

## **The acceptability of physician-assisted suicide as a function of circumstances: A preliminary study of Turkish students' views**

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The views of young Turkish people on the acceptability of physician-assisted suicide (PAS) in the case of patients suffering from intractable pain or in a state of complete dependence were examined. Ninety-nine participants aged 18-25 were presented with scenarios depicting different situations in which a patient, who suffered from an illness that left her in a state of complete dependence or in a state of severe physical pain, requested for a life-ending procedure. In these scenarios age, curability of the disease and whether or not the patient actually requested PAS were furthermore manipulated. Participants were asked to indicate the extent to which PAS would be an acceptable procedure in each scenario. A relative majority of participants (31%) expressed the view that, irrespective of circumstances, PAS was never acceptable. A substantial minority of participants (27%) expressed the view that PAS was practically always acceptable under the circumstances described in the scenarios (unbearable physical pain or complete dependence). A smaller minority of participants (17%) expressed the view that PAS is acceptable under the condition that the suffering patient repeatedly requests it, and another minority (24%) expressed the view that PAS is acceptable under the condition that the patient is old (i.e., 85 years).

Whether physicians should actively help patients to die by means of either euthanasia or physician-assisted suicide (PAS) is highly controversial. In euthanasia, physicians intervene directly and purposely to end patients' lives; this is often called active euthanasia to differentiate it

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from the withholding or withdrawing of treatment needed to maintain life. In PAS, physicians provide patients with the means to end their lives by themselves. Recent legislation regulates PAS in Switzerland, and in the US states of Montana, Oregon, and Washington, and both euthanasia and PAS in Belgium, Luxembourg, and the Netherlands (Blank & Merrick, 2005; McDougal & Gorman, 2008). Similar legislation is under discussion in other US states, Canada, and elsewhere in the world. In Turkey, neither euthanasia nor PAS is legal (Tepehan, Özkara, & Yavuz, 2009). To assist a person in suicide is considered a crime that is severely punished (Article 84 of the Turkish Criminal Law). There is, however, evidence that assisted suicide or passive euthanasia frequently occur in Turkey (e.g., *Hürriyet Daily News*, 2010).

Several studies have been conducted in Turkey regarding health care providers' views about end-of-life issues. Özkara et al. (2004) found that 84% of their sample of physicians from seven different regions of Turkey ( $N = 949$ ) agreed with the view that "every individual has the right to terminate his or her own life". Thirty-nine percent of them were not against the practice of euthanasia; moreover 70 % of them thought that it should not be punished. If euthanasia were legal, 50% of them would approve of it. More than 90% of them defined euthanasia as "the performance of death upon the request of a patient, who has a progressive, unbearable and fatal disease after a long and painful period with no hope of recovery in today's medicine, with the assistance of a physician, in better conditions and without pain" (Özkara et al. 2004, p. 112). Özkara, Civaner, Oğlak, and Mayda (2004) examined the effect of a course on ethical values and euthanasia on the attitudes of 111 students enrolled in the College of Health Sciences of the university of Izmir. The percentage of students who agreed with the view that everyone has the right to decide about his or her own life and health passed from 89% before the course to 98% after. The percentage of students who agreed with the view that the doctor should not be punished passed from 23% to 50%. Support for euthanasia, however, did not significantly change (25% to 31%).

Turla, Özkara, Özkanli, and Alkan (2006) found that 43% of the physicians in their sample of health professionals from different hospitals in Samsun ( $N = 545$ ) agreed with the view that physicians should be able to perform euthanasia. Among nurses and among technicians, however, the percentages were 26%, and 30%, respectively. Among the health professionals who favored euthanasia, 12% thought it should be decided by the physician alone, 10% by the family alone and 63% by both. Kumaş, Öztunç, and Alparslan (2007) found that 34% of the nurses in their sample from different hospitals in Adana ( $N = 186$ ) favored the legalization of

euthanasia whereas 40% were opposed and 26% were undecided. Nurses working in intensive care units services were more favorable (42%) than other nurses.

