Доклади на Българската академия на науките
Comptes rendus de l'Académie bulgare des Sciences
Tome 79, No 11, 2026

MEDICINE
Forensic medicine

PHYSICIANS' ATTITUDES TOWARDS EUTHANASIA IN TURKEY: THE IMPACT OF RELIGIOSITY AND SOCIOECONOMIC DEVELOPMENT

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Received on August 11, 2026
Presented by D. Damianov, Member of BAS, on October 27, 2026

Abstract

Socioeconomic development and religious belief are determining factors in physicians' attitudes towards euthanasia in Turkey. The aim of this study is to evaluate the impact of physicians' sociodemographic characteristics, religious self-identification, and regional socioeconomic development on their euthanasia attitudes. This descriptive, cross-sectional study was conducted via an online questionnaire (Nov 29, 2023 - Apr 30, 2024) among physicians across Turkey. Data were analyzed using SPSS 21 via Pearson Chi-square and multivariate logistic regression. Of the 2653 participating physicians, 53.5% support euthanasia, and 57.2% support passive euthanasia. While 60.8% of physicians in the most socioeconomically developed provinces view euthanasia positively, support decreases as development declines ($p < 0.001$). Non-religious physicians support euthanasia 8.8 times more than religious ones (OR: 8.815; 95% CI: 7.234–10.742; $p < 0.001$). In conclusion, sociocultural and religious structures must be considered when establishing legal regulations and health policies regarding end-of-life decisions.

Key words: euthanasia, physician, socioeconomic development level, religious belief

Introduction. The word euthanasia translates to "good death". According to the World Medical Association, it is the administration of a lethal substance by

https://doi.org/10.7546/CRABS.2026.11.15

a physician at the explicit request of a patient with decision-making capacity [1]. It is categorized into active euthanasia (direct application causing death), passive euthanasia (withdrawing life-sustaining treatment), and physician-assisted suicide (PAS) (providing medical means for the patient to end their life) [2].

Euthanasia remains highly controversial. Following historical debates, late 20th-century initiatives led to its legalization in certain countries based on their distinct legal and ethical structures [3]. Today, active euthanasia is practiced in nations like the Netherlands, Belgium, Canada, and Spain [4]. Religiosity is a primary factor opposing the legalization of life-terminating interventions [5]. Countries where it is legal generally possess secular tendencies [6]. Major world religions often reject these practices, believing they negatively affect destiny after death [5, 6].

The aim of this study is to evaluate the impact of physicians' sociodemographic characteristics, religious self-identification, and regional socioeconomic development on their attitudes towards euthanasia.

Materials and methods. ***Study design.*** This descriptive cross-sectional study was approved by the Ondokuz Mayis University Clinical Research Ethics Committee (B.30.2.ODM.0.20.08/574). Data were collected online between Nov 29, 2023, and Apr 30, 2024.

Population and sample. The population of the study consists of physicians working in various public and private healthcare institutions across Turkey. According to the 2023 Health Statistics Yearbook data, there is a total of 204 223 physicians in Turkey [7]. The sample size was statistically calculated as 384, with an anticipated frequency of 50%, a 5% margin of error, and a 95% confidence interval. The distribution of the participants by their titles and the provinces they work in shows similarity to the general population data.

Data collection and classification. A questionnaire inquiring about sociodemographic characteristics, occupational information, and attitudes was used as the data collection tool. The socioeconomic development level of the provinces where the participants live was classified from the 1st tier (most developed) to the 6th tier (least developed) based on the Socio-Economic Development Ranking of Provinces (SEGE) reports published by the Republic of Turkey Ministry of Industry and Technology [8].

Statistical analysis. Data analysis was performed using IBM SPSS version 21.0. The Pearson Chi-square test was used for comparisons between groups, and multivariate logistic regression analysis was used to determine independent influencing factors ($p < 0.05$). The study findings were reported in accordance with the STROBE criteria.

Results. Of the 2653 participants, 49.6% ($n = 1315$) were female, and the mean age was 40.17 ± 12.7 years. General practitioners formed the largest group at 22.2% ($n = 589$). Most participants lived in 1st-tier developed provinces (46.5%, $n = 1234$). Regarding religion, 37% ($n = 981$) self-identified as religious (Table 1).

Table 1

Distribution of participants' demographic characteristics

	n	%
Gender		
Female	1315	49.6
Male	1338	50.4
Marital status		
Married	1703	64.2
Single	801	30.2
Divorced	149	5.6
Parental status		
With children	1506	56.8
Without children	1147	43.2
Professional title		
General practitioner	589	22.2
Resident physician	579	21.8
Specialist physician	490	18.5
Assistant professor	205	7.7
Associate professor	338	12.7
Professor	452	17
Province development level		
1st-level developed province	1234	46.5
2nd-level developed province	394	14.9
3rd-level developed province	464	17.5
4th-level developed province	237	8.9
5th-level developed province	171	6.4
6th-level developed province	153	5.8
Self-identified religiosity		
Yes	981	37
Undecided	502	18.9
No	1170	44.1

Overall, 53.5% ($n = 1419$) supported euthanasia, while 46.5% opposed it. Passive euthanasia was supported by 57.2% ($n = 1518$). Support reached 60.8% in 1st-tier provinces and fell to 44.4% in the least developed ones ($p < 0.001$) (Table 2).

