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Contents

С дълбока с кръв в душите съобщаваме, че на 76-годишна възраст ни напусна проф. д-р Васил Анастасов, д.м.н., доайен на Съдовата хирургия и ангилогията в България, дългогодишен учен и специалист със световно признание, далеч надхвърлящ националните измерения.

Професор Анастасов е роден в Сунгурлу, Гърция на 28 март 1944г. Завършва Карловската гимназия „Васил Левски", а през 1968 ВМИ „И. П. Павлов" гр. Пловдив. Специалист по обща хирургия, съдова хирургия и ангиология.

Професор Анастасов е от съоснователите на специалността „Съдова хирургия и ангиология" в България. Основател на Националното дружество по Съдова хирургия и ангиология, дългогодишен главен редактор на списание „Съдова хирургия и ангиология", член на ред. колегията на списание Folia medica, дългогодишен зам. председател на Националното дружество по Съдова хирургия и ангиология.

Специализирал във Франция, Италия, Куба, Белгия, САЩ, Русия, Турция, Гърция. Ерудит, владеещ 5 езика. Автор на над 200 научни публикации и съобщения в наши и чуждестранни издания, съавтор на 8 монографии и учебници по съдова хирургия.

Професор Анастасов бе един от основателите на днешната Клиника по Съдова хирургия и ангиология към УМБАЛ „Св. Георги" и катедра по Сърдечно-съдова хирургия към МУ – Пловдив. Дългогодишен преподавател, в последствие ръководител на клиника по „Съдова хирургия и ангиология" и катедра по Сърдечно-съдова

хирургия. Изградил няколко поколения специалисти в тази област.

Професор Анастасов бе член на редица световни и национални съюзи и организации, сред които: Европейската асоциация по съдова хирургия и ангиология, Световния форум по флебология, международния съюз по ангиология, почетен член на Гръцкото национално дружество по Съдова хирургия и ангиология; Представя България като член в Средиземноморската лига по Съдова хирургия и ангилогия.

Награден с приз Лекар на България за 2009г и най-добър съдов хирург за Пловдив в анкетата на Дарик радио от 2013г.

Професор д-р Васил Анастасов бе всепризнат специалист във България и света, извършил хиляди операции в страната и десетки из цяла Европа. Лектор по Съдова хирургия в университетите на Рим, Флоренция и Неапол. Виден карловец и родолюбец, спасил хиляди човешки животи.

До последния си дъх остана верен на медицинското изкуство, отзоваваше се на всеки помолил за съдействие и подкрепа, с висок морал и голямо сърце! Живя в хармония с идеалите си, с голяма грижа към болките на хората, честно и скромно!

Поклон пред светлата му памет !

д-р Богомила Чешмеджиева, д.м.
Колектива на Клиника по съдова хирургия и ангиология
УМБАЛ“Св.Георги“ЕАД

Quality of Life of the Elderly Suffering from Diabetes Mellitus

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Abstract

Introduction: Old age is directly linked to the development of chronic diseases. One of them, and prominent, is Type 2 Diabetes Mellitus (SSD2) while Type 1 Diabetes Mellitus (SSD1) is very rare in the elderly.
Purpose: The purpose of this study was to investigate the effects of diabetes on quality of life in elderly people and their treatment.
Methodology: The study material consisted of articles on the topic found in Greek and international databases such as: Google Scholar, Mednet, Pubmed, Medline and the Hellenic Academic Libraries Association (HEAL-Link).
Results: Diabetes Mellitus is a complex disease characterized by many symptoms of which the most prominent and most prominent are hyperglycemia (blood sugar elevation) and glucosuria (the onset of blood sugar) which are often expressed in the patient with polydipsia and with polyuria not uncommon is accompanied by weight loss. More than 20% of the general population has SD. over 65 years. This percentage is increasing as the number of older people increases, as the age limit increases.
Conclusions: Elderly people with diabetes have a poorer quality of life compared to the general population. In addition, most antidiabetic treatments are associated with weight gain which has a negative impact on patients' quality of life.
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Keywords: *diabetes mellitus, effects, third age and treatment*

1. INTRODUCTION

Old age is directly linked to the development of chronic diseases. One of them, and prominent, is Type 2 Diabetes Mellitus (SSD2) while Type 1 Diabetes Mellitus (SSD1) is very rare in the elderly. [1]

The symptomology of AD is usually milder when it occurs in the early stages in older people. It manifests with fatigue, muscle weakness, weight loss but without missing the main symptoms of diabetes such as polyuria, polydipsia, polyphagia. [2]

Hypoglycemic non-ketoic hyperosmotic coma (YMVYK) and Arterial Stroke (SAE) are likely to occur first whereas ketoacidosis is rarely (unless there is infection, myocardial infarction, and other strokes). [3]

It is clear that people with AD are at greater risk of acute and chronic complications such as micro- and macro-angiopathy. In addition, due to age and coexistence of other diseases, increased mortality

in complications, difficulties in monitoring and adjusting for health problems such as moving or financial difficulties, inability to self-care and care. All of this has a detrimental effect on the lives of diabetics and their quality of life. [4]

The **purpose** of this study was to investigate the effects of diabetes on quality of life in elderly people and their treatment.

The **study material** consisted of articles on the topic found in Greek and international databases such as: Google Scholar, Mednet, Pubmed, Medline and the Hellenic Academic Libraries Association (HEAL-Link), using keywords: diabetes mellitus, Impact, Elderly Age and Treatment.

2. SPEAKING ABOUT THE QUALITY OF LIFE OF ELDERLY DIABETES

Diabetes Mellitus is a complex disease characterized by many symptoms of which the most prominent and most prominent are hyperglycemia (blood sugar elevation) and glucosuria (the onset of blood sugar) which are often expressed in the patient with polydipsia and with polyuria not uncommon is accompanied by weight loss. [5]

More than 20% of the general population has SD. over 65 years. This percentage is increasing as the number of older people increases, as the age limit increases. [6]

The development of SD attributed to older ages [7]:

worsening tolerance to glucose and insulin secretion disorder, which is attributed to the normal aging of the human body.

