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EC PULMONOLOGY AND RESPIRATORY MEDICINE

Research Article

Beliefs and Attitudes of Health Professionals toward Death and Euthanasia

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Received: June 06, 2020; **Published:** June 24, 2020

Abstract

Introduction: Euthanasia and assisted suicide are important issue, with conflicting views in the medical community and a variable legal frame work from country to country.

The purpose of thiw thesis is to explore attitudes of physicians and nurses on euthanasia and their attidutes toward the death and to attempt to link these two views.

Materials and Methods: The sample of the study consisted of 126 physicians and nurses whose views were investigated with the use of the Euthanasia Attitude Scale (EAS) and the Death Attitude Profile-Revised (DAP-R). Data were analyzed using SPSS v.26 and t-test, ANOVA and Pearson correlation were used, while Factor Analysis was also used to categorize the varisbles-questions of the two questionnaires.

Results: The majority of the participants were nurses (n = 82, 65,1%), while 34,9% (n = 44) were physicians. 73,8% of the sample believe that a person suffering from painful end-stage disease should have the right to refuse treatment that extends their life and in this context, 65,9% do not feel negative about a person who hastens the death of a loved one. Thus, 72,2% believe that there should be legal ways in which a person coild pre-aprove his death. Overall, individuals in the sample reported a score of nearly 80 on the EAS scale indicating a marginally positive attitude toward euthanasia, which appeared to be lower in those with doctorate (p = 0,029). On the contrary, no correlation was found between euthanasia views and resondents attitudes toward death. Moreover, the factor analysis gave 4 dimensions to the EAS questionnaire, while to the DAP-R questionnaire, gave 5 dimensions. These dimensions seemed to be strongly correlated with the overall questionnaires, althouth the individual correlations between them were weak.

Concusion: The findings of the present study show the physicians and nusrses in the sample were marginally positive for euthanasia and assisted suicide.

Keywords: *Euthanasia; Doctors and Nurses; Attitudes to Death*

Introduction

The practice of assisted killing is increasinggly being discussed in agrowing number of countries and is increasingly seen as a last resort for those suffering from serious and irreversible diseases. While legislation in many countries refers to euthanasia and assisted suicide only if patients have an incurable disease and a very limited life expectancy due to a physical disorder, in some countries, assisted suicide is also an option for people who are not patients with incurable diseases, such as those suffering from a serius psychiatric illness. In Hellas however this is prohibited.

On the other hand, people who work in the field of health and more specifically, doctors and nurses, come in contact with people who are in the last stages of their lives and thus, form opinions on the subject of euthanasia, the which may be different from the citizens' average responses and may be affected precisely by their frequent contact with death.

The definitions of euthanasia and incitement to suicide are different between countries. For active euthanasia - or simply euthanasia - a person, usually a doctor, actively and deliberately ends a patient's life with some medical means such as injecting a neuromuscular relaxant. According to the laws of the Netherlands and Belgium, euthanasia is usually limited to voluntary cases, in which the patient is mentally fit and explicitly requests euthanasia [1].

Intentional euthanasia occurs when the patient is mentally fit but has not requested euthanasia. Non-optional euthanasia refers to cases where the patient is not mentally fit and cannot request euthanasia. In the Netherlands, Belgium and most European countries, involuntary and non-voluntary cases are not considered euthanasia but "termination of life without the express consent of the patient". The term "passive euthanasia" should be avoided because it refers to the termination of possibly life-sustaining treatments and not to medical intervention to terminate one's life patient. In the United States and many other countries, termination of treatment that can last a lifetime is considered ethical and legal when performed with the consent of the patient or power of attorney [2].

Assisted suicide (Physician-assisted suicide, PAS) occurs when lethal drugs are prescribed or provided by the doctor at the request of the patient and are self-administered by the patient in order to end his/her life. In the United States, there is debate about whether the appropriate term for this practice is PAS, or physician assistance for a death (physician aid-in-dying). The term PAS is most often used, especially in Europe, where death with the help of a doctor is a more comprehensive term that includes euthanasia, termination of life without the explicit requirement of the patient and PAS. However, it should be noted that it is good to focus on the essential issues related to these practices and not on linguistic controversies [3].

In Hellas, both euthanasia and the concept of assisted suicide are explicitly prohibited. There is no specific legislation and so all cases involving these cases are judged on the basis of the general rules of the penal code for homicide. Euthanasia has been treated, both by society and by the church, as a crime or a sin, respectively.