Karadeniz et al. (2008) showed that a majority of health professionals (53%) of their sample ( $N = 632$ ) from major hospitals in the province of Manisa and Ereyes agreed with the view that patients with an incurable disease should not live half dead because of suffering and being hopeless. They was, however only a minority holding the view that if a patient informs a doctor of his euthanasia wish, the doctor should help him die unless it is painful (23%) and that euthanasia decision should be given by the patient (42%). Tepehan, Özkara, and Yavuz (2009) showed that a majority of nurses (53%) and physicians (56%) in their sample of health professionals working in several hospitals in Istanbul ( $N = 411$ ) wanted euthanasia to be legalized. Sixty-five percent of the nurses and 73% of the physicians agreed with the view that an individual has the right to decide about his or her own death. Among the professionals who worked in an ICU service these figures were 73% and 78%, respectively. When the question concerned euthanasia for patients with an incurable and lethal disease who were not legally competent, 36% of nurses and 35% of physicians working in an ICU service still favoured euthanasia. A majority of health professionals stated that euthanasia was secretly performed in Turkish hospitals.

### **The Present Study**

The present study aimed to complete the previous ones. It differed from the studies reported above in two ways. Firstly, the sample was not a sample of health caregivers or future caregivers but a sample of young people who were not training for any medical career: They were ordinary citizens. Knowing citizens' views about end of life issues is important because bioethics can no longer be conceived as the exclusive domain of theologians, philosophers or health professionals (Jacoby & Siminoff, 2008). As patients and as voters, ordinary citizens are directly involved in bioethics. As patients, they are the very persons who, at the end of their life, may express (or not express) their desire that their life is ended and benefit (or not benefit) from health professionals' help. As voters, they may support (or not support) current or future legislation regarding end of life issues. To exclude ordinary citizens from current debates in bioethics would simply amount to run counter the very idea of democracy.

Secondly, it is the acceptability of PAS that was specifically examined, not other forms of life-ending procedures, and it is the cognitive

process by which participants arrived at a judgment about the acceptability or not of PAS that was assessed, not just the output of this process. Regarding many societal issues, most people have personal positions, and these positions can be complex ones. The individual differences in participants' responses to ethical dilemma cannot be considered as just simple linear variations along response scales. They usually reflect participants' basic philosophical positions regarding the appropriateness of behaving in such and such way in general or under specific circumstances (e.g., Mullet et al., 2012). As a result, we strictly replicated the methodology that was used by Ahmed, Sorum, and Mullet (2010) in their study on the acceptability of PAS to people in Kuwait because this methodology allows for a characterization of people's possibly complex personal views. We also considered the same factors.

Ahmed et al. (2010) presented university students with scenarios depicting different situations in which a patient, who suffered from an illness that left her in a state of complete dependence or in a state of severe physical pain, requested for a life-ending procedure. In these scenarios age, curability of the disease and whether or not the patient actually requested PAS were furthermore manipulated. In this study five different personal positions were found. For 44% of the participants, PAS was always totally unacceptable. For 23%, it was unacceptable, but less so when the patient was older or had requested it repeatedly. For 16%, it was unacceptable for a young patient, but acceptable for an elderly patient. For 5%, it was unacceptable for a patient in extreme pain, but was acceptable for a patient in complete dependence. For 11%, it was unacceptable if the patient did not request it, but acceptable if she did. Thus, the majority of these students opposed PAS either categorically or with slight variations depending on circumstances. Yet, a minority found it acceptable in some cases, particularly when the patient was elderly and had requested PAS.

