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# Turkish Health Professional's Attitudes Towards Euthanasia

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## 1. Introduction

Death, the end of life, is one of the most real things in life. Therefore it has always been the major concern of people to meet with it. It is not the death but the process of dying worries people. Although the moment of death may be at any time, for some reason, it has been perceived as identical with the old age. Much research has indicated that almost in every country, particularly in the developed countries, aged population increases, which brings extra burden to the health care systems and social services. The diseases encountered in old age are mostly chronic and long lasting, which necessitate the provision of health care services in long and costly manner. This, inevitably, brings the problem of the distribution of limited sources into discussion (Aksoy, 1998). Every country has its own priorities in health services. Although most attention in the West has focused on the elderly as terminal patients, in some countries the major focus might be on younger adult AIDS patients or on children dying from malnutrition or infectious diseases. Another important category, although much smaller in number, are critically ill or extremely low birth weight babies. In each of these categories, the issues might be similar but the solutions differ significantly from country to country.

Before getting into detail on end of life decision-making, it is of benefit to give some basic information about the country. Turkey is a nation state with almost 68 million population comprising people from different ethnic backgrounds. The male and female populations are almost equal to each other. It has a young population with 55% under the age of 20 (Republic of Turkey, Prime Ministry State Institute of Statistics, 2002). The major faith tradition in Turkey is Islam (95%). There are some Jews, Christians and others. Although Turkey is a secular state by its governmental system, since there is such a great majority of Muslims with a long tradition, religion plays a significant role in ethical reasoning in public mind, though not in official level. The rate of population over 65 is 8%, and the life expectancy at birth is 70.2. (Republic of Turkey, Prime Ministry State Institute of Statistics, 2002) Turkey is a unique country in its region as a Muslim State officially committed to adapt western life style and tradition.

Decision-making is an important process, especially in terminal stages of the illnesses. The moral quality of a clinical decision is dependent on the process of that decision and not only on the outcome. We are accountable and responsible for the way in which our decisions are

reached. Since our understanding of the patient's perspective will always be limited, good communication and acceptance of the patient's view is essential in reaching the desired goal of a consensus decision. (Randall and Downie, 1996) It is pretty easy to make the 'right decision' if the patient can involve to the decision making process. Autonomous patients can choose the extent to which they wish to participate in decisions about these treatments; if they wish to be fully involved they are adequately informed. However, non-autonomous patients are unable to participate in deriving the balance of benefits to burdens and risk in the particular situation. Advance statements are offered as a solution in case of non-autonomous patients.

There is not a proper advance statement in Turkey. Even it is not legal to put Do-Not-Resuscitate (DNR) orders. However this does not mean that it is not practiced in clinics. Many doctors and nurses in anaesthesiology and reanimation departments reported to us that there are many voluntary and involuntary DNR orders are practiced in ICUs and the wards. Therefore there is no point to talk about the legal binding of advance statements and DNR orders. In recent years some Turkish bioethicists strongly suggested the necessity of advance statements and DNR orders. (Oguz, 2001) Oguz argues that a good application of DNR order, under the light of the concept of 'futility of treatment', the number of euthanasia requests will decrease.

## 2. Information

Euthanasia is a terribly troubling word, meaning literally, according to some, “a good death,” but according to others a morally outrageous death. According to some researchers euthanasia is the act of taking the life, for reasons of mercy, of a person who is hopelessly ill. A basic distinction is made between two kinds of euthanasia, namely passive and active.

Active euthanasia is identical with mercy killing and involves taking direct action to end a life, for example, intentionally giving a person a lethal dose of a drug to end a painful and prolonged period of dying. Passive euthanasia is allowing a patient to die when he or she could have been kept alive by the appropriate medical procedures. Active euthanasia can be defined as any treatment initiated by a physician with the intent of hastening the death of another human being who is terminally ill and in severe pain or distress with the motive of relieving that person from great suffering.