Since 1947, Gallup, in a representative survey of about 1,000 to 1,500 people, has asked the American public the following question: "When a person suffers from an incurable disease, do you think doctors should be allowed to do so?" to end the patient's life with some painless means if the patient and his family request it?" The question leaves the patient's age, illness, prognosis and symptoms ambiguous and presupposes that the act that ends the life is necessarily painless. It also emphasizes the consent of the family, which is neither a moral nor a legal requirement of any jurisdiction.

Euthanasia attitude scale-EAS

The EAS is a 30-point Likert scale questionnaire that measures attitudes toward euthanasia. The scale uses both positive (16 items) and negative (14 items) statements to control the effect of consensus. The answers are on a 4-step Likert scale. The possible answers "I totally agree", "I agree", "I disagree" and "I completely disagree" are graded with 4, 3, 2 and 1 when it comes to positive questions and 1, 2, 3 and 4 when it comes to negative questions. For each questionnaire the score is obtained from the sum of the individual 30 questions and ranges from 30 - 120. Prices below 75 indicate a negative overall attitude, while values > 75 indicate a positive overall attitude towards euthanasia. EAS questions deal with a variety of issues, both active and partial passive euthanasia, such as the condition of the brain dead, life-enhancing technology, ethical issues and legal issues (Holloway., *et al*. 1995). According to the latter, the questionnaire has excellent properties, such as stability, internal consistency, power of distinctions and reliability of test-review.

Death investigation questionnaire-Death attitude profile-revised

The DAP-R is a standardized instrument [4] used to measure the attitude toward death. The scale is intended to capture two mortality components using five subscales. Acceptance of death consists in the cognitive awareness of the individual and the emotional response to this knowledge. Three types of death acceptance are measured, while fear of death and reaction to that fear (avoidance of death) are also incorporated. For the purposes of this study, measuring the acceptance of death is important because knowledge and attitudes about life-ending decisions require the acceptance of the inevitable of death. The DAP-R scale consists of 32 elements that measure five dimensions of religious behavior.

Methodology

Population under study

The target population of this study were hospital health workers-professionals in Polygyros, Halkidiki. The survey was conducted from December 2019 to February 2020. The sample was selected with ease sampling, with the main criterion being the researcher's immediate access to the study population due to the limited collection time. The eligibility criteria for participation in the study were the health professionals to be permanent staff of the hospital with at least 1 year of previous service.

The total population that completed the questionnaires at the Public Hospital of Halkidiki in Polygyros, was 126 people of which 82 were nursing staff and 44 doctors of various specialties.

More specifically, the questionnaire used in the present study consists of three separate thematic sections and a total of 69 questions. The first part includes questions about the demographic and general characteristics of the sample, the second part consists of the 30 questions of the Euthanasia Attitude Scale (EAS) and the third of the 32 questions of the Death Investigation Questionnaire (Death Attitude Profile-Revised, DAP-R). Both questionnaires have been translated and weighted into Greek [5-7] and given to the author for use after authorization by the authors. The independent variables of this study were defined as gender, age, marital status, years of service, and employment status of the individuals who participated in the study. On the other hand, the dependent variables were defined as the views of nurses and physicians on euthanasia and their attitudes toward death, that is, the questions in the second and third parts of the questionnaire.

Data analysis was performed on SPSS v.26 software. Both descriptive statistics and inductive statistics were used to analyze the data. More specifically, absolute and relative frequencies were used to present the demographic and socioeconomic characteristics of the sample, while to present the views of the participants in the survey, location and dispersion measures were used. Of the sample. In addition, in order to separate the thirty questions of the second part of the questionnaire into five factors, and of the third part into four factors, the factor analysis was used, as well as the reliability analysis of the resulting factors. Furthermore, for all questions, the internal consistency factor Cronbach's a was calculated, which took the satisfactory value $\alpha = 0.648$. Parametric t-test (for two independent samples) and ANOVA (for more than 2 independent samples) were performed to investigate the impact of the views of the participants in the study on what are the most important factors that play a decisive role in their views and attitudes are differentiated accordingly demographic characteristics. In addition, correlation control was used Pearson (for correlations in regular variables). Finally, $\alpha = 0.05$ was defined as the significance level, which corresponds to a confidence level of 95%.