Elderly people with diabetes are a heterogeneous group with a different life expectancy, accompanied by the chronic conditions that accompany it and their ability to self-control blood glucose or make an insulin injection themselves if needed. [8]

The prognosis for older people with diabetes is worse than for their non-diabetic peers. On average, they live fewer years. In the diabetic group, patients over the age of 75 are at greater risk of developing chronic complications. These individuals are more susceptible to myocardial infarction and end-stage renal disease and are twice as often hospitalized for hypoglycemia. [9]

The presence of diabetic complications [mainly cardiovascular complications, visual disturbances (up to blindness), renal failure, neuropathy, diabetic foot and possibly amputation of the lower leg] results in physical disabilities, lack of self-care, life for the elderly sufferer and his family. [10]

In addition, the treatment itself, by increasing body weight (which mainly affects women) and causing hypoglycemia, burdens both the regulation of MS and the quality of life of patients. [11]

Many factors can affect patients 'degree of compliance, including patients' demographic and psychological characteristics, factors related to the disease itself as well as factors related to health care systems. [12] Family problems or psychological disorders can affect patients' ability to effectively manage their illness, thus making them inadequate to cope with it, thus burdening their quality of life. [13]

Older people with diabetes need to adapt to a different lifestyle and accept the limitations of diabetes. Treatment must be personalized. Elderly people with long-term diabetes and numerous chronic complications need a more liberal approach to achieve specific treatment goals. Additional objectives should be to avoid hypoglycemia, safety of treatment, and patient acceptance. [14]

The recommended dietary recommendation of the elderly in nutrient macronutrients and personalization of their carbohydrate and fat content are no different from the general

recommendations for middle-aged diabetic patients. [15] However, any increase in dietary fiber should be done cautiously in the elderly, especially those who are not ambulatory or tend to dehydrate. Due to the reduced alcohol tolerance with increasing age, alcohol absorption by elderly patients should be carefully considered. [5]

Exercise can significantly reduce the decline in maximal aerobic capacity (VO2) that occurs with age, improve risk factors for atherosclerosis, slow down age-related muscle mass decline, reduce overall body thickness and improve insulin sensitivity. All of these can be beneficial for elderly patients with diabetes, promoting the quality of their daily lives. [16]

In elderly patients with STDs, weight loss has been associated with improved sleep quality, mental health, quality of life and more generally the patients' psychosocial health. [17] Results from recent studies have shown that reducing or neutralizing the body weight provided by new treatments based on the incretin effect can lead to improved patient compliance, resulting in improved treatment satisfaction and improvement. quality of life, but these drugs do not work in people with long-term ST so they are rarely given without co-administration of other drugs. [18]

3. CONCLUSION

Elderly people with diabetes have a poorer quality of life compared to the general population. In addition, most antidiabetic treatments are associated with weight gain which has a negative impact on patients' quality of life. Also crucial are the personality and emotional reactions of the elderly diabetic and how they can affect the course of the disease. Therefore, it is necessary to create prevention, treatment and health promotion programs that could play a decisive role in modifying those factors that appear to affect the quality of life of older patients. [19].

References:

1. Evangelia, N., Kastorin, Ch., & Panagiotakos, D. (2011). Nutritional standards and diabetes mellitus. Greek Journal of Dietetics and Nutrition, 1 (2), 78-86.
2. Katsiki, N., Eliadis, F., Zantidis, A., & Didangelos, T. (2009). Diabetes mellitus: Diagnosis and classification. Diabetes Care, 32, 1.
3. Sotiropoulos, AE., Apostolou, ON, (2008). Diabetic ketoacidosis and hyperglycemic non-keto hyperglycemic coma. MEDICAL, 94 (3), 350-367.
4. Pita, R., Grigoriadou, E., Marina, E., Kouvatsou, Z., Didangelo, T., Karamitsos, D., (2006). Quality of Life and Type 1 Diabetes. Greek Diabetic Chronicles, 19 (4), 282-294.4. Pita, R., Grigoriadou, E., Marina, E., Kouvatsou, Z., Didangelo, T., Karamitsos, D., (2006). Quality of Life and Type 1 Diabetes. Greek Diabetic Chronicles, 19 (4), 282-294.
5. Yfantopoulos G., Sarris M. (2001). "Health-related quality of life. Measurement methodology ". Greek Medical Archives 18 (3): 218-229
6. Sarris M. (2001) "Sociology of Health and Quality of Life". Papazisis Publications, Athens.

7. Atlas, D. (2015). International diabetes federation. IDF Diabetes Atlas, 7th edn. Brussels, Belgium: International Diabetes Federation.
8. American Diabetes Association. (2013). Diagnosis and classification of diabetes mellitus. Diabetes care, 36 (Supplement 1), S67-S74.
9. Atkinson, M. A., Eisenbarth, G. S., & Michels, A. W. (2014). Type 1 diabetes. The Lancet, 383 (9911), 69-82.
10. Kirkman, M. S., Briscoe, V. J., Clark, N., Florez, H., Haas, L. B., Halter, J. B., & Pratley, R. E. (2012). Diabetes in older adults. Diabetes care, 35 (12), 2650-2664.
11. Scully, T. (2012). Diabetes in numbers. Nature, 485 (7398), S2.
12. Goldstein, D. E., Little, R. R., Lorenz, R. A., Malone, J. I., Nathan, D., Peterson, C. M., & Sacks, D. B. (2004). Tests of glycemia in diabetes. Diabetes care, 27 (7), 1761-1773.
13. Rubin, R. R. (2000). Diabetes and quality of life. Diabetes Spectrum, 13 (1), 21-21.
14. Alam, U., Asghar, O., Azmi, S., & Malik, R. A. (2014). General aspects of diabetes mellitus. In Handbook of clinical neurology (Vol. 126, pp. 211-222). Elsevier.
15. Jönsson, B. (2002). Revealing the cost of Type II diabetes in Europe. Diabetologia, 45 (1), S5-S12.
16. Daphogiannis-Kourtis, C. (1995). The training of diabetic child in the regulation of diabetes mellitus in relation to physical exercise (Doctoral dissertation, National and Kapodistrian University of Athens (NERC). School of Health Sciences. Department of Nursing).
17. Hellenic Diabetic Society, Contemporary Diabetes, Medical Publications Page, Athens: 2019.
18. Karamitsos D., Diabetology (bound edition) Theories and Practices in the Treatment of Diabetes, Siokis Medical Publications: 2009.
19. Tachtsoglou K., Eliadis Ch., (2015). Impact of diabetes on the quality of life of patients. Perioperative Nursing 4 (2): 50 - 57.

Evaluation of the Effect of Dark Triad on Motivatıon and Conflict of Interest in Hospitals

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Abstract

Organizational behavior literature states that the behaviors of the employees towards themselves, each other and the organizational structure and system are not always positive and they sometimes exhibit some negative, destructive, undesirable behaviors that prevent productivity and efficiency. The studies indicate that such behaviors, which are called negative behaviors, have increased since 1990s due to various reasons and need to be examined comprehensively. From this point of view, the concept of the dark triad determines the extent to which organizational employees' behaviors conform to the classification of narcissism, machiavelism and psychopathy, and predicts their possible consequences.

The aim of this study is to determine the degree of personality traits of narcissism, machiavelism and psychopathy, which are called dark triad, and the effects of these behaviors on motivation and conflict. Data were obtained from 200 people who had validated questionnaires from the questionnaires applied by face-to-face interviews from 4 private hospitals which were determined by convenience sampling.

As a result of the study, machiavelism, which is one of the dark triad dimensions, was not found to have a significant relationship with conflict and it was found that there was a very weak positive relationship with motivation ($p < 0.05$). On the other hand, psychopathy and narcissism personality traits had a positive and weakly significant relationship on conflict and motivation ($p < 0.05$).