Passive euthanasia can be defined or considered as discontinuing or not starting a treatment at the request of the patient. Further distinction is made between voluntary, involuntary, and non-voluntary euthanasia. According to this distinction, voluntary euthanasia occurs when the decision to terminate life by the physicians corresponds with the patient's desire to do so and the patient willfully gives consent of its implementation. Involuntary euthanasia occurs when the decision to end life is implemented against the patient's wishes. Non-voluntary euthanasia refers to cases where patients are unable to make their wishes known, for example a person who is brain dead and in a permanent or irreversible coma. According to another researchers active voluntary euthanasia and physician-assisted suicide are often combined and mentioned in one breath. They defined active voluntary euthanasia as the deliberate termination of life, by someone other than the patient, at the patient's request and physician-assisted suicide as intentionally helping a patient to end his or her life at his or her request. Euthanasia means ending a patient's

life according to certain principles and under certain circumstances, where medicine can not cure or provide a life of acceptable quality. In two different ways based on physicians' action and patients' consent. It can be active or passive according to physicians' actions, and it is important to separate DNR orders and physician-assisted suicide from them; especially in countries like Turkey that are debating the level of technological development and their values. According to patients' consent, it is necessary to emphasize voluntary, non-voluntary and involuntary types of euthanasia (Aksoy 2000, Aksoy 1998, Ozkara et al 2001).

### **3. Attitudes towards euthanasia in Turkey**

Euthanasia has deep historical roots. Before Hippocrates, euthanasia was a routine procedure and physicians assumed that they had the authority to kill patients for whom they gave up the hope of recovery, without asking for their permission (Ney 1997). They accepted this as a part of their medical practice. Hippocrates regarded this procedure as a hindrance to the establishment of confidentiality between physicians and patients. Probably this is the reason for the words in The Hippocratic Oath, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel." This guarantee which Hippocrates provided by his oath, established the basis of the confidence between physicians and patients for 2500 years.

The effects of the Hippocratic Oath were noticed in Anatolia in the 19th century after modern medical schools had been established. Written sources (Lequenne 1991) show that euthanasia continued to be widely used after Hippocrates and was a socially exalted procedure among Galatians who settled in Anatolia in 287 BC and some other civilizations followed them. During this period suicide was also exalted by the society, and had some similarities with the harakiri tradition in Japan. Islamic domination put an end to both the euthanasia practice and its high regard in society in Anatolia. Euthanasia was wiped out of the society's living conscience during the period when Anatolia used to be a part of Islamic civilization. But it has continued to be a part of the social subconsciousness. The contemporary situation of the concepts of death and euthanasia in Anatolia, which entered a new period after the establishment of modern Turkey, was determined by its culture which was considerably affected by this social subconsciousness and Islamic belief.

Euthanasia is another ethical issue related to end of life decision making. The concept of euthanasia entered the agenda in Turkey in 1975. At the beginning, it was thought to be the problem of the countries where medicine was highly developed. The medical technology in Turkey was not very well-developed to make the euthanasia debate necessary at that time. Life sustaining systems rarely existed, intensive care and health care facilities were in poor conditions and hardly accessible. It has become an important problem in Turkey in the last decade, as the result of technological and medical developments. There are still some problems about the attainment and purchasing of health care facilities, and also about the level of medical care. But especially the developments in life sustaining systems and their efficient usage in daily practice made euthanasia an important subject for society. As physicians, patients, patients' relatives, insurance companies and jurists met the dilemma routinely, and as the mass media began to put it on the agenda more, a lot of discussions

have taken place. This is an important pressure which forces the State to form some attitude about euthanasia.