Results

Demographic characteristics of the sample

The following table 1 shows the demographic characteristics of the 126 participants in the study. Out of the total number of respondents, 57.9% (n = 73) of women and 42.1% (n = 53) of men participated. Regarding the age distribution of the sample, it emerged that 18.3% (n = 23) were aged 20 to 40 years, 65.1% (n = 82) were aged 40 to 60 years and 16.7% (n = 21) was over 60 years of age. In addition, the majority of study participants were nurses (n = 82, 65.1%) while 34.9% (n = 44) were physicians. Regarding the educational level, the sample appears divided into the five options given to it, as almost 25% (n = 31) of the individuals hold a university degree, when the TEI (technical nurse education) graduates make up 31.7% (n = 40) and of the Lyceum-pre-nurse education 23% (ν = 29). Of the individuals in the sample, in addition, 15.1% (n = 19) state that they have a master's degree and 5.6% (n = 7) that they have a doctorate. Finally, 10.3% (n = 13) of the respondents had previous service in the field of health up to 5 years, 20.6% had previous service 10-15 years (n = 26), 34.9% had previous service 15 - 25 years (n = 44) and 34.1% (n = 43) had more than 25 years of service. Finally, of the total number of respondents, 56.3% (n = 71) had contact with end-stage patients, while 43.7% (n = 55) did not have it (Table 1).

Gender	Male	N 53	% 42,1
	Women	73	57,9
What age group do you belong to?	Until 20 years old	0	0
	20 - 40	23	18,3
	40 - 60	82	65,1
	> 60	21	16,7
Occupational Health	Doctor	44	34,9
	Nurses	82	65,1
Level of Education	Pre-nurse education	29	23
	Technical nurse education	40	31,7
	Bachellor	31	24,6
	Master	19	15,1
	Doctora	7	5,6
Years of work in the field of health	> 5	13	10,3
	10 - 15	26	20,6
	15 - 25	44	34,9
	> 25	43	34,1
You are treating end-stage patients	No	71	56,3
	Yes	55	43,7

Table 1: *Demographic and socio-economic characteristics of participants.*

Analysis of stasis scale results against euthanasia

This paragraph presents in detail the results concerning the EAS scale, which was the second part of the questionnaire. First, in the table below, the detailed results of the research are presented, based on the 4-point Likert scale used. Thus, 67.5% of the sample fully agree or disagree with the proposition, according to which, even if a patient of the final stage clearly expresses his preference to die against the extension of his life, no act should be performed. which causes the death of the patient and 58% believe that under any circumstances they believe that doctors should try to prolong the lives of their patients and that there is never a justification for ending a person's life even if he suffers from final disease stage. On the other hand, only 29.4% believe that some patients receive exclusively palliative care, although 50% of the sample consider it more humane to take the life of a person suffering from end-stage disease. In addition, 73.8% of the sample believe that a person suffering from a painful end-stage disease should have the right to refuse treatment that extends his or her life, and in this context, 65.9% do not feel negative about a a person who hastens the death of a loved one. Thus, 72.2% believe that there should be legal ways in which a person could pre-approve his death. However, on the other hand, 57.1% of the sample could not consider any medical case in which the termination of life would be an act of mercy, although 68% of the sample would support the decision to reject additional treatment.If in a dying patient, in case of secondary disease. It is worth noting that 80.2% of the sample support the decision to provide "only palliative care" if a terminally ill patient dies, and in fact, 73% state that if they were faced with the prospect of a loved one suffering a slow and painful death, would support his/her decision to refuse medical treatment to sustain life. In addition, 66.7% of the sample believe that turning off life support machines is an act of mercy to a person who lives but is "brain dead." At the same wavelength, 77% of the sample state that if they were faced with a state of slow and painful death, they should have the right to choose to end their life in the easiest and fastest way, as the same percentage considers it difficult to prolonged pain for someone who is very seriously ill and wants to die. On the other hand, 65.9% of the sample believe that no one, including doctors, is allowed to decide the end of the life of a suffering person, although only a majority of 37% believe that anyone is helping a terminally ill patient. die is just a common criminal and 45% say that no matter how much a person may beg to die to avoid unbearable pain, no one should help that person fulfill their wish.

The discrepancies are complete with a majority of 72 - 73% stating that a person should have the right to choose to die if he or she is a terminally ill patient and suffers and that a terminally ill patient should be allowed to reject support systems. of life.