Keywords: *Dark Triad, Motivation, Conflict of Interest*

Introduction

According to Kowalski (2001), three of the socially disturbing personality behaviors were particularly striking (Machiavellianism, narcissism and psychopathy) and organizational psychology researchers started to work on the subject. The concept of dark triad, which emerges from this point of view, is used in organizations to describe the undesirable three personality traits. Although these three concepts differ conceptually, the dark triad personality traits show a positive correlation with each other when practices are performed in the normal population and are handled together. Research on the Dark Triad has increased considerably in recent decades and is still on the rise. Just between 2002 and 2009, Google Scholar hit analysis reveals a 38-fold increase in the dark triad's scientific research. Although research on the Dark Triad has increased

in number, it can still be said that little is known about it and the debate about the organizational consequences of the dark triad still continues. Because the effect of narcissism, makyevelism and psychopathy on organizational outcomes is highly variable and it is not possible to say anything clearly. In particular, some researchers argue that Machievelism and psychopathy have a negative effect on organizational outcomes than narcissism (Özsoy, 2018;

Jonason and Webster, 2010; Paulhus and Williams, 2002; Rogoza and Cieciuch, 2018; Furnham et al, 2013).

Dark Triad.

Dark triad consists of three dimensions in psychology and organizational behavior literature. These are Machiavellianism, narcissism and psychopathy.

a) Narcissism

The term narcissism dates back to Greek mythology. According to legend, Narkissos, who is quite handsome, does not respond to the love of the beautiful fairy Echo. Narkissos, so punished by the gods, owns a river where he goes to drink water. she sees her reflection and falls in love with her. Whatever he does, he can't stop looking at his own reflection and dies just by the river (Koçak, 2014).

Narcissism was first associated with Narcissus the hunter by Havelock Ellis (1898), before being studied by psychoanalytic theorists, and was discussed in the context of auto-eroticism (self-evaluation as a libidinal object). In later years narcissism became a concept that early psychoanalytic theorists (Freud, 1914), object relations theorists (eg, Kernberg, 1967) and self theorists (eg, Kohut, 1977) frequently worked (Eldoğan, 2016).

The structure of subclinical or normal narcissism emerged from Raskin and Hall (1979) attempts to describe a subclinical version of personality disorder described by DSM. Factors obtained from clinical syndrome included randiosity, entitlement, dominance, and superiority (Paulhus and Williams, 2002).

b) Psychopathy

The adaptation of psychopathy to the subclinical field is the newest of the three (Hare, 1985; Lilienfeld and Andrews, 1996). The central character elements include high impulsivity and excitement seeking along with low empathy and anxiety (Paulhus and Williams, 2002)

Despite their different origins, the personalities that make up the Dark Triad have some common features. All three have varying degrees of socially malicious character with self-promotion, emotional coldness, duplicity, and aggressiveness. (Paulhus and Williams, 2002).

According to some authors (Levenson et al., 1995; Jones and Paulhus, 2002; Babiak and Hare, 2006; Skeem et al., 2011; Eveertsson and Meehan, 2012; Mathieu et al., 2014), the most basic characteristics of psychopaths are;

• The tendency to behave out of morality,

• The tendency to despise and ridicule people,

• The tendency to feel remorse and emotionless; mismatch,

• Not paying too much attention to human relationships and often having difficulty getting along with others,

• Frequent impulsive behavior. Psychopaths tend to make sudden and sharp decisions without thinking in detail in the extension of impulsivity (Özsoy and Ardıç, 2017) .

c) Machiavellianism

Machiavellian concept came from the book "The Prince" written by the Italian politician Niccolo Machiavelli who lived in the 16th century and wrote his political thoughts and recommendations. In this book, Machiavelli states that, in general, a manager should be open to using all interpersonal manipulative

tactics such as looting and lying in order to achieve his aim, in other words he advocates the approach that şey everything is permissible on the path to purpose (Jones and Paulhus, 2009).

Psychopaths behave impulsively, abandon friends, and family, and pay little attention to their reputations, but makyeveklists plan ahead, build alliances, and do their best to maintain a positive reputation. Moreover, Machiavellians are more strategic than impulsive. They refrain from manipulating family members and avoid any behavioral tactics, such as weakness, that could damage their reputation. In summary, appear to be (a) manipulativeness, (b) callous affect, and (c) a strategic-calculating orientation. This last element is often overlooked by researchers. (Jones and Paulhus, 2014).

Conflict of Interests

Conflict refers to a situation that arises in the presence of incompatible situations in the most general sense. Conflict is a situation in which an individual obstructs, obstructs or limits his or her goals and aspirations in an effort to achieve one's goals and aspirations. The fact that two or more parties have different interests, goals, values and beliefs or misunderstandings can be considered as sources of conflict. (Deutsch, 2003).

Conflict in business is defined as a process in which employees or groups prevent each other to achieve their goals and interests. In other words, conflict is a process in which A turns to any preventive behavior in order to prevent B from achieving his goals and interests. In order to be able to talk about the conflict in the business, even if there is a situation that may create a conflict, the conflict does not occur unless one or both parties are aware of it and clearly perceive it (Robbins, 2003).

The organizational psychology literature approaches conflict as traditional, behavioral and interactionist. The traditional approach sees any conflict in the enterprise as unnecessary and damaging to the enterprise. Conflict is therefore a negative situation for the enterprise and should be avoided by both individuals and groups. According to the traditional approach, it has given supportive results in the researches about group behavior in 1930-1940s. Behavioral approach is perceived as a natural formation for businesses and groups. According to the behavioral approach, conflict is inevitable and has some benefits for the business. Behavioral approach was widely accepted from the 1940s to the mid-1970s. Unlike the behavioral approach, the interactive approach sees conflict as positive. For this reason, the greatest contribution of the conflict in the interactive approach is that the group can create a good working environment with an appropriate leadership model in which the group can evaluate itself and use its creativity. (Özkalp and Kırel 2005)

Motivation

The concept of motivation is one of the oldest issues in business literature. The concept is derived from the word "Motive" in English and French. Motivation can be defined in the most general sense as the sum of efforts to continuously mobilize one or more people towards a specific purpose. (Eren, 2001).

The concept of motivation can be thought of as magic, which in some cases can be understood as something mysterious and immediately leads people to be productive and ready to give energy to work. Motivation,

however, is more about how employees are treated and perceive their work rather than something magical. (Keenan, 1996). Another reason why motivation is so incomprehensible is that motivation cannot be easily seen directly and can be determined by estimating the employee's behaviors. (Steers and Porter, 1987).

Method

Purpose and Importance of Study

It is extremely important that business employees work in harmony with each other. The undisputed necessity of teamwork, especially in healthcare, makes this even more important. This situation is related to the personality traits of the employees. According to the personality characteristics of the employees, the type and number of conflicts seen in the enterprises change and their solutions and possible consequences differ. According to the current approach, conflict in enterprises is inevitable and seen as a necessity for self-renewal and evaluation of the business, but it can have destructive consequences as a result of not being managed properly. On the other hand, personality traits can affect one's perception of his / her job and the energy he / she will spend on his / her job. Therefore, non-clinical personality traits can affect both conflict and motivation. The aim of the study, which is planned from this point of view, is to reveal the effect of dark triad on conflict and motivation.

Hypotesis of the study

H1:Dark triad dimensions are effective on conflict.