In view of the findings reported above, it seems that people's attitude to end-of-life decision-making in Turkey and in Kuwait are different: a substantial percent of health professionals in Turkey was not bluntly opposed to euthanasia or PAS. This may be a reflection of lay people's attitudes. As in the study by Ahmed et al. (2010), we expected to find contrasted personal positions among Turkish people but we expect that, overall, this set of positions will be more uniform in percentages than the one found in Kuwait. We expect that a substantial percentage of Turkish young people would express an always unacceptable position, but we also expect that another substantial percentage express one or several contingent positions, as has already been found in other countries like India (Kamble, Sorum, & Mullet, 2012), and France (Munoz Sastre et al., 2010).

## METHOD

**Participants.** Participants in this study were 96 young Turkish university students (49% female, and 51% male) at a public university in Turkey. Their mean age was 22 years ( $SD = 1.81$ ). The first author recruited them by making announcements in various university classes. All of the participants volunteered to participate in the study. Participants were guaranteed anonymity of their responses and confidentiality of the data.

**Material.** The material consisted of 36 cards containing a story of a few lines, a question, and a response scale. The stories were composed according to a four within-subject factor design: Type of suffering x Incurability x Request x Age,  $2 \times 2 \times 3 \times 3$ . The quality of care was held constant as was reported to be the best available. Each story contained these four pieces of information in the following order: (a) the patient's age (35, 60, or 85 years), (b) the level of curability of the illness (i.e., completely incurable versus extremely difficult to cure), (c) the type of the suffering (i.e., extreme physical pain or complete dependence), and (d) the extent to which the patient requests the life-ending procedure (i.e., no request, some form of request, repeated formal requests). All patients were identified as "Mrs." The only additional information was "She is currently receiving the best possible treatment."

An example of scenario is the following: "Mrs Yilmaz is 85 years old. She has a serious illness, totally incurable given current knowledge. She is currently receiving the best possible treatment. She is completely dependent; she cannot breathe by herself and she cannot feed herself. She has asked clearly and repeatedly to resort to euthanasia or physician assisted suicide. Do you think physician assisted suicide would be an acceptable procedure in this case?" The response scale was a 15-point scale with a left-hand anchor of "Not acceptable at all" and a right-hand anchor of "Completely acceptable". The cards were arranged by chance and in a different order for each participant.

**Procedure.** Each student was tested individually or in small groups of 6 to 10 persons in the classroom. The first researcher conducted each session in two phases as suggested by Anderson (1982). In the familiarization phase, the researcher gave an instruction to students including a general framework of the study, the rules of testing, and fundamental information about the scenarios. Then, the participants took 12 vignettes randomly from the complete set. They read each vignette, after

which the instructor reminded them of the items of information in the vignette. The participants then made an acceptability rating tentatively. After completing the 12 ratings, they were allowed to look back at their responses and change them

In the main study phase, the participants were given the entire set of 36 vignettes. The participants then made a final acceptability rating, implying that, after completing the 36 ratings, they were not allowed to look back at their responses and change them. The completion of the main survey took approximately 20-25 minutes.