Factor stasis scale analysis vs. euthanasia

In order to further analyze the results of the Stationary Stage against Euthanasia, factor analysis took place, as noted in the chapter on research methodology. In this paragraph, its results are presented in detail, so that further analysis is possible.

The following is the scree plot from which it appears that the best option is to create four factors, as so many factors have a value that is greater than the unit (Figure 1) [8].

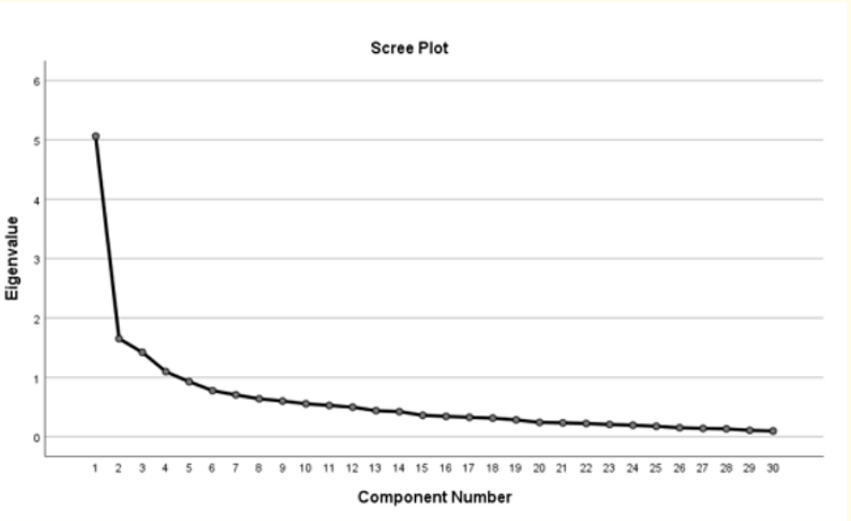

Figure 1: *The eigenvalue diagram.*

The results for the 30 questions of the second part of the questionnaire it turns out that the data are suitable for factor analysis (KMO = 0.806 > 0.5, p-value of Bartlett's test of sphericity 0.000 < 0.05). Thus, this analysis is statistically significant (KMO = 0.806, x^2 (435) = 1583.21, p < 0.05). In addition, the best option is to create four factors that interpret a fairly significant percentage of the variability of the data, of the order of 53.89%. Also, regarding the table that follows, it is worth noting that based on the common practice, the loading of the questions should show values greater than 0.30 [8].

Questions with lower values than this are excluded from their participation in the factors. As mentioned above, at the beginning of the present, four factors were created, the names of which are as follows:

- Factor 1: The role of the professional in maintaining life
- Factor 2: The right to euthanasia
- Factor 3: The obligation to maintain life
- Factor 4: The role of the professional in euthanasia.

Questionnaire to investigate the attitude towards death

According to the results of the survey, the majority of the sample of 67% agree either moderately or completely, with the fact that death is without a doubt a macabre experience. However, this is a question that shows one of the largest percentage of agreement in the sample. Anxiety is caused by the idea of death in 51% of the sample, while a similar percentage of 48% state that they avoid the thoughts of death at all costs. Their belief that after death they will be in paradise is testified by people who make up 21% of the sample, while 26% of the sample treat death as the end of all problems. One of the largest percentages of agreement in the questionnaire is the proposal, according to which, death should be treated as something normal, indisputable and inevitable. The agreement rates reach 78%. 46% of the sample are bothered by the definiteness of death, when only 26% believe that death is the entrance to a place of absolute satisfaction and only 18% believe that death offers an escape from the awful world. However, 36% of the sample admit that whenever the thought of death comes to the mind, it tries to drive it away. It is also noted that for 32% of the sample. Death is liberation from pain and suffering, while 46% of the sample state that they always try to think about death. Paradise will be a better Sacrifice than this world, according to 41% of the sample, although for 70% death is a natural dimension of life. In addition, it is worth noting that death is a union between God and eternal bliss for 43% of the sample, and is a promise of a better life for 30% of the people surveyed. 34% are worried about the uncertainty of what is happening. After death, and on the other hand, only 15% say they are looking forward to life θά after death. However, for 38% of the sample, death is neither good nor bad, although 27% say they see death as a relief from the burdens of this life. Faith plays a big role in 40% of the sample, as he states that one thing that gives him comfort in dealing with death is his faith in the afterlife. Moreover, for 24% of the sample, death offers a wonderful relief to the soul, while for 42%, the challenge of death for reasons of mercy is acceptable. Finally, it is worth noting that 38% of the sample state that they are looking forward to a reunion with their loved ones after his death.