H2: Dark triad dimensions are effective on motivation.

Type of Study

The study was planned as cross-sectional and descriptive.

Population, Sample and Limitations

The population of the study consists of private hospitals in Istanbul. Accordingly, the data of the study were obtained from physicians, nurses and assistant health personnel working in 4 private hospitals in Istanbul between 15.02.2019-20.04.2019 and who were selected by convenience sampling and accepted to participate in the study.

Data collection method and analysis of data

In order to measure the conflict level, 21 Organizational Conflict Inventory I "(ROCI-I) scale, which was developed by Rahim (1983) and was taken from Güler's (2009) research, was used. The questions were divided into five answer options: strongly disagree, disagree, undecided, agree and strongly agree, and the respondents were asked to mark the most appropriate option for them. In the scale, as the answers given to the questions 4, 5, 9, 10, 11, 12, 16 and 19 approach the option of absolutely agree, the degree of conflict increases.

In order to measure the motivation levels of hospital employees, the Motivational Stability Scale, developed by Constantin, Holman and Hojbotă (2011), was obtained from the Turkish Version of the Motivational Stability Scale: Validity and Reliability Study (Sarıçam et al., 2013). The scale consists of 13 questions and is scored as 1 (I strongly disagree) and 5 (I strongly agree). As the scores given to the questions increased, the level of motivation increased.

In order to measure the dark triad (machiavelism, psychopathy, narcissism) characteristics of the employees, the Dark Triad Scale, which was developed by Jonason and Webster (2010) and taken from the Dark Triad Scale: Turkish Adaptation Study (Eraslan-Çapan et al., 2015), was used. The scale consists of 12 questions and each question is scored as 1 (Strongly Disagree)

and 9 (Strongly Agree). Of the questions, the total of questions 1,2,3 and 4 are machiavelism, the total of questions 5,6,7 and 8 are psychopathy and the total of 9,10,11 and 12 questions are narcissism.

In the research, frequency tables, central and prevalence criteria and Pearson correlation test were used. 0.05 was used as the level of statistical significance. In addition, one sample Kolmogorov-Smirnow test, examination of central-prevalence criteria and histogram were tested for the normal distribution of the data. as a result, it was found that the data corresponded to the normal distribution. Therefore, parametric hypothesis tests were used in the study.

Result of Reliability and Validity Analysis

The reliability analysis of the conflict scale was conducted and the coefficient of alfa=0.90 was reached. There were no negative effects on the scale. On the other hand, the cronbach alpha value of the motivation scale was found to be 0.95. On the dark triple scale, the alpha value was 0.94 and again no negative effect was found. The KMO value of the multi-factor analysis for the validity of the conflict scale was 0.89. In Bartlett's Sphericity Test, p <0.05. Total variance explanation was found to be 60,742%. As the first factor explained 35.48% of the total variance, the single factor structure was put forward by considering the aim of the study. On the motivation scale, the KMO value was 0.94 and the Bartlett Sphericity Test was p <0.05. Single-factor structure has emerged, the variance is 60.85 percent explanation.

KMO value in the dark triple scale was 0.80 and Bartlett's Sphericity Test was p <0.05. The three-factor structure and item distribution, which is the same as the original scale, emerged and explained 69.30% of the total variance. According to this, articles 1,2,3 and 4 show machiavelism, items 5,6,7 and 8 show psychopathy, items 9,10,11 and 12 show narcissism.

FINDINGS

Characteristics	Categories	f	%
Gender	Male	83	41,5
	Female	117	58,5
Age	20-30	111	55,5
	31-40	70	35,0
	41-50	18	9,0
	50+	1	0,5
Educational Status	High School	47	23,5
	Vocational School	50	25,0
	Bachelor	69	34,5
	Master	32	16,0
	Doctorate	2	1,0
Administrative duty	Yes	45	22,5
	No	155	77,5
Position	Phycian	9	4,5
	Nurse	84	42,0
	Auxiliary health personnel	107	53,5
Total		**200**	**100,0**

Table 1:*Some Socio-Demographic and Professional Characteristics of the Participants*

58,5% of the participants were female, 55,5% were between the ages of 20-30, 34,5% were backhelor and 53,5% were auxiliary health personnel (physiotherapist, medical attendant, medical technologist etc.).

	Conflict	Motivation	Machiavellianism	Psychopathy	Narcissism
Mean	3,09	3,38	1,85	2,15	3,39
Median	3,19	3,69	1,50	2,00	2,50
Mode	3,48	3,54	1,00	1,00	1,00
St.Deviation	0,74	1,07	1,14	1,22	1,45
Min	1,14	1,00	1,00	1,00	1,00
Max	5,00	5,00	7,00	7,25	9,00

Table 2: *Conflict, Motivation and Dark Triad Dimensions Mean*

The mean conflict of the participants was 3,09 ± (0,74), the mean motivation was 3,38 ± (1,07), the average of machiavelism was 1,85 ± (1,14), the mean of psychopathy was 2,15 ± (1,22) and The mean narcissism was 3.39 ± (2.45).

		1	2	3	4	5
Conflict (1)	r	1	,548**	,108	,223**	,243**
	p		,000	,127	,001	,001
	n	200	200	200	200	200
Motivation (2)	r		1	,176*	,275**	,289**
	p			,012	,000	,000
	n		200	200	200	200
Machiavelli-anism (3)	r			1	,510**	,393**
	p				,000	,000
	n			200	200	200
Psychopa-thy (4)	r				1	,474**
	p					,000
	n				200	200
Narcissism (5)	r					1
	p					
	n					200

Table 3: *Conflict and Motivation Correlation with Dark Triad of the Participants (Pearson Correlation Test was Used).*

The relationship between machiavelism and conflict was not detected (p> 0,05), and it was found that there was a very weak positive relationship with motivation.

Psychopathy and narcissism were found to have a weak positive relationship with conflict and motivation (P <0,05).

Discussion and Results

Cooperation and coordination in health care is very important. Particularly in recent years, human resources departments are looking for ways to employ people suitable for both the culture of the organization and the structure of the employees and the job by conducting various personality analyzes to pre-recruitment persons. In this respect, it is necessary to determine the clinical dark triad in the enterprises and to reveal its effect and status on the two indispensable issues of conflict and motivation.

According to the results of our study, the highest score in the dark triad dimensions of the participants was narcissism (3,39+1,45), second place was psychopathy (2,15+1,22), and last place was makyevelizm (1,85+1,14). (Table 2). When the scale is scored between 1 and 9, it is seen that individuals have these characteristics at non-clinical level. According to Rapier (2005), Freud used the word "narcissism esinde in his essay on Sexuality Theory. Freud's article "An Introduction to Narcissism" is considered to be his first important work on narcissism. The place of narcissism in psychoanalysis is based on this article. However, while Freud treats narcissism as a condition, Jung and many researchers treat it as an ongoing phenomenon (Karaaziz and Atak, 2013). Therefore, narcissism is actually expected in all members of society. The important thing is the normal and pathological distinction and it can be said that the health workers in our research need to be liked like all people.