The first euthanasia discussions had started in 1990s in Turkey. Official religious authorities and medical associations declared euthanasia as unacceptable. In those days there were very few people who have supported euthanasia in Turkey (Oguz, 1996). However, during the course of the time the research conducted in different centers have indicated that health care professionals, especially nurses support the assisted suicide and euthanasia (Bahcecik et al, 1998; Akcil et al, 1998; Ersoy and Altun, 2001). Despite these findings both passive and active euthanasia remain unlawful in Turkish Criminal Law. While passive euthanasia is considered as unintentional killing by law (Turkish Criminal Law. Article: 455), active euthanasia is punishable as intentional killing (Turkish Criminal Law. Article: 448) (Artuk, 2001) Like in all divinely revealed religions euthanasia is absolutely forbidden in Islamic understanding. (Rispler-Chaim, 1993)

In Turkey there is a great difference between the level of medical technology and the physician-patient relationship regarding the contemporary norms. Paternalistic attitudes are common and this also suits the expectations of society. Physicians rarely inform their patients about their diagnosis and treatment, even when it is not a fatal or hopeless situation. The primary reasons which physicians put forward about this fact are that they had to attend to too many patients and patients' educational level was not adequate (Hayran, 1994). Undoubtedly these are important factors, but there are evidences which indicate that they can not be the main ones. Even in private clinics where the number of patients per physician is very low, physicians' preferences regarding the relationship are quite similar to those of their colleagues in general hospitals. I think the main reason is the physicians' identity which is determined by medical education and social status. The physician-patient relationship in Turkey totally leans on the belief that a physician always does the best for their patient and always protects life. This belief established the myth of the "little god" physician. This view began to change and be corrupted dramatically in the last few years. The most appropriate word which describes the contemporary situation is chaos.

Today, many social institutions especially the mass media severely criticize physicians' attitudes in Turkey. Sometimes these criticisms turn out to be unfair attacks on medicine. This is the result of corruption in the myth of "little god" physician, and social disappointment about that. The associations of medical professionals try very hard to avoid any harm to medicine as a social institution while passing through this chaotic period. They try to re-establish confidentiality in physician-patient relationships on a stronger basis like the "informed consent doctrine". The foundation of the associations for specialized doctors of medicine is one of the main positive steps in realizing this purpose.

One of the most important factors which determines society's attitude towards euthanasia is religion. 90% of the Turkish population are Muslims. As there are various sects and tariqas that cause significant differences, it is important to begin with an overall review of Islamic approach to euthanasia. There are important differences between Islamic countries. The first group contains the countries which are governed by Islamic rules. These countries accept sheria as their legal and administrative code, like Iran and Saudi Arabia. In Iran Shia Muslims and in Saudi Arabia Sunni Muslims as sects of Islam, rule the State. The second group consists of countries which have secularly governed states, but their laws are based on sheria, like Egypt and Algeria. Actually this is the largest



group. Turkey differs from these countries. Although the majority of the population is Muslim, the State is totally secular. Secularism in Turkey includes both the administrative, legislative and all other social systems. Despite a radical Islamic movement, which takes Turkey as its main target, cultural characteristics and historical background in 20th century led to a strong resistance in the society. Islam's approach to death is quite clear. Allah is the master of life and death. A Muslim is expected to know and accept that there are divine purposes in life's turning to be a painful one and in the delay of desired death. Ending life personally or asking somebody to do it instead, is regarded as an attempt to share Allah's power, so this is assumed to be an unforgivable sin. According to the Koran the wish for death is forbidden (Sahih-i Buhari, 1982; Nisâ sura of Koran). Suicide is the biggest sin (Sahih-i Buhari, 1982). No funeral prayer is made for such people, this means they can never be recipients of Allah's forgiveness. This situation affects the family as well, and causes isolation in society. Murder is a lighter sin. Even if there is no adequate reason found for tolerance, there is a chance for Allah's final forgiveness, because there is no rule which hinders his last prayer. When Islam's approach to death is examined with regards to the results of euthanasia, it is clear that in countries where sharia is in operation either totally or only legally, practicing euthanasia is impossible. Since Imam-i Gazali, an Islamic commentator (Karaman, 1971), Islamic rules have been assumed to have reached perfection, so there could be no additional rules except the interpretation of the existing ones. In Islam, rules about death are very clear that there is no place for interpretation. Islamic rules put every aspect of life in an order and health care issues are one of these aspects. Because of this, medicine in Islamic countries has developed according to these rules. This development has not reached the level of modern medicine yet, so euthanasia is not considered a real problem yet.