## RESULTS

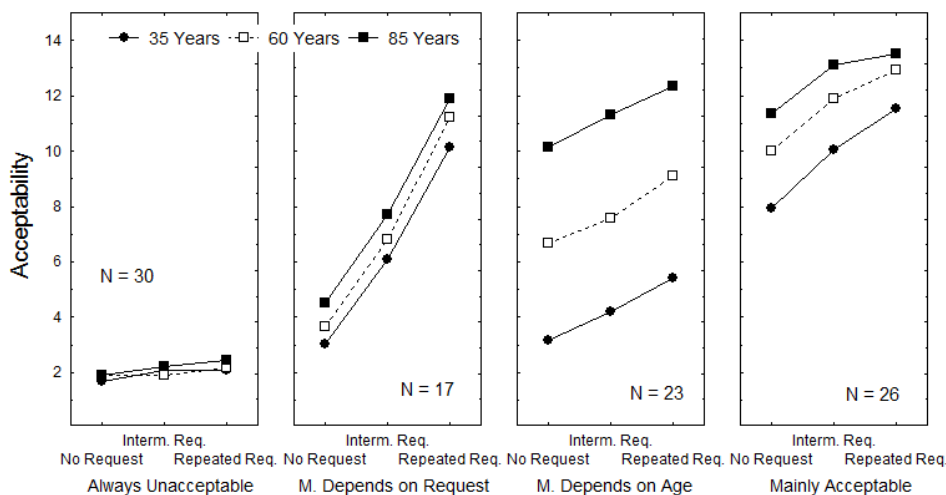
To look for groupings of participants, a cluster analysis was performed on the raw data in accordance with the recommendations of Hofmans and Mullet (2013); that is, we used K-means clustering based on Euclidian distances. Four clusters of participants were identified. They are shown in Figure 1, with mean acceptability ratings pooled across levels of incurability and types of suffering. In the first cluster ( $N = 30$ ), the (relative) majority cluster, was termed *Always Unacceptable*: The mean value of the responses was 2.04. This cluster is shown in Figure 1 (left panel); 43% of the female participants and 19% of the male participants were in this cluster.

The second cluster ( $N = 17$ ,  $M = 7.23$ ) was termed *Mainly Depending on Request*. As shown in Figure 1 (second panel from the left), the responses clearly depended on the patient's request (the curves are ascending). An ANOVA was performed on the raw data. The design was Type of Suffering x Incurability x Request x Age  $2 \times 3 \times 3 \times 3$ . Owing to the great number of comparisons conducted, the significance threshold was set at .003 (.05/15) using the Bonferroni correction. The main results are shown in Table 1. When request was present and repetitive, the acceptability rating was higher than when it was not repetitive or there was no request. Post-hoc analyses showed that the mean acceptability value observed when request was not repetitive ( $M = 6.88$ ) differed significantly from the mean values observed in the two other cases, ( $M = 11.08$ , and  $3.73$ , respectively),  $p < .001$ . When the patient was 85, the acceptability rating was higher than when she was 60 or 35. Post-hoc analyses showed that the mean acceptability value observed when the patient was 60 ( $M = 7.23$ ) significantly differed from the mean values observed in the two other cases ( $M = 8.04$  and  $6.43$ , respectively),  $p < .001$ . No interaction was significant;

10% of the female participants and 26% of the male participants were in this cluster.

**Table 1. Main results of the ANOVAs. For the sake of brevity, only main effects and significant interactions have reported. Complete results are available from the corresponding author.**

Factor	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	<i>Eta</i> <sup>2</sup> <sub><i>p</i></sub>
Cluster Mainly Depending on Patient's Request					
Type of Suffering	1	92.20	1.35	.26	.08
Incurability	1	17.62	0.52	.48	.03
Patient's Request	2	2 774.11	57.00	.001	.78
Patient's Age	2	132.77	13.02	.001	.45
Cluster Mainly Depending on Patient's Age					
Type of Suffering	1	156.71	7.51	.01	.25
Incurability	1	46.63	2.48	.13	.10
Patient's Request	2	361.68	25.47	.001	.54
Patient's Age	2	3 392.03	74.51	.001	.77
Cluster Mainly Acceptable					
Type of Suffering	1	245.27	4.35	.05	.15
Incurability	1	7.34	0.27	.61	.01
Patient's Request	2	688.78	31.46	.001	.56
Patient's Age	2	638.24	45.63	.001	.64
Request x Age	4	14.76	4.78	.001	.17



**Figure 1.** Patterns of results corresponding to the Always Unacceptable cluster (left panel), to the Mainly Depending on Circumstances cluster (second panel), and to the Mainly Depending on Age cluster (third panel), and to the Mainly Acceptable cluster (right panel). In each panel, (a) the mean acceptability judgments are on the y-axis, (b) the three levels of patient request are on the x-axis, and (c) the three curves correspond to the three levels of patient age.