On the other hand, although the second-ranked psychopathy (2,15+1,22) is an undesirable situation in the enterprises, it can be thought that having the individuals at the non-clinical level can remove it from the negative situation when directed correctly by the person or manager.

Machievelism (1,85+1,14) comes last. In particular, it is expected that health workers should behave more ethically and ethically than other professional groups and apply this to all areas of their lives. Almost all of the healthcare professionals, especially the Hippocratic oath, are taken into the business life with an oath that includes commitment to moral principles during their graduation periods. In addition, the necessity and necessity of complying with the ethical principles within the scope of the training they receive is given to them continuously. Therefore, the principles of morality that determine the distinction between right and wrong and makyevelism sometimes contradict. Because a situation for the benefit of the person may not be morally correct. Instead of maximizing one's own benefit, one may perhaps choose moral behavior by not acting rationally. This result obtained from our study is actually as expected.

When the other results of the study were examined, there was no statistically significant relationship between conflict and makyevelism dimension, while a weak positive relationship was found between psychopathy and narcissism (Table 3). The lack of a relationship between makyevelism and conflict may be due to the influence of individuals with this pattern of behavior in the enterprise to maximize their own benefits and to choose whether or not to make certain behaviors. Because any conflict with other employees has the potential to return indirectly as a harm to the person. Considering this, it is expected that the employee

should avoid conflict in the enterprise.

The emergence of a weak positive relationship between psychopathy and conflict is an expected result of non-pathological psychopathy behavior. The tendency to behave immoral, which is the basis of psychopathy behavior, to despise people, to mock them, to feel remorse and tend to be emotionless, superficial human relationships, not to maintain long-term relationships, to show commitment and loyalty to others, aggressive behavior and non-compliance , not paying much attention to human relations and often having difficulty getting along with others, showing impulsive behaviors are an indicator of the possibility of conflict with other people in the enterprise and emerged as one of the variables affecting the conflict in our research (Özsoy and Ardıç, 2017) .

On the other hand, every person is happy to receive reactions such as being liked, appreciated and appreciated by other people. These expectations or requirements are narcissistic requirements. All people need these needs. But the expression of these requirements can often lead to negative emotions. Although not explicitly stated, the aim here is to receive and accept the value it deserves by the environment. The individual spends a lot of time to satisfy this need and is open to doing everything. Following this effort, an individual who cannot live the value or admission he believes he deserves may experience narcissistic injury. This injury can occur with daily life events and even with situations that can be considered insignificant to others. (Karaaziz & Atak, 2013). In our study, the reason of the relationship between narcissism and conflict can be considered as the result of the reaction of the person in case of appreciation, acceptance or failure to fulfill his wishes and expectations. conflicts with other dimensions in a study conducted in Turkey examined the relationship of the dark triad size and there was a significant positive relationship in general. Therefore, results consistent with our study were observed (Yürek, 2018).

In our study, the relationship between dark triad and motivation was also discussed and a very weak relationship was found with makyevelism, while a weak relationship was found with psychopathy and narcissism. The reason why the relationship between machievelism and motivation is so weak may be that makyevelists adopt and motivate their own goals instead of any business goals. In other words, the way to maximize its own benefit is to what extent it does not fulfill its business objectives. To be more precise, it is only in the job description and does the minimum expected of itself, does not show extra role performance or citizenship behavior. On the other hand, those who have narcissistic and psychopathy characteristics can make more efforts in terms of motivation due to the characteristics they have in order to be able to take part in the business or to be liked or belonging to a group.

As a result, dark triad is a new issue for businesses and needs to be worked on. The explanations on the subject may increase with the studies in other samples and models. In addition, managers and employees will be able to better understand how to behave in such a way and how they can be directed to desired behaviors for organizational purposes.

References

1. Deutsch, M. (2003). "Cooperation and Conflict: A Personal Perspective on the History of the Social Psychological Study of Conflict Resolution", In M. A. West., D. Tjosvold, , K. G. Smith (Eds.), International Handbook of Organizational Teamwork and Cooperative Working (pp. 9-45). W.S. En: John Wiley & Sons.
2. Eldoğan, D. (2016). Which Narcissism? A Review of the Comparison of Grandiose and Fragile Narcissism. Turkish Psychology Articles, 19 (37), 1-10.
3. Eraslan-Çapan, B., Satıcı, S.A., Yılmaz, M.F. & Kayiş A.R. (2015). The Dark Triad Scale: Adaptation and Validation to Turkish ". Presented at the 13th National Congress of Psychological Guidance and Counseling, 7-10 October, Mersin, Turkey.
4. Eren, E. (2001). Management and Organization, Istanbul, TR: Beta Basım Yayım Dağıtım.
5. Furnham, A., Richards S.C. ve Paulhus, D. L. (2013). The dark triad of personality: A 10 year review. Social and Personality Psychology Compass, 7(3), 199-216.
6. Güler., B. (2009). The Relationship Between Organizational Citizenship Behavior and Intra-Organizational Conflict: A Research in Health Sector. Marmara University, Social Sciences Institute, Master Thesis, Istanbul (Supervisor: Asst. Prof. Dr. A Salim).
7. Jonason, P. K., & Webster, G. D. (2010). The Dirty Dozen: A Concise Measure of The Dark Triad. Psychological Assessment, 22(2), 420-432.
8. Jones, D. N., & Paulhus, D. L. (2009). Machiavellianism. In M. R. Leary & R. H. Hoyle (Eds.), Handbook of individual differences in social behavior (pp. 93-108). New York, NY, US: The Guilford Press.
9. Jones, D.N. & Paulhus, D.L.(2014). Introducing the Short Dark Triad (SD3): A Brief Measure of Dark Personality Traits. Assessment, 21(1), 28-41
10. Karaaziz, M. & Erdem Atak, İ. (2013). A Review on Narcissism and Narcissism Releated Researchs. Nesne, 1(2), 44-59.
11. Keenan, K. (1996). The Guide of Manager: Motivation. Translate: E., Koparan. İstanbul, TR: Remzi Kitabevi.
12. Koçak, T. B., (2014). Narcissism and It's Mythological Origin. http://www.gazetebilkent.com/2014/04/14/narsisizm-ve-mitolojik-kokeni/.
13. Özkalp, E., & Kırel, Ç. (2005). Organizational Behaviour, Eskişehir, TR: Etam Yayınları.
14. Özsoy, E. & Ardıç, K. (2017). The Effect of Dark Triad (Narcissism, Machiavellianism and Psychopathy) on Job Satisfaction. Management and Economy, 24(2), 391-406.
15. Özsoy, E. (2018). Dark Triad and Counterproductive Work Behaviors: Which of the Dark Triad Traits is More Malevolent?. Journal of Business Research-Turk, 10 (4), 742-756
16. Paulhus, D. L., & Williams, K. M. (2002). The Dark Triad of personality: Narcissism, Machiavellianism and psychopathy. Journal of Research in Personality, 36(6), 556-563.;
17. Robbins, S. P. (2003). Essentials of Organizational Behavior, Upper Saddle River, New Jersey, USA: Prentice Hall Inc.:163-164
18. Rogoza, R. & Cieciuch, J. (2018). Dark Triad traits and their structure: An empirical approach. Current Psychology, 1-16
19. Sarıçam H., Akın A., Akın Ü. İlbay A.B. (2013). Turkish Version of the Motivational Stability Scale: Validity and Reliability Study. Turkish Journal of Education, 3(1), 60-69.