#### **4. Turkish health professionals' attitudes towards euthanasia**

The concept of euthanasia and health professional's attitudes towards euthanasia have been discussed in many research in Turkey. Mayda et al (2005) in their study reported that 43.8% of the oncologists did not object to euthanasia. Some 33.7% had been asked to perform euthanasia and 41.5% believed that euthanasia was performed secretly although it is against the law in Turkey. Forty-two doctors (50.6%) noted that they had withdrawn treatment in patients. The most frequently cited reasons for objecting to euthanasia were its unethical nature and the possibility of abuse. Although the overwhelming majority of the population in Turkey is Muslim, religious rules are not seen as the leading cause of objection to euthanasia. In fact, secularism and education may have influenced people's attitudes toward euthanasia. This is clearly reflected in the questionnaire completed by doctors, who have a high level of education. Doctors who encounter terminally ill patients with cancer should update their knowledge about patients' rights and euthanasia. Doctors, who are often asked to perform euthanasia, especially in the cancer setting, can help to illuminate the debates about euthanasia.

In Turkey several studies have shown the following to be the most frequently given reasons for objecting to euthanasia: the possibility of its abuse (41.6%–72.8%) and conflict with ethical values (24.9% and %32.9) or with religious beliefs (18.7% and %21.7) (Ozkara et al 2001,2002,2003,2004a,2004b). In another study from Turkey have been administrated by

Turla et al (2006). The study participants 43.5 % were medical doctor and 45.5% auxiliary health professionals. Of all participants, 33.6% did not object to euthanasia and 7.9% were asked to perform euthanasia. Eighty point seven percent of the participants noted that euthanasia could be abused even if a euthanasia law were passed. Only 7.9% of the health professionals were requested to perform euthanasia. This can be explained by that fact that the study included not only physicians but also other health professionals. It can be concluded that the health professionals should have a chance to discuss euthanasia and that their attitude toward and their expectations and worries about euthanasia should be taken into account when a euthanasia law is drafted.

The one of cross-sectional study was evaluated health professional's attitudes towards euthanasia in Manisa and Erciyes in Turkey (Karadeniz et al. 2008). Participants were doctors, nurses, and midwives in this study. Whereas 38.4% of the health personnel utterly agree to the definition of euthanasia as an act or practice of painlessly putting to death a person suffering from an incurable disease at his or her will, 11.2% of them express their absolute objection to the definition. While 46.7% of them fully support the idea that religious beliefs affect the decision to undergo euthanasia, 28% support the idea simply, and 4.3% of them don't support the idea at all. The idea that life support to a patient should be decreased if he or she expresses his wish to undergo euthanasia is rejected by 35.4% of them, but welcomed by 28.2%. However, 18.7% of them were undecided; 40.7% of them completely disagreed to the idea that a patient should not be fed if he or she expresses his wish to undergo euthanasia; 33.9% simply disagreed the idea; and 15% were undecided. The patient's wish to undergo euthanasia if he or she cannot live without a life support is rejected by 27.9% of them, whereas 25% of them are undecided. The view that euthanasia should be a legal procedure in all countries is supported by 16.5% and rejected by 29.3%. However, 24.4% of them are undecided. Those who say they will not perform euthanasia at all even if it becomes a legal procedure comprise 43.4% of them; while 5.7% say they can; and 23.9% of them are undecided. That the decision to undergo euthanasia should be given by the patient himself or herself is completely rejected by 21.7%; supported by 24.8%; and 19.9% are undecided. The percentages of health personnel who utterly disagree and who simply disagree to the opinion that the life of a patient should be terminated if he or she is in the vegetative state are the same: 26.6%. Those who are undecided are 28.2%; 42.4% of them say that they themselves would undergo euthanasia, while 17.9% of them say they would not; 5.7% of them were undecided. In Turkey, the approach of the health professional groups related closely with the subject and patients is being researched in many studies.

