is incorrect to carry out medical interventions that cause pain and ache to my patient/relative with a terminal illness.	18 (32.1)	23 (41.1)	15 (26.8)
Palliative care can be given at home when necessary, conditions are established.	33 (58.9)	12 (21.4)	11 (19.6)
Moral support is given to patients with a terminal illness and their relatives during diagnosis, treatment, and care.	38 (67.9)	9 (16.1)	9 (16.1)
All patients approaching death and their relatives should be informed about the palliative care alternative.	39 (69.6)	7 (12.5)	10 (17.9)

TABLE 6. Distribution of the three most important items of basic needs and concerns of patients and their relatives in study groups

Items	Having a chronic disease	Having a relative with a chronic disease now/in the past	Having a chronic disease and a relative with a current/past chronic disease	No chronic disease	*p*
Main concerns of patients					
Fear of death	7 (46.7)	12 (54.5)	5 (45.5)	3 (75.0)	
Fear of pain	5 (33.3)	6 (27.3)	5 (45.5)	0 (0)	0.787
Fear of not being self-sufficient	3 (20)	4 (18.2)	1 (9.1)	1 (25.0)	
Basic needs of patients					
Relief from pain and suffering	10 (66.7)	13 (61.9)	7 (63.6)	3 (75.0)	
Professional medical care	3 (20)	5 (23.8)	3 (27.3)	1 (25.0)	1.000
Moral support	2 (13.3)	3 (14.3)	1 (9.1)	0 (0)	
Main concerns of patients' relatives					
Fear that someone close will die	6 (50)	13 (81.3)	6 (66.7)	3 (75.0)	
Fear of not being self-sufficient in the care of a relative	5 (41.7)	3 (18.8)	2 (22.2)	1 (25.0)	0.656
Lack of access to health care and health professionals	1 (8.3)	0 (0)	1 (11.1)	0 (0)	
Basic needs of patient relatives					
Medical care support	7 (77.8)	14 (63.6)	7 (77.8)	2 (66.7)	
Medical information support	1 (11.1)	5 (22.7)	1 (11.1)	1 (33.3)	0.972
Prescribing and supplying drugs	1 (11.1)	3 (13.6)	1 (11.1)	0 (0)	

There was no relationship between the palliative care awareness of the participants in our study and the presence of chronic disease, the status of being in the last phase of the disease, the presence of having a relative with a chronic disease, and the type of chronic disease of the relative ($p > 0.05$). Among participants who had relatives with diabetes, the rate of having never heard of palliative care was significantly higher compared to those with relatives with other chronic diseases ($p = 0.032$) (Table 4).

Table 5 shows the distribution of knowledge and opinions of the participants who had knowledge of palliative care. Of the participants, 80.4% stated that palliative care improves the patient's quality of life; 76.8% stated that palliative care is the care provided to increase the comfort of people with a terminal illness; 73.2% stated that palliative care is the care provided to a terminally ill patient to prevent pain and ache at the end of his/her life and that the aim of palliative care is to provide social and emotional support; 71.4% stated that preferring palliative care is not forgoing other treatments; 44.6% thought that palliative care starts with the diagnosis of terminally ill patients and their relatives and ends in the bereavement period.

When the distribution of the three most important basic needs and concerns of patients and their relatives according to their knowledge of palliative care was examined, it was found that there was no significant difference between the groups ($p > 0.05$). However, participants tended to have similar concerns and needs regardless of their group (Table 6).

DISCUSSION

The study evaluated the palliative care awareness and knowledge among individuals receiving inpatient health services for any reason. Although the majority of the individuals (83.6%) who participated in the research and/or their relatives were inpatients who had received health services previously and/or currently due to any chronic disease, 84.4% had never heard of or knew about palliative care and only 5.3% stated that they knew and could explain palliative care. Previous studies have revealed similarly low levels of palliative care awareness among most adults living in nursing homes,[32] elderly people,[33] hematology and oncology patients,[34,35] relatives of patients receiving palliative care,[23] and society,[36–38] had a low level of palliative care awareness. This lack of awareness of palliative care services is considered among the reasons for not being able to benefit from these services,[32–34,39] and this issue is expressed as worrying.[38] Considering the low rates of palliative care awareness in the studies, it can be predicted that people will not directly apply to health institutions to benefit from palliative care services for themselves or their relatives. However, they may benefit from palliative care through expert recommendations and guidance. In the Turkish context, the low awareness observed in our study can be partly explained by the limited impact of national palliative care initiatives. Since 2010, the Ministry of Health has launched the Pallia-Türk project to establish palliative care units nationwide and integrate these services into the family medicine system.[6] However, despite these efforts, public knowledge and understanding remain limited, which aligns with reports showing that both

patients and their families have inadequate information about palliative care.[22,40] A major reason for this gap is the insufficient training of family physicians, the lack of standardized referral mechanisms, and the inconsistent implementation of guidelines.[6,40] Moreover, cultural perceptions in Türkiye frequently associate palliative care with end-of-life care, leading individuals to seek these services only when symptoms become severe or upon the recommendation of a physician.[41] These findings suggest that, although national initiatives such as Palliaturk have improved infrastructure, additional strategies are needed to increase awareness through community-focused education campaigns, healthcare provider training, and culturally sensitive approaches.