DAP R factor analysis

In order to further analyze the results of the DAP_R Scale, factor analysis was performed, as noted in the chapter on research methodology. In this paragraph, its results are presented in detail, so that further analysis is possible.

The following is a scree plot from which it appears that the best option is to create four factors, as so many factors have a value that is greater than one (Figure 2).

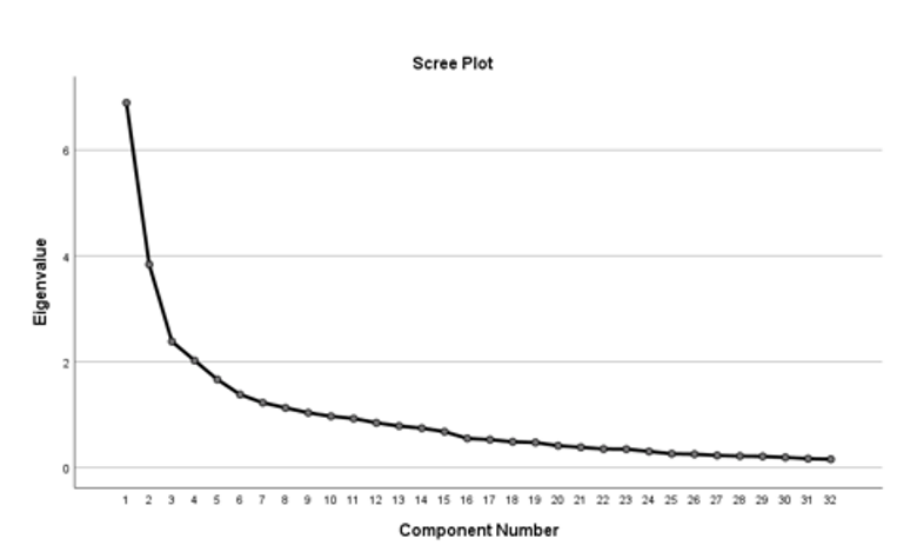

Figure 2: *The eigenvalue diagram.*

The results regarding the confirmatory factor analysis for the 32 questions of the third part of the questionnaire. The KMO and Bartlett's test listed in the appendix shows that the data are suitable for factor analysis (the KMO = 0.772 > 0.5 index, p-value of the Bartlett's test of sphericity 0.000 < 0.05). Thus, this analysis is statistically significant (KMO = 0.772, x^2 (496) = 1764.03, p < 0.05). In addition, the best choice is to create five factors that account for a significant percentage of the variability of the data, of 52.43% the loading of the questions should show values greater than 0.30 (Batsidis, 2013). Questions with lower values than this are excluded from their participation in the factors, although it is worth noting that in this questionnaire no questions were excluded.

As mentioned above at the beginning of this paragraph, five factors were created, the names of which are as follows:

- Factor 1: Acceptance of death
- Factor 2: Avoid death
- Factor 3: Fear of death
- Factor 4: Escape means
- Factor 5: Neutral attitude.

The analysis of the correlation between perceptions of euthanasia and attitudes towards death

The analysis of the correlation of the two central variablesis through Pearson's control and although statistically significant, is not very high between the correlations also between the 5 dimensions of the Euthanasia Questionnaire with the four dimensions of the Death Questionnaire, the study of the data referred to, does not reveal a moderate or strong, positive or negative correlation between the two variables and their individual elements, although there are some statistically significant low-intensity correlations (Figure 3).