Another research investigates thoroughly the psychologists' approach to euthanasia practices in Turkey which is considered illegal in Turkey. The research participants were psychologists (n=100) who were working in Izmir (West Anatolia) and Ankara (Middle Anatolia). The participants were found to believe that euthanasia is being secretly practiced in Turkey despite being illegal and 85% view euthanasia as a legal right for patients with certain diseases (Ozkara 2004c).

Other study has been carried out to determine the opinions of nurses working in intensive care units (ICU) of the several hospitals in Adana (South Anatolia). This descriptive study was performed on 186 nurses working in the ICUs. The mean age of the nurses who 26.9  $\pm$  3.9, 73.7% of them had graduated from vocational schools, and the mean duration of

professional experience was  $6.6 \pm 5.1$ . Of all the nurses, 50.0% were married, 44.6% working at the ICU of internal medicine; 55.9% thought that euthanasia was the right of a patient as a human being, and 24.8% of them would ask for euthanasia if they were bedridden. Legal euthanasia in Turkey was not supported by 39.8% of the nurses, and there were more nurses supporting the legality of euthanasia (both active and passive). In case it becomes legal, 63.4% of the nurses think that euthanasia should be practiced by a team that determined by law, 81.7% would not want to take part in an euthanasia practice, 81.2% think that it could be exploited by people. Of all the nurses 44.1% believe that euthanasia is being practiced in some conditions in our country. It was seen that nurses working in at ICU's support passive euthanasia rather than active euthanasia (Kumas 2005).

Tepehan, et al (2009) have evaluated doctors' and nurses' attitudes to euthanasia in intensive care units and surgical, internal medicine and paediatric units in Turkey. A total of 205 doctors and 206 nurses working in several hospitals in Istanbul participated. Significantly higher percentages of doctors (35.3%) and nurses (26.6%) working in intensive care units encountered euthanasia requests than those working in other units. Doctors and nurses caring for terminally ill patients in intensive care units differed considerably in their attitudes to euthanasia and patient rights from other health care staff. Recently, physician assisted suicide has been the topic of much controversy. Some nurses may see assisted suicide as an ethical dilemma; other nurses assisted suicide is still illegal.

A descriptive study investigated the current status of ethics instruction in Turkish nursing education programs. The sample for this study comprised 39 nursing schools, which represented 51% of all nursing schools in Turkey. The results revealed that 18 of these nursing schools incorporated an ethics course into undergraduate and three into graduate level programs. Most of the educators focused on the basic concepts of ethics, deontological theory, ethical principles, ethical problems in health care, patient rights and codes of ethics for nurses. More than half of the educators believed that students' theoretical knowledge of ethics is applied to their clinical experiences. The teaching methods used included discussion in class, lectures, case studies, small group discussion, dramatization and demonstration. Assessment was carried out by means of written essays and written examinations (Gorgulu & Dinc 2007).

Another study were to give Turkish university students on attitudes to euthanasia, and to assess the impact of type of education on attitudes towards euthanasia and to determine the influence of socio-demographics on attitudes of the students towards euthanasia. In total, 878 volunteered undergraduate registered students with the mean age of  $21.13 \pm 1.92$  year from six universities were surveyed. The students were divided into two groups according to education program as follows: Health Science students (HS) and Liberal Arts and Business students (LAB). Two students major groups-Health Science ( $n = 421$ ) and Liberal Arts and Business ( $n = 457$ ), were compared. 48.4% of the students were positive to euthanasia. The socio-demographic factors, including mother's education level, family's socio-economic background, religious belief and religiosity were seen to be influenced on attitudes towards euthanasia among the overall students. No significant difference regarding the acceptance of euthanasia between the Health Science majors and the Liberal Arts and Business majors. Mainly, 40% of the Muslim students are opposed to



euthanasia, whereas 86.7% of the atheist students are the most in favour of euthanasia. The religion was selected as the most important reason for being negative to euthanasia. The results showed that resistance to euthanasia is apparently associated with demographics and non-scientific reasoning among Turkish undergraduate students (Bas Aslan & Cavlak 2007).