In the multivariate analysis, when 1st-tier developed provinces were taken as the reference, the probability of supporting euthanasia significantly decreased as the development level declined. It was determined that participants who described themselves as non-religious were approximately 8.8 times more likely to support euthanasia compared to religious participants (OR: 8.815; 95% CI: 7.234–10.742;

Table 2

Association between sociodemographic characteristics and support for euthanasia

	Do you think euthanasia should be performed?		Total	p
	Yes	No		
Province development level				
1st-level developed province	750[a] (60.8)	484[b] (39.2)	1234	**<0.001**
2nd-level developed province	207[a] (52.5)	187[a] (47.5)	394	
3rd-level developed province	221[a] (47.6)	243[b] (52.4)	464	
4th-level developed province	103[a] (43.5)	134[b] (56.5)	237	
5th-level developed province	70[a] (40.9)	101[b] (59.1)	171	
6th-level developed province	68[a] (44.4)	85[b] (55.6)	153	
Self-identified religiosity				
Yes	254[a] (25.9)	727[b](74.1)	981	**<0.001**
Undecided	274[a] (54.6)	228[a] (45.4)	502	
No	891[a] (76.2)	279[b] (23.8)	1170	

Within each row, different superscript letters (a and b) indicate a statistically significant difference between column proportions ($p < 0.05$), whereas the same superscript letter indicates no statistically significant difference. Bold p-values indicate statistical significance ($p < 0.05$).

$p < 0.001$). The probability of supporting euthanasia among the undecided group was 3.5 times higher compared to religious participants (OR: 3.454; 95% CI: 2.749–4.339; $p < 0.001$) (Table 3).

Table 3

Multivariate analysis of attitudes towards euthanasia according to province development level and religious self-identification

	OR	(95% CI)	p
Province development level			
1st-level developed province	1		**<0.001**
2nd-level developed province	0.875	0.678–1.131	0.309
3rd-level developed province	0.662	0.521–0.841	**0.001**
4th-level developed province	0.565	0.414–0.773	**<0.001**
5th-level developed province	0.585	0.407–0.841	**0.004**
6th-level developed province	0.590	0.404–0.860	**0.006**
Self-identified religiosity			
Yes	1		**<0.001**
Undecided	3.454	2.749–4.339	**<0.001**
No	8.815	7.234–10.742	**<0.001**
Constant	0.437		**<0.001**

Cox & Snell R Square = 0.200, Nagelkerke R Square = 0.268, Accuracy= 0.721.
Bold p-values indicate statistical significance ($p < 0.05$).

Discussion. Euthanasia is one of the most controversial issues regarding the termination of life, where medical ethics and law intersect. While the idea that every individual deserves a dignified death is emphasized by those who advocate for euthanasia, those who believe in the absolute inviolability of human life state that euthanasia is unacceptable [9].

In studies regarding physicians' views on euthanasia in Turkey, it is observed that support rates for the practice of euthanasia vary considerably [10, 11]. Major studies evaluating physicians' attitudes towards euthanasia abroad also report that support rates show dramatic differences, evidencing the lack of an international consensus [12–14].

In our study, 53.5% of the 2653 physicians support applying euthanasia. Similarly, Özkara et al. [11] found that 49.9% of physicians supported it if specific legal conditions were met. On the other hand, a longitudinal analysis by Inglehart et al. [15] across 62 countries showed Turkey ranked 57th in public support, with positive attitudes decreasing over the years. In contrast, our findings reveal support among Turkish physicians has increased [11]. This situation may stem from rising education levels, euthanasia becoming a more visible global debate, and the growing importance of patient autonomy.

In Belgium and the Netherlands, where euthanasia is legal, support rates among physicians are remarkably high [13]. In contrast, in countries like the United Kingdom where it is prohibited, healthcare professionals predominantly express opposing views [14]. In Asian and Middle Eastern regions, support rates are also generally lower due to strong religious and cultural codes [12]. These global contrasts relate to deep-rooted differences in ethical understanding, legal norms, and healthcare systems. In our study, 57.2% of physicians support passive euthanasia. Evaluating Turkish literature on a timeline shows this support gradually increasing [16], likely related to increasing legal awareness in end-of-life decisions.

In our study, it has been statistically proven that as the socioeconomic development level decreases, the support for euthanasia decreases. The analysis by Inglehart et al. [15] also demonstrates that socioeconomic handicaps, such as a shortened life expectancy and a low gross national product, are directly correlated with negative attitudes towards euthanasia. The strength of traditional family bonds and the preservation of conservative practices in less developed provinces may have made physicians' attitudes more distant [17]. In developed provinces, on the other hand, high levels of urbanization, education, and income, along with optimal access to healthcare services, pave the way for individuals to prioritize autonomy in their end-of-life decisions [8, 18].

Religious self-identification is one of the strongest predictors in physicians' attitudes towards euthanasia. In our analysis, participants who did not describe themselves as religious provided the strongest support for euthanasia, while religious participants were the least supportive group. Comprehensive literature

reviews also confirm that as the degree of religious commitment increases among healthcare professionals, approval for interventions aimed at terminating life drops dramatically [19, 20]. The fact that religious individuals' perceptions of life and death are based on sanctity-based references is directly connected to their rejection of euthanasia practices.

This study aims to better understand physicians' attitudes regarding euthanasia and to help develop more conscious health policies in the context of patient rights. In the future, qualitative studies are needed to measure the extent of medicolegal concerns and psychological burdens that physicians may experience in end-of-life practices.

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