Some studies have indicated that only a small proportion of society benefits from palliative care services due to cancer-related and non-cancer-related reasons.[35,39] While health professionals' efforts in planning and delivering palliative care services cannot be denied, evidence shows that their palliative care knowledge is often insufficient.[24,42–44] Therefore, questioning individuals who benefit from and proactively participate in health services will increase the use of services and contribute to developing these services. In this context, awareness can be raised through mass media such as social media, radio, and television,[33,36] as well as brief information on issues such as the scope of palliative care, instruction on who can apply and how to apply, and pricing is given in public education sessions such as workshops with peer groups, awareness weeks, and campaigns to increase the palliative care awareness of the society.[35,36] In addition, it is recommended that instruction on palliative care should begin earlier at a school age.[17]

Currently, many social media channels, such as YouTube, TikTok, Spotify, Instagram, and Facebook, include videos that provide information on palliative care in different languages by health professionals and individuals benefiting from these services. Besides these videos, websites of national and international public and private health institutions and associations have informative texts and videos about the scope of palliative care.[45] In our country, a palliative care awareness week is annually held between 29 April and 3 May. So, despite such efforts to increase the knowledge and awareness of palliative care, why is the level still low? This may be partly because individuals seek palliative care only when symptoms escalate, often guided by health professionals' recommendations, and not proactively.[46] Additionally, misconceptions equating palliative care with end-of-life care or "giving up" deter engagement.[47] Inconsistent campaign messaging and limited training among healthcare professionals further hinder awareness and referrals.[47,48] Systemic barriers, such as specialist shortages, difficulties in identifying patients nearing end of life, and cultural stigmas around death, also restrict access and visibility.[47] Moreover, older adults, a key target group, prefer traditional media over digital platforms,[49] limiting the reach of social media campaigns. More evidence is needed, and qualitative and quantitative studies should be conducted to investigate the reasons for low awareness of palliative care in society and strategies to increase awareness. In the literature, it has been stated that individuals' healthcare-seeking behaviors[50] and palliative care awareness increase when symptoms affect their daily life.[51] In line with the literature, our study also revealed that most individuals hospitalized in clinics outside of the palliative care and intensive care units had never heard of the term "palliative care." Conversely, younger participants demonstrated higher levels of awareness compared to older adults, reinforcing the need for targeted, age-specific communication strategies.

The low level of palliative care awareness has substantial implications for both access to and utilization of services. Ozdemir *et al*. reported that even when patients were eligible for palliative care, only 35% of those aware of the services actually used them, with lack of information identified as a major barrier.[52] Moreover, even when healthcare professionals recommended palliative care, less than half of the patients proceeded to utilize it, suggesting that limited knowledge contributes to delayed referrals and hinders the early integration of supportive care into chronic disease management.[52] Similarly, Javanparast *et al*. emphasize that low levels of awareness remain a key obstacle to accessing palliative care and highlight that increasing awareness is a critical strategy for improving both utilization and equity of access.[53] Taken together, these findings underscore the urgent need for targeted, evidence-based strategies to improve public and patient awareness, facilitate earlier referrals, and ensure the timely integration of palliative care into chronic disease management.

In our study, there was no statistically significant difference in the knowledge of palliative care according to the status of having a chronic disease or having a relative with a chronic disease. Furthermore, no meaningful difference was determined in the palliative care knowledge among individuals with chronic renal failure, cardiovascular disease, cancer, or chronic obstructive disease (COPD). It was also observed that most of the relatives with diabetes did not know about palliative care at a statistically significant level. In chronic diseases such as COPD, the unpredictability of the disease progression and the misconception that palliative care is solely for end-of-life care prevented them from benefiting from palliative care.[54] However, cancer diagnosis and receiving quality care in the last year of life increase palliative care awareness.[33] In our study, no individuals were approaching death in the last phase of their illness, and the number of individuals per chronic disease was low. These factors prevented us from making definite judgments on the subject. Therefore, we recommend large-scale studies.