Πίνακας 25. Συσχέτιση των υποκλιμάκων των δύο ερωτηματολογίων (EAS και DAP-R)

	EAS	Ρόλος επαγγελ στη διατήρηση ζωής	Δικαίωμα στην ευθα-νασία	Υποχρέωση διατήρησης στην ζωή	Ρόλος επαγγελ στην ευθανασία	Αποδοχή θανάτου	Αποφυγή θανάτου	Φόβος θανάτου	Μέσο διαφυγής	Ουδέτερη αντίδραση	DAP-R
EAS (συνολικό)	1	,808**	,808**	,780**	,544**	-,317**	-,168	-,265**	,059	,127	-,267**
Ρόλος επαγγελ στη διατήρηση ζωής		1	,471**	,544**	,465**	-,410**	-,246**	-,365**	,002	,006	-,408**
Δικαίωμα στην ευθανασία			1	,481**	,293**	-,206*	-,106	-,223*	,053	,153	-,174
Υποχρέωση διατήρησης στην ζωή				1	,347**	-,182*	-,047	-,053	,065	,144	-,085
Ρόλος επαγγελ στην ευθανασία					1	-,094	-,050	-,190*	,103	,012	-,112
Αποδοχή θανάτου						1	,269**	,364**	,282**	,178*	,801**
Αποφυγή θανάτου							1	,582**	,102	-,101	,655**
Φόβος θανάτου								1	,009	,095	,733**
Μέσο διαφυγής									1	,101	,406**
Ουδέτερη αντίδραση										1	,274**
DAP-R συνολικό											1

Case Processing Summary

		N	%
Cases	Valid	125	99,2
	Excluded[a]	1	,8
	Total	126	100,0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
,864	10

CaseProcessingSummary

		N	%
Cases	Valid	126	100,0
	Excluded[a]	0	,0
	Total	126	100,0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
,787	6

CaseProcessingSummary

		N	%
Cases	Valid	126	100,0
	Excluded[a]	0	,0
	Total	126	100,0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
,788	7

CaseProcessingSummary

		N	%
Cases	Valid	126	100,0
	Excluded[a]	0	,0
	Total	126	100,0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
,717	4

CaseProcessingSummary

		N	%
Cases	Valid	126	100,0
	Excluded[a]	0	,0
	Total	126	100,0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
,579	5

MultipleComparisons

DependentVariable: EAS

(I) Επίπεδο Εκπαίδευσης	(J) Επίπεδο Εκπαίδευσης	MeanDifference (I-J)	Std. Error	Sig.	95% ConfidenceInterval	
					Lower Bound	UpperBound
Δ.Ε.	ΤΕΙ	-4,45948	2,80179	,114	-10,0064	1,0874
	ΑΕΙ	-4,29255	2,96780	,151	-10,1681	1,5830
	Μεταπτυχιακό	-8,71869*	3,39066	,011	-15,4314	-2,0060
	Διδακτορικό	5,39409	4,83774	,267	-4,1835	14,9717
ΤΕΙ	Δ.Ε.	4,45948	2,80179	,114	-1,0874	10,0064
	ΑΕΙ	,16694	2,74889	,952	-5,2752	5,6091
	Μεταπτυχιακό	-4,25921	3,20080	,186	-10,5960	2,0776
	Διδακτορικό	9,85357*	4,70662	,038	,5356	19,1716
ΑΕΙ	Δ.Ε.	4,29255	2,96780	,151	-1,5830	10,1681
	ΤΕΙ	-,16694	2,74889	,952	-5,6091	5,2752
	Μεταπτυχιακό	-4,42615	3,34708	,189	-11,0526	2,2003
	Διδακτορικό	9,68664*	4,80730	,046	,1693	19,2040
Μεταπτυχιακό	Δ.Ε.	8,71869*	3,39066	,011	2,0060	15,4314
	ΤΕΙ	4,25921	3,20080	,186	-2,0776	10,5960
	ΑΕΙ	4,42615	3,34708	,189	-2,2003	11,0526
	Διδακτορικό	14,11278*	5,07926	,006	4,0571	24,1685
Διδακτορικό	Δ.Ε.	-5,39409	4,83774	,267	-14,9717	4,1835
	ΤΕΙ	-9,85357*	4,70662	,038	-19,1716	-,5356
	ΑΕΙ	-9,68664*	4,80730	,046	-19,2040	-,1693
	Μεταπτυχιακό	-14,11278*	5,07926	,006	-24,1685	-4,0571

*. The mean difference is significant at the 0.05 level.

Figure 3

Discussion

According to the results of the research, the average value of the euthanasia questionnaire was higher than the lower limit, and based on this it is considered that there is a positive attitude towards euthanasia. It is recalled that this limit is set at 75 points, when the average value of the sample was 79.45.