20. Steers, R.M. & Porter, L.W. (1987). Motivation and Work Behaviour. New York, USA: McGraw-Hill.
21. Yürek, D. (2018). The Relation of Dark Triad Personality Traits with Rejection Sensitivity, Interpersonal Conflict Resolation Stylies and Attachment: The Mediating Role of Early Maladaptive Schemas, Unpublished Master Thesis, İzmir Katip Çelebi University, Social Sciences Institute.

Психосоциална оценка на пациенти с окологични заболяватия в болничните заведения

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Резюме

За модерната медицина в демократичния свят познаването на потребностите на пациентите, както и здравните грижи за тях, се оценяват като необходими за лечебния процес. Диагнозата тумор сама по себе си е стресогенно събитие. Тя води след себе си и серия от вторични стресори, с които тези пациенти трябва да се справят. Целта е да се проучи приспособяването на пациентите с окологични заболяватия в болничните заведения. Чрез проведено мащабно проучване са очертани основните тенденции и аспекти в поведението на пациентите с онкологични заболявания, както и справянето с подобна тежка диагноза. Направен е опит за анализиране ролята и мястото на здравните грижи, за приспособяването на пациентите в болничните заведения и са изведени са изводи..

Keywords: *духовни грижи, пациенти, клинични условия*

Въведение

Психология на здравето поставя своя основен фокус върху разбирането и изследването на връзката между биологичното функциониране, поведението и социалната среда, както и тяхното влияние върху състоянието на здраве и болест. Основната цел е подобряване на здравето както на физиологично, така и на психично равнище. Въпросът за причините за възникването и развитието на онкологичните заболявания, както и справянето с подобна тежка диагноза, е широко разискван вече десетилетия в различни аспекти – медицински, фармакологичен, биологичен, в това число и от психологическа гледна точка. Причината е, че ракът се превърна в една от най-застрашаващите човешкият живот болести (1)

Диагнозата тумор сама по себе си е стресогенно събитие. Тя обаче води след себе си и серия от вторични стресори, с които тези пациенти трябва да се справят. Такива са тежестта на лечението и страничните ефекти от него, промените в домашните навици, прекъсването на работа и произхождащите от това финансови затруднения, ограниченията по отношение на участието в социалния живот и контактите с близките хора (Ianakiev, 2014). Тези моменти на криза понякога са продължителни, а ефектите от тях – силно изтощителни и травмиращи. Разгледани в дългосрочен план те могат да окажат силно негативно влияние върху редица аспекти от живота на пациента. Тревожността, дистресът и депресията са често срещани психични състояния при онкологични пациенти,

които допълнително усложняват антитуморното лечение и грижите за тях (7).

Психо–социалните рискови фактори, наречени още стресори, представляват неблагоприятни въздействия върху човешкия организъм, които водят до разстройство в неговото равновесие и адаптация към средата. Психологичният отговор, познат като психологичен стрес, се изразява чрез тревожност, агресия, защитни механизми и криза на личността (3), което налага социална и психологична подкрепа на болния в неговата опитност в болестта (6)

Цел

Целта на изследването е да се проучи приспособяването на пациентите с онкологични заболявания в болничните заведения.

Методи и материали

Проучването обхваща 350 пациенти на стационарно лечение от седем университетски и многопрофилни болници в страната, за двугодишен период. Данните от проучването са обработени чрез статистическа програма SPSS а графиките са изготвени посредством програмата Microsoft Excel.

Резултати и обсъждане

Социална среда. Адаптация. Фактори за адаптация към болничната среда

Приспособяването на пациента е от значение не само за неговото привличане и участие в лечебния процес, но и по отношение на неговата удовлетвореност. В контекста на това потърсихме мнението на пациентите относно тяхната приспособимост към заобикалящата ги предметна и социална среда в болничното заведение. Впечатляващи са отговорите на болните, които споделят, че са се приспособили много бързо – 75,5%, според 19,3% приспособеността им зависи от специалиста, за 2,9% този процес е станал много бавно и едва 2,3% считат, че не са успели да се приспособят.

Поинтересувахме се от степента и динамиката на приспособимост към социалната среда в болничните заведения – лекари, медицински сестри и санитари. От Табл.1 е видно, че най-бързо пациентите се приспособяват към медицинските сестри в отделението – 80,0%, следвани от лекари – 72,2% и санитари – 68,1%. Очевидно е, че в дейностите по приемане и грижи, медицинските сестри имат активно участие за изграждане на здрава атмосфера, в която болният по-лесно да се адаптира.

Степен на приспособимост	Лекари	Медицински сестри	Санитари
Да, много бързо	72,2%	80,0%	68,1%
Да, много бавно	4,0%	2,9%	4,6%
Да, условията бяха приемливи	21,7%	15,2%	23,9%
Не, не успяха да ме приспособят	2,0%	1,1%	3,4%

Table 1:*Степен и динамика на приспособимост на пациентите към социалната среда в болничното отделение*

Търсейки мнението на пациентите за това, как показват съпричастността си към тях медицинските сестри, получихме следните отговори (Фиг. 1). Повече от половината респонденти споделят: чрез лечение – 46,3% и оказване на здравни грижи 25,0%. Едва ¼ от тях са посочили: проявата на внимание и съчувствие – 20,1%, разговорите – 6,0% и духовното насърчаване – 2,3%, като елемент от грижите. Анализирайки резултатите е видно, че в съвремието на сестринската професия, духовната грижа и добродетелите са изместени от клиничната грижа и манипулативна техника, което само по себе си е тревожен факт. Отговорилите „чрез лечението" са статистически значимо най-много в сравнение с останалите $p < 0.05$.

Fig. 1: *Съпричастност на медицинските професионалисти към пациентите*

Болничното лечение, особено при пациенти, които нямат предварителен опит, често е придружено с тревожност и смут. При 48,4% от анкетираните болни, най-осезаема е липсата на семейството, дома – 13,0%, децата – 11,5%, да споделят с някого всичко което изпитват – 10,7%, работата – 4,6%, приятелите – 3,5%, съпруг/а – 3,2%, домашната храна – 2,9%, домашния любимец –1,4% и за 0,9% в графа друго това са разходките сред природата. Отделянето от семейството, приятелите и обичайните дейности, е допълнителен стрес за всеки пациент. Лишаването му от непосредствена подкрепа в момент, когато се чувства физически зле, натоварва и потиска допълнително неговата психика (Фиг. 2)

Fig. 2: *Фактори влияещи на адаптацията*

Емоционално състояние на болните в болничните заведения

Здравните проблеми на болните безспорно се отразяват върху цялостното им благополучие и емоционално състояние. Приемането на тежко хронично заболяване или на неизлечима болест е една от най-големите трудности за пациента. При изследването установихме, че 68,1% се справят „сравнително добре“ със заболяването, 29,9% – „трудно“ и 2,0% „не се справят“. Отговорилите „сравнително добре“ са статистически значимо най-много в сравнение с останалите p< 0.05 (Фиг. 3).