The third cluster ( $N = 23$ ,  $M = 7.76$ ) was termed *Mainly Depending on Patient's Age*. As shown in Figure 1 (third panel from the left), the responses clearly depended mainly on the patient's age (the curves are clearly separated) but also on the patient's request (curves are slightly ascending). When request was present and repetitive, the acceptability rating was higher than when it was not repetitive or there was no request. Post-hoc analyses showed that the mean acceptability value observed when request was present but not repetitive ( $M = 7.68$ ) differed significantly from the mean values observed in the two other cases ( $M = 8.95$  and  $6.66$ , respectively),  $p < .001$ . When the patient was 85, the acceptability rating was higher than when she was 60 or 35. Post-hoc analyses showed that the mean acceptability value observed when the patient was 60 ( $M = 7.77$ ) significantly differed from the mean values observed in the two other cases ( $M = 11.26$  and  $4.25$ , respectively),  $p < .001$ . No interaction was significant; 20% of the female participants and 28% of the male participants were in this cluster.



The fourth cluster ( $N = 26$ ) was termed *Mainly Acceptable*: The mean value of the responses was 11.37. This cluster is shown in Figure 1 (right panel). For the participants in this cluster, in the more “unfavourable” case—a younger patient not requesting PAS or euthanasia—the acceptability was still relatively close to the middle ( $M = 6.19$ ) of the acceptability scale (8). When request was present and repetitive, the acceptability rating was higher than when it was not repetitive or there was no request. Post-hoc analyses showed that the mean acceptability value observed when request was not repetitive ( $M = 11.69$ ) differed significantly from the mean values observed when there was no request ( $M = 9.75$ ) but not from the mean value observed when request was repetitive ( $M = 12.67$ ). When the patient was 85, the acceptability rating was higher than when she was 60 or 35. Post-hoc analyses showed that the mean acceptability value observed when the patient was 60 ( $M = 11.61$ ) significantly differed from the mean values observed in the two other cases ( $M = 12.66$  and  $9.83$ , respectively),  $p < .001$ . The Request  $\times$  Age interaction was significant. In the case of repetitive request, the effect of the patient’s age was weaker (a difference of 1.98 points) than in the case of no request (a difference of 3.42) or simple request (a difference of 3.10). Twenty-eight per cent of the female participants and 27% of the male participants were in this cluster.

A one-way ANOVA showed that mean ages did not significantly differ from one cluster to the other. A Chi<sup>2</sup> test showed that the percentage of female and male participants significantly differed from one cluster to the other,  $p < .05$ . Females were more numerous than males in the Always unacceptable cluster.

## DISCUSSION

The present study examined the views of a sample of young Turkish university students on the acceptability of PAS in the case of patients suffering from intractable pain or in a state of complete dependence. We expected to find contrasted personal positions among participants. Four qualitatively distinct personal positions were evidenced. A relative majority of young people (31%) expressed the view that, irrespective of circumstances, PAS was never acceptable. This finding was consistent with previous findings showing that a substantial proportion of health professionals in Turkey were hostile to this procedure (Karadeniz et al., 2008; Tepehan et al., 2009; Turla et al., 2006). It was also consistent with Ahmed et al.’s (2010) findings among Kuwaiti students.

It should be noted, however, that if this view was shared by 43% of the female students, it was the view of only 19% of male students. This finding was new and intriguing. In previous studies, such strong gender differences had never been shown. The issue here is possibly a methodological one. In previous studies, attitudes were assessed using generic items whereas in the present study concrete scenarios were employed, which were organized in a way that allowed to examine the effect of circumstances on participants' attitudes. When an omnibus ANOVA was conducted on the whole set of data, with gender as a between-subject factor, the gender difference was, as in previous studies, found to be not significant. Gender differences regarding end-of-life issues are thus subtle differences, which may not always be detected using conventional techniques.