Sociodemographic[32,33,37] and health-related characteristics[50,51,55] that affect palliative care awareness and the level of knowledge. Previous studies have consistently reported that men have lower awareness compared to women, individuals with low income demonstrate less knowledge compared to those with higher income[32,37] and people with lower educational attainment show reduced awareness when compared to those with higher levels of education[33,37] In line with these findings, our study revealed that palliative care awareness was higher among younger individuals, women, undergraduates, and government employees. This consistency with previous research suggests that sociodemographic factors strongly shape knowledge levels. One possible explanation is that women, individuals with higher education, and those with higher income tend to demonstrate better health-seeking behaviors, which positively affect their level of awareness. Kıraç and McIlfatrick *et al*. also emphasized in their studies that these groups are generally more proactive in accessing healthcare services and information.[56,57] Based on these results, we can suggest that it is necessary to focus more on men, those with low income, low education levels, and elderly individuals in educational activities organized in society to increase palliative care awareness.

In our study, the majority of the participants who stated that they had heard about palliative care and could explain it stated that palliative care is provided to people with a terminal illness, to increase the quality of life, to reduce the pain of patients at the end of their lives, and to provide social and emotional support. However, 44% stated that palliative care starts with the diagnosis and ends with the bereavement period. In another study conducted in our country, 25% of the families who had heard the concept of palliative care before defined palliative care as "end-of-life care," and 25.5% defined it as "the care given to prevent the patient from feeling pain and ache in the last days".[22] Similar to our study result in studies on this, it has been stated that palliative care is mostly related to "caring for people who were dying", "end-of-life care" and "maintaining comfort in the last days of life".[26,32] These findings underscore a persistent misconception that palliative care is restricted to terminal care rather than being an approach that can be integrated earlier in the disease trajectory. Sítima *et al*. highlighted that misconceptions, lack of awareness, and the strong association of palliative care with the dying phase remain significant barriers to timely access, particularly during the early stages of chronic illnesses.[47] In our study, the belief of a significant portion of those who answered questions about knowledge about palliative care that palliative care either begins at the time of diagnosis and ends with grief or is valid for all patients regardless of the disease reflects a notable gap in knowledge and awareness. Such misconceptions may delay referrals to palliative care services, resulting in missed opportunities for early symptom management, psychosocial support, and quality-of-life improvements.[58] Addressing these barriers through community-focused education initiatives and targeted training for healthcare professionals is therefore essential to promote earlier integration of palliative care and ensure more equitable access to services.

The findings of this study suggest that there is a gap in palliative care awareness and knowledge among patients receiving care for chronic illness and their relatives. It is essential that healthcare professionals receive regular training to improve their understanding of palliative care and effectively communicate its benefits to patients and families. The finding in our study that women, younger individuals, and those with higher levels of education and income showed greater awareness suggests the need for targeted interventions, particularly to reach older adults, men, and those with lower socioeconomic status. Culturally sensitive, age-appropriate educational materials should be developed and disseminated through both traditional media (e.g., television, radio) and community-based programs. To improve timely access to supportive services, efforts should be made to disseminate information on palliative care, not only at the end of life but also in the early stages of chronic disease management. At this point, public health campaigns, awareness weeks, and collaborations with local organizations can further increase community engagement and understanding.

This study has several limitations. First, since the research was conducted in a single center, the results may not reflect the opinions and knowledge levels of individuals from different geographic areas or healthcare institutions. The generalizability of the findings is limited. Additionally, the data were based on participants' self-reports, which increases the risk of social desirability and recall bias. Moreover, although the total number of participants was 360, some questions were answered by fewer people. This resulted in some questions requiring more detailed knowledge of palliative care, and therefore, participants who had never heard of palliative care were unable to answer these questions. Therefore, this variation in response rates should be taken into account when interpreting the findings. The study also included a limited number of participants from specific disease groups, making it difficult to draw disease-specific conclusions. Considering these limitations, future studies with larger, more diverse samples and the inclusion of qualitative components are recommended to explore the deeper reasons behind the low level of palliative care awareness and to develop strategies to improve it.

CONCLUSIONS

Palliative care awareness is low among the population, most of which consists of individuals with chronic diseases and their relatives, who are hospitalized to receive health care. Considering that patients in the last phase of chronic disease and their relatives benefit more

from palliative care, this result is not desired. It is thought to have negative reflections on the use and development of palliative care services. For this reason, starting from the diagnosis of chronic diseases, individuals should be informed about palliative care services and ensure that palliative care is adopted in the early stages.

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CONFLICT INTEREST

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