While a topic long debated in Western nations at a public level, euthanasia (Physician-assisted suicide) in Turkey has been a subject relegated to debate among a small group of subject experts. For the first time, as a component of Turkey's First Gerontology Atlas (GeroAtlas) research project, euthanasia has been investigated from the perspective of the elderly. Based on the analysis of gender specific data acquired in the project, a number of observations have been presented. The purpose of this research is not solely to present the perspectives of the elderly concerning euthanasia, but to call attention to the need to bring deliberation on this topic into the realm of public opinion, to go deeper and bring new perspectives to light, and emphasize the need for people from all segments of society to enter this debate (Tufan 2009).

In other interventional study was undertaken to assess the impact of physiotherapy education on the knowledge and attitudes of physiotherapists (PTs) and physiotherapy students (PSs) toward euthanasia. The study, which included a total of 494 participants (311 PTs; 183 PSs) aged 18 to 52 y from the western and central portions of Turkey. Results indicated that PTs (48.9%) were more likely to approve of euthanasia than PSs (38.3%) ( $P < .05$ ). The legalization of euthanasia was favored by 43.7% of PTs, compared with 29.5% of PSs ( $P < .05$ ). On the other hand, PTs and PSs expressed similar views regarding euthanasia, including reasons for accepting or opposing euthanasia and acceptable conditions for its use ( $P > .05$ ). Overall results showed that sex and age had no effect on whether euthanasia was accepted ( $P > .05$ ); religiousness was found to have the greatest effect on attitudes toward euthanasia ( $P < .05$ ). The findings of the current study suggest that (1) the attitudes of PTs are different from those of PSs, and (2) the Islamic point of view has a negative impact on the attitudes of PTs and PSs toward euthanasia (Cavlak, et al 2007).

Kok, et al (2003) in their study to determine the approach and expectation of physicians at Erzurum (East Anatolia) on the subject of euthanasia. In this cross-sectional study, a questionnaire was applied to 69 physicians working at Erzurum. Out of 69 physicians that replied the questionnaire 55% was male, 63% of physicians declared that they are against euthanasia practice to be legalised. 68 % of participants said that euthanasia discussion in our country is beneficial. In other study 87 physicians working at Duzce, an important city of Black Sea region. 72% of participants were male and the mean age is  $33.14 \pm 7.29$  years, and 54% of participants were specialist. 48% of physicians declared that they are against euthanasia practice to be legalised. While only 12% of the doctors attending our study declared that they had come across formal request of euthanasia 42% said that they believed that euthanasia in our country has been practiced secretly although it is forbidden. 84 % of participants said that euthanasia discussion in our country is beneficial (Ozkara, et al 2004d).

Bilgen, et al (2009) in their study was to assess the attitudes and practices of doctors and nurses about end-of-life decisions and compare our results with those observed in different European countries. The data was collected from nurses and doctors, using a

standardized questionnaire adapted from the EURONIC study. A total of 250 structured questionnaires were delivered, and 135 (77%) of them were accepted for analysis. The end-of-life decision was taken in 39.4% of the hospitals and personal involvement was 40%. Although an ethical committee was present in the hospitals of 61.5% of responders, a written policy was present in only 3.1% of the units. The mean attitude score was 6.5. Seventy-five percent of the contributors agreed that everything possible should be done to ensure a neonate's survival regardless of the prognosis and 65.2% of responders believed that costs of health care should not affect nontreatment decisions. Most of the responders (65.2%) agreed that severe mental disability as an outcome was equal to or worse than death. In patients in whom medical intervention would be futile, or would not offer sufficient benefit to justify the burdens imposed, hospitals should set up a functional ethical committee in order to decide in matters of withholding or withdrawing intervention.