A substantial minority of young people (27%) expressed the view that PAS was practically always acceptable under the circumstances described in the scenarios (unbearable physical pain or complete dependence). This result was consistent with Kamble et al.' (2013) findings showing that a substantial proportion of Indian students were, under the same circumstances, favorable to this procedure. Small subsamples of participants holding this view had also been found in studies conducted in France (but not in Kuwait).

The existence of these two structured views – always unacceptable and mainly acceptable – among an otherwise relatively homogeneous sample clearly demonstrates that the civil society in Turkey is, as the civil society in India but contrary to the civil society in Kuwait, much divided regarding the issue of end-of life decision-making. All authors whose work has been reviewed above have emphasized this feature of modern Turkey (Özkara et al., 2004a, 2004b; Karadeniz et al., 2008). Future studies regarding this huge divide, should examine, among other things, the impact of religious beliefs on people's views regarding PAS and other related societal issues.

A smaller minority of young people (17%) expressed the view that PAS is acceptable to the condition that the suffering patient repeatedly requests it, and still more acceptable when the patient was older. Their judgment process can be expressed by the following equation: Acceptability =  $f(\text{Request} + \text{Age})$ . This result was consistent with findings repeatedly encountered in studies conducted in France (Frileux et al., 2003; Guedj et al., 2005; Teisseyre et al., 2005). It is also consistent Kamble et al.' (2012) findings among Indian students. It should be noted that a comparable percentage (11%) of students endorsing this view was found in Ahmed et

al.'s (2010) study conducted in Kuwait. This view is the one that best expresses full respect for the patient's autonomy. In a previous study conducted among Turkish students (Özkara, 2004b), about nine out of ten of them spontaneously agreed with the view that "everyone has the right to decide about his or her own life and health"; that is, they clearly expressed their appreciation of the autonomy principle. Future studies should explore the reasons why this appreciation does not fully translate in a personal position favoring respect for autonomy when concrete situations are encountered. They should also check whether the gender difference found in the present study regarding this position hold.

Finally another minority of young people (24%) expressed the view that PAS is acceptable under the condition that the suffering patient is old and still more acceptable when the patient requests it. As in the previous case, their judgment process can be expressed by the following equation: Acceptability =  $f(\text{Age} + \text{Request})$ ; that is, the integration rule was also additive but the relative weights of the factors were different. This result was consistent with Kamble et al.' (2012) findings among Indian students. It should be noted that a comparable percentage (16%) of students endorsing this view was found in Ahmed et al.'s (2010) study conducted in Kuwait. On a priori grounds, this view is contrary to the justice principle, according to which all patients must be treated in the same way, irrespective of age, gender or other demographic characteristics. This view cannot be explained by people's belief in physical reincarnation as was the case in Kamble et al.'s (2013) study. Future studies should explore the reasons that ground this view.

### **Limitations**

The study has, of course, limitations. First, the group of participants was a convenience sample, was of only moderate size, and was restricted to Turkish university students from only one city. Second, age may play a role, i.e., the judgments of older people may differ from those of our exclusively young sample: It would be important to repeat the study using old as well as young, educated as well as less educated participants. Third, the participants responded to vignettes, not to real patients. The use of vignettes, however, is useful—it permits statistical analyses to reveal how people weigh and combine separate factors—and has been validated (Fruchart, Rulence-Pâques, & Mullet, 2007). Fourth, the experimenter did not ask further questions to elucidate the reasons, no doubt both personal and religious, for the participants' responses

In summary, (a) most Turkish young people do not appear to be systematically opposed to PAS, although female students appeared to be more hostile to it than male students, (b) the most important factor in providing acceptability (either a small amount in one cluster or a large amount in another cluster) was advanced age, and (c) additional acceptability was provided by the patient's request, especially among male students, but much less than in studies in Western countries. As these young people enter society, they and others like them are likely to influence Turkish policy-makers and jurists to take a more nuanced view of PAS.

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