Fig. 3: *Справяне на болните с болестта*

Болестта неминуемо дава отражение върху болните и е от съществено значение за качеството им на живот. Тя е причина 58,4% от пациентите да преоценят живота си, 27,1% все още мислят по някой въпроси и само 14,5% не са преоценили живота си след установяване на заболяването. Отговорилите „да, направих си равносметка“ са статистически значимо най-много в сравнение с останалите p< 0.05(Фиг.4).

Fig. 4: *Преоценка на живота от болните*

В свободен отговор анкетираните са преоценили различни аспекти от живота си по време на боледуване. В най-голям процент първа група респонденти преоценяват „ангажиментите", които поемат и „отношението към парите" – 75,5%, „всичко" – 5,1%, жизнената си философия – 4,9%, цената на здравето – 2,6%, начина си на живот – 2,0%, смисъла на живота – 0,3%, вярата – 0,3%, мисленето си – 0,3%. Фактите красноречиво говорят, че болестта е многомерна и е възможно да придаде друг смисъл на живота на човека (Фиг.5)

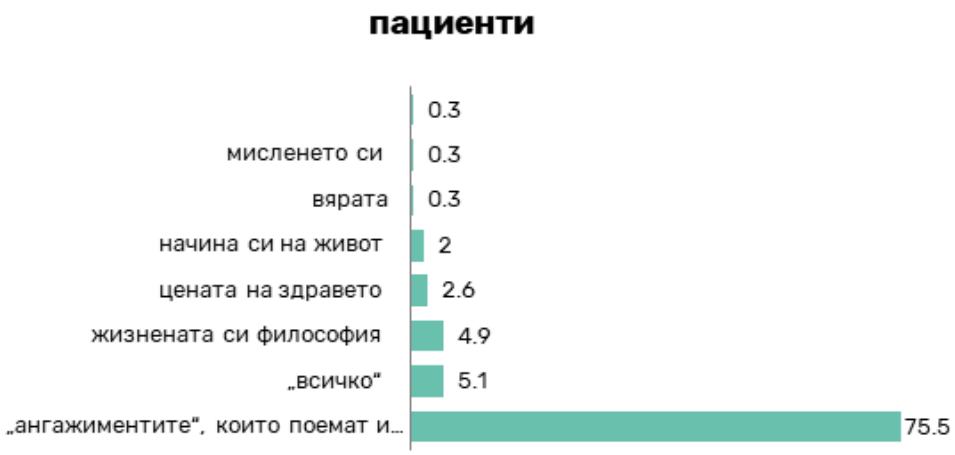

Fig. 5: *Аспекти на преоценката в живота*

Запитахме болните: Как се чувстват по време на боледуване? При възможност за повече от един отговор, процентите са ранжирани както следва: повече от половината анкетирани – 52,3% се уповават на вярата в благополучният изход от заболяването, 40,0% се гневят, а за 22,3% надеждата дава енергия и сила за борба с болестта. В настроението на един болен могат да се забележат и неспокойствие – 16,0%, тъга – 15,4%, решителност – 11,7% и др. Видно е, че духовният дистрес е свързан с духовно страдание и болка, гняв и отчаяние. Страха от неизвестността, социалната изолация и промяната в начина на живот неизбежно се отразяват върху душевното състояние на болния. За това, когато боледува душата, тя трябва да бъде лекувана. Това определя и очакванията и нуждата от разбиране и грижи, необходими за качеството на предлаганата здравна услуга. С най-висок процент на отговорилите е „вярвам", „гневя се" и „надежда" и те статистически значимо се отличават от другите $p<0,05$ (Фиг. 6)

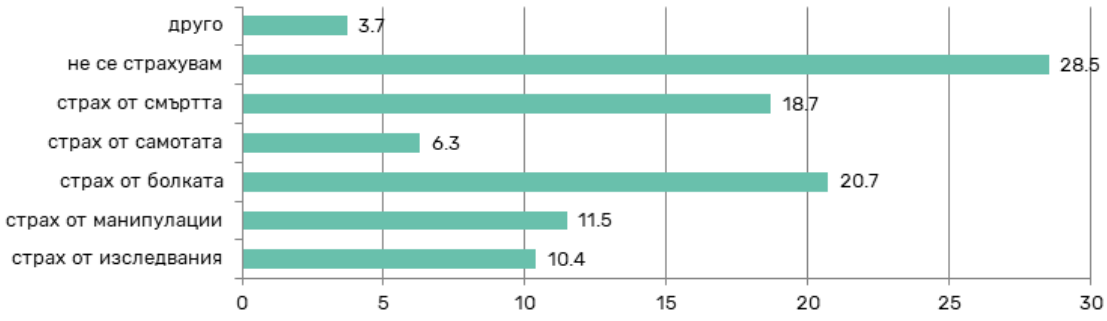

Fig. 6: *Самооценка на състоянието по време на хоспитализация*

Страхът от заболяването отразява личните особености на всеки човек. От анкетираните болни само 28,5% не се страхуват, а останалите 71,5% изпитват старах. Причините за страховите изживявания на анкетираните са: страх от болката – 20,7%; страх от смъртта – 18,7%, страх от манипулации – 11,5%, страх от изследвания –10,4%, страх от самотата

Fig. 7: *Страхови изживявания на болния*

Съществува вероятност някой болни да не показват своите притеснения и страхове, ръководени от различни подбуди. Болестният страх е мъчително чувство изискващ от медицинските професионалисти подкрепящо поведение към всеки болен.

Изводи

1. Впечатляващи са отговорите на болните, които споделят, че са се приспособили много бързо по време но болничния престой – 75,5%.
2. При 68,1% от респондентите установихме, че се справят „сравнително добре“ със заболяването.
3. Болестта е причина 58,4% от пациентите да преоценят живота си. В най-голям процент преоценяват „ангажиментите“, които поемат и „отношението към парите“ – 75,5%.
4. Повече от половината анкетирани – 52,3% се уповават на вярата в благополучният изход от заболяването.
5. Тревожен остава факта, че 71,5% от анкетираните болни изпитват старах /от болката – 20,7%; страх от смъртта – 18,7%/ и само 28,5% са дали отрицателен отговор

References

1. А. Манлихерова. Здравни убеждения и стратегии за справяне при онкоболни.
2. Ив. Стамболова, Г. Чанева. Управление на здравните грижи, 2007
3. Национална здравна стратегия, 2007-2012.
4. Н. Йорданов, П. Аспарухова. Духовните грижи в съвременната медицинска практика у нас.Folia palliatricaq, 2017.
5. П. Балканска. Приложна психология в медицинската практика. С., Булвест, 2009.
6. Ц. Воденичаров, С.Попова. Социална медицина, 2009г.
7. Ю. Янакиев, Е. Атанасова, Р. Иванова. Онкологични пациенти на оперативен етап на лечение.