Another study was to reveal what pneumologists who worked in oncology clinics thought about euthanasia. The mean age of the pneumologists included in the study ( $n=110$ ) was  $32.90 \pm 7.01$  years. Of the pneumologists, 40.8% were against euthanasia and 46.7% believed that euthanasia was performed in Turkey although it was illegal. Thirty-one point five percent of the pneumologists working in oncology clinics and 14.3% of the pneumologists working in clinics other than oncology clinics faced euthanasia requests. The opinions of health professionals taking care of terminally ill patients on euthanasia and patient rights are very important. Frequent requests for euthanasia and the health professionals' belief that euthanasia is performed secretly in Turkey demonstrate that euthanasia should be discussed openly and attitude and approach towards euthanasia should be investigated (Yalniz, et al 2010).

In many European countries, the last decade has been marked by an increasing debate about the acceptability and regulation of euthanasia and other end-of-life decisions in medical practice. Growing public sensibility to a 'right to die' for terminally ill patients has been one of the main constituents of these debates. Cohen, et al (2006) have described and compared acceptance of euthanasia among the general public in 33 European countries. Results showed that the acceptance of euthanasia tended to be high in some countries (e.g. the Netherlands, Denmark, France, Sweden), while a markedly low acceptance was found in others (e.g. Romania, Malta and Turkey). A multivariate ordinal regression showed that weaker religious belief was the most important factor associated with a higher acceptance; however, there were also socio-demographic differences: younger cohorts, people from non-manual social classes, and people with a higher educational level tended to have a higher acceptance of euthanasia. While religious belief, socio-demographic factors, and also moral values (i.e. the belief in the right to self-determination) could largely explain the differences between countries, our findings suggest that perceptions regarding euthanasia are probably also influenced by national traditions and history (e.g. Germany).

## 5. Factors of affecting attitudes towards euthanasia

According to several study of result have described various factors which have a great influence on most individuals' view of euthanasia. These factors include cultural and religious beliefs, age, gender and socio-demographic factors.

### 5.1 Age

Age has a very strong impact on people's attitudes towards euthanasia. An elderly person with a terminal illness is vulnerable. They may lack the knowledge and skills to alleviate their symptoms, and may well suffer from fear about the future and anxiety about the effect of the illness on others. The elderly person's decision making about euthanasia may be affected by confusion, dementia, depression or other related symptoms, which could be relieved with appropriate treatment and social support. Great pressure is experienced by elderly people to request euthanasia because many of them already feel a burden to their families and caregivers. Another study in India to determine the elderly's attitude towards death, the majority were not afraid of death, due to their strong faith in God. About 61.5% of the elderly supported euthanasia, but expressed concern that euthanasia might be misused as a means of getting rid of invalid elderly persons and avoiding the responsibility of caring for them. In the study conducted by one researcher a significant association between age and the choice for euthanasia was found. It was also reported another study that support for voluntary euthanasia is even stronger among the elderly.

### 5.2 Race

Life-prolonging techniques became increasingly available and there were possibly generational and cultural changes in patients' attitudes. According to several researchers attitudes towards the dying patient and the appropriate treatment approach are based on cultural and emotional factors. A cross-cultural perspective on any aspect of the attitude process could enrich our understanding in that it could provide insights that reach to the very core of societal stability. The first process is the way we express our attitudes toward other people and secondly is attitude change.

### 5.3 Religion

It is simply assumed that most Christians are united in their opposition to assisted suicide and voluntary euthanasia. Although many regular churchgoers apparently agree with legalizing some forms of active euthanasia, most theologians and church leaders remained opposed. Some church leaders suggest that to accept that one is not going to get well and therefore to request help to die is an act of faithless misery, a decree of hopelessness, and as such an offence against two of the central theological qualities, faith and hope. In the study conducted by another researcher, it was reported that Buddhists ideas in relation to euthanasia converge with Christian views.