Comparison of the results of the present study with another Greek using the same questionnaire showed the following: in the study of Vourdami [7], which first used the Greek version of EAS, the average score of the EAS scale was found to be 74.6, marginal < 75 which is the limit for a positive attitude towards euthanasia, indicating that Greek doctors express themselves negatively towards euthanasia, but also to assisted suicide, although for special categories of doctors, such as, for example, oncologists, its acceptance Euthanasia ranges at a higher rate than all physicians. In addition, in the present study the mean was found to be higher (79.5) which means a more positive attitude of the sample of the present study towards euthanasia. In both studies, no statistically significant relationship was found between gender and attitude towards euthanasia, while in terms of age, younger ages had a marginally more positive view in both studies,

although statistically insignificant. In agreement with the study of Vourdami, health professionals with lower backgrounds presented a statistically significant more positive attitude towards euthanasia. However, an important difference in relation to Bourdami's work is the difference in attitude towards euthanasia among health professionals who treat patients in the final stage. In the present study, those who treated patients in the final stage (71 health professionals) showed a statistically significant positive attitude towards euthanasia (81.2), compared with those who did not receive treatment (55 health professionals) (77.2). In contrast, in the work of Vourdami, participants (18) who treated patients in the final stage had a negative attitude towards euthanasia. This difference may be due to the relatively small sample of health professionals in the work of Bourdamis who treats end-stage patients. In a study by Mickiewicz., *et al*. [9] referring to a study in Spain, the results show greater acceptance of euthanasia and assisted suicide. Similarly, Finnish nurses (40%) and the Finnish public (50%) agreed that in some cases euthanasia is acceptable [10]. Another Greek study from 2010 showed that a large number of respondents (47% of doctors, 45.2% of nurses, 49.1% of relatives and 52.8% of mothers) approved the legalization of an accelerated death by a patient with end-stage cancer [11]. Also, in a Yugoslav study from 1988, more than half of the people in the sample who were oncologists, family doctors, medical students and nurses opposed active euthanasia and its legalization [12].

Regarding the determinants that influence attitudes towards euthanasia, the present study showed the significant effect of the level of education, as according to the results of the research, PhD holders have a clearly more negative attitude towards euthanasia compared to other people who participated in her. However, there are other studies that have shown the influence of other factors in shaping people's attitudes towards euthanasia [9,10]. In the Netherlands, a study of 1509 nurses found that less than half of respondents (45%) would be willing to serve on committees that examined cases of euthanasia and PAS [13]. In countries such as Israel, a high degree of euthanasia support was also found (50% - 67%), with the exact degree of support depending on whether the person had known the patient or, conversely, had significant contact with the intensive care unit patient treatment [14].

The highest levels of support for euthanasia have been found in countries such as Belgium, where euthanasia has already been decriminalized, as noted in the theoretical section of this paper. A study of 3327 nurses found that 92% believed they would give lethal doses to patients who had been explicitly asked and who suffered from extreme levels of uncontrollable pain or other discomfort [15-45].

Limitations of the Study

In any case, the possible weaknesses and shortcomings of the present research should be noted, with the first and perhaps most important being the relatively small sample. The sample size appears to have to some extent influenced the factor analysis performed, resulting in a small deviation in the generated factors of one of the two questionnaires. In addition, the use of convenience sampling by this particular hospital means that the population of participating health professionals is not representative. This potentially creates problems with sampling bias and does not allow the generalizability of the results to be generalized. In any case, the issue is so important that further study is needed to draw useful conclusions and help understand this very specific issue.

Conclusion

The findings of this study showed that the doctors and nurses of the sample were marginally positive against euthanasia and assisted suicide, which is a difference compared to previous research in Greece and on the other hand, a convergence with the belief that It appears to have been formed in the European Union, as shown by a number of relevant surveys reported in the context of this dissertation on Belgium, Spain, the United Kingdom and others. However, it should be noted that the attempt to link the pro-euthanasia position with some specific beliefs of the respondents regarding their attitude towards the phenomenon of death did not appear to produce statistically significant differences.

This fact can also be diagnosed as a condition in which people are in favor of or against euthanasia and this is not related to their opinion on the phenomenon of death. It would be interesting to generalize the study and the attempt to link the two issues to a more extensive sample, which would include people of different professional orientations, in order to determine whether engaging in healthcare is a key factor in stimulating or not stimulating. the positive attitude towards euthanasia.

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