In South Africa Muslims made a declaration that active euthanasia where patients may end their lives by lethal injection is impermissible under any circumstances and that passive euthanasia where patients may withhold treatment or artificial life-support is only permissible if a trustworthy, reliable opinion and specialist feels that there is no hope of survival. In the study to determine American attitudes toward the physician's role were found that various religious groups have strong effects on attitudes toward many social, political and moral issues.

Protestants have been found to hold different attitudes concerning active euthanasia than Catholics. Among Protestant clergy, 73.2% accepted active euthanasia as a viable option, as opposed to 63.1% of the Catholic clergy. Protestants tended to favour active euthanasia more often than Catholics.

#### 5.4 Gender

Patients' choices for care in the event of terminal illness relate to a complicated set of demographic, educational and cultural factors. One of study found that women wanted life-sustaining treatments less often than did men. In a study that was conducted by another researcher about euthanasia and women, when mercy killings occur they are usually administered by men for women, with two-thirds of those being female. She also reported that women are over represented in assisted suicide and euthanasia reports. In addition, women will be affected most by euthanasia simply because they live longer and have fewer resources than men.

#### 5.5 Socio-demographic factors

Researchers found that social changes, such as circumstantial changes, have an effect on people's attitudes towards euthanasia in South Africa. Another study was shown that economic factors play a role in the individuals' request for euthanasia. They mentioned that as medical treatment at the end of life becomes more than ever expensive, health insurance above all in the USA are beginning to question the economic soundness of providing long-term treatment to terminally ill patients. According to many researchers highly educated, politically liberal people with a less religious self-perception are most likely to accept active euthanasia in the case of a terminally ill patient (Ramabele 2004).

Many countries display their approach towards euthanasia according to their own conditions. Euthanasia is legal only in Holland and Belgium. Legal status of euthanasia varies from country to country. In contrast, euthanasia is still illegal in many countries. It was defined as "murder on request" in criminal laws of some countries such as Germany and Austria and it was not clearly defined but prohibited in some other countries such as Japan and Turkey.

In Japan, people who perform euthanasia are sentenced to six months to seven years imprisonment. In Turkey, active euthanasia is not clearly defined in the criminal law, but it is considered "murder." There is not an agreement about passive euthanasia, but it is not thought to deserve strict punishment. Assisted suicide is considered a kind of help to commit suicide.

#### 6. Conclusions

In this book chapter we want to discuss Turkish health professional's attitudes towards euthanasia. Under these conditions, it is important to keep the discussion healthy and alive. Any effort which tends to reach a consensus on this subject will help us in finding a way towards a rational solution for the euthanasia debate in Turkey.

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## **Euthanasia - The "Good Death" Controversy in Humans and Animals**

Edited by Prof. Josef KuÅ™e

ISBN 978-953-307-260-9

Hard cover, 248 pages

**Publisher** InTech

**Published online** 15, September, 2011

**Published in print edition** September, 2011

No one really wants to die, or do they? From classical times to our post-modern era of medical high tech, societies have struggled with the thorny issue of euthanasia, and what it entails. Who shall be entitled to a "good death" and in what form shall it arrive? This book provides the reader with insight and enlightenment on the medical, philosophical, social, cultural and existential aspects of "good death" amid our digitized, individualized and ageing society, hampered by rising health care costs but unchained from one standardized level of care.

### **How to reference**

In order to correctly reference this scholarly work, feel free to copy and paste the following:

Gulten Kaptan, Lecturer Ozden Dedeli and Levent Onen (2011). Turkish Health Professional's Attitudes Towards Euthanasia, Euthanasia - The "Good Death" Controversy in Humans and Animals, Prof. Josef KuÅ™e (Ed.), ISBN: 978-953-307-260-9, InTech, Available from:  
<http://www.intechopen.com/books/euthanasia-the-good-death-controversy-in-humans-and-animals/turkish-health-professional-s-attitudes-towards-euthanasia>

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