Beginning of the End of Life

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Abstract

According to The Oath of Hippocrates, it is said that 'I will give no deadly medicine to anyone if asked, nor suggest any such counsel.' When we respect Hippocrates as father of medicine, we should abbey the Oath of that naturally. But not so, there could be another thinking about it.

Another definition of euthanasia has been 'A deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering.' From this point of view, Euthanasia has been not allowing nature to take its course, stopping biologically futile treatment, stopping treatment when the burdens outweigh the benefits, using morphine and other drugs to relieve pain, and using sedatives to relieve intractable mental suffering in a dying patient.

If we have an ethics like The Oath of Hippocrates, we never permit such an intervention ethically or morally at all. We understand the concept of self-decision making, of course. However, we live socially, not to be isolated. The life has not stand alone, a person is a child of parent, a parent of a child, a partner of the other, a member of a community or an association where the person lives, they are all the facts. Euthanasia, in another word as Physician Assisted death has been primally concept with twenty-first century of first and second decade. It is important to discuss openly and clearly the theme of euthanasia, simply because all we are to be mortal existence. Death comes everybody equally.

Keywords: *Palliative care, Euthanasia, Oath of Hippocrates, Ethics, Moral*

The Case

According to the Asahi on 25th July 2020, two doctors killed a fifty-one-year-old lady suffering from amyotrophic lateral sclerosis for several years, in the house where she lived.1) They visited her and easily came into her room, because her carer thought they were friends of hers. Some kind of medication had been given by them within ten minutes at her bed. It seems it was her request to help her successfully die. The police suspected the two doctors, as they found out that the patient got in touch with the medical specialists via Social Network Services Twitter account in the last few weeks or months.

The lady had been cared for several years by professional care-workers, family members and a physician in charge.2) They had lived near her, making close relationship with her. However, she didn't tell them how miserable life she had, and how much she was suffering by her disease. She really would like to end her life as soon as possible, but could not do that by herself because of her physical condition. Nevertheless, her family members and carers didn't know about her

feeling after amyotrophic lateral sclerosis advanced with all dependent life going.
The lady had normal childhood. She was a very handsome person who graduated from Christian University in Kyoto, after a couple of years she majored in architecture to be admitted in a graduate school in the United States.3) She was a very active person and loved visiting foreign countries. She travelled abroad, was not married, and lived alone.

Background

In Japan similar cases had happened before the case emerged in the last half century.4)

First case arose in 1961 at Nagoya. A fully dependent man, who had quadriplegia, wanted to die easily by medication to escape fully dependent life any more. One of his sons gave poisonous agricultural chemicals to his father. Then, a court case started. The court showed six factors to consider euthanasia. Those were

1) Incurable disease and life limiting.
2) Unbearable severe suffering.
3) The only purpose was palliation of painful death.
4) Clear consciousness and the will of the patient and clear recognition.
5) Means by doctor based.
6) Ethically right way to die.

Second case arose in 1991 in Yokohama. The patient diagnosed with multiple myeloma, advanced at that time, was unconscious; a family member really wanted to support or help for easy death. The young physician in charge gave a medication for patient's death.

In this case, the court appointed four factors to consider euthanasia. Those were

1) Severe physical suffering to be unbearable.
2) No way to avoid death and severe limiting life .
3) No way to palliate suffering except euthanasia.
4) Willing to hasten life himself with clear recognition and to confirm it objectively.

Yet, continuing the cases in the last decade of twentieth century in Japan, third one was in Kyoto in 1996, fourth - in Kawasaki in1998, and fifth in Toyama in 2006. Two of three cases were not prosecuted by the authority. It meant a kind of recognition of euthanasia by Japanese court. However, there is no legislation for euthanasia until nowadays in the society of Japan.

A researcher has shown 'Principle of six eyes' around his family with traditional medical circumstances.4) This principle means the two patient's eyes , other two of the physician in charge, and another two of an allied health profession together in the situation, talking about the dying process of the patient. Just three persons make decision about his death and dying. This is a traditional way in the context of dying, however, there is no document or clear confirmation. A traditional way for dying patient to confirm euthanasia is oral communication.

Changing meaning of Euthanasia

In "Euthanasia" by Dr. Munk, he pointed out four aspects of dying process.5) First of all, the moment of death is not as dreadful or painful in reality as it is often supposed. This was one of the contemporary arguments against deliberate killing. Secondly, Munk noted mental or psychological aspect of death, echo the physical condition when the physician or relatives around patient supported maintaining an attitude of hope. If so, patients were mostly calm at the time. Thirdly, Munk thought the state

of the intellectual or emotional aspect at the moment of death. That was so-called 'lightening up before death' phenomenon. Fourthly and lastly, suffering is not 'naturally or necessarily incident to the act of dying', but is due to surrounding circumstances that can be changed or managed.

Therefore, we could change more comfortable condition for the patient, such as the provision of appropriate bedding, physical position in the bed, fresh air in the room, or rehabilitation intervention to support life during last weeks or days. When we act Dr. Munk's way of caring, there would not be need for euthanasia, because of patient-oriented life to be spent in deathbed. However, the circumstances around patient changed at the end of nineteenth century, when World War took place, especially in Europe.

The majority of physicians at the end of nineteenth century in England and the United States were opposed to the deliberate killing of a dying patient, which they saw as morally wrong, dangerous to individuals, and to society. One of the reasons why nineteenth-century physicians were not engaged in discussion about the physician-assisted suicide variety of 'euthanasia' was because they were directing their attention to issues of palliative care which would secure 'euthanasia' in the classical sense, such as an evangelical idea for good death.

In 1914 a medical correspondent to The Times cited, on the subject of 'the pains of death', earlier works by Savory and Brodie in support of his arguments, rather than Munk. The meaning of death began to change, the key word was death pain. When World War One took place at the time, a lot of young solders were harmed, crippled and died with severe pain within or without battle. Because of war, much of death emerged at frontline of battle with severe pain by fight. It was developed pain control by some medication. It helped much the solders. The war broke both human beings and calm and comfortable death.

Medicine was establishing how to integrate the use of the new pain-relieving drugs into practice, however it was at the same time seeking to uphold notions of the 'good death'. This was a particular challenge in a context where there was religious and theological opposition to the use of these drugs for 'easy' dying, which were seen as unnatural and ungodly.

This was not only to relieve suffering in the context of a 'natural death', but also to deliberately end a life so that suffering might be overcome, although 'unnatural' death resulted. This has been the fight between medical approach and religious or theological one since then.

The core issue of Euthanasia

Euthanasia originally meant a pleasant death, but has now come to mean mercy killing or the deliberate action by which a pleasant death may be produced.6) Table 1 shows assumptions of euthanasia, from philosophical, medical and legal point of view. We understand there are many factors for euthanasia, it means the term euthanasia was ambiguous, doubtful and unclear concept to take carefully with the context.

Some say it is to do more comfort for patient, other say it is to stop patient's suffering. One approach is medically to control symptoms, the other one is philosophically or psychologically to handle suffering or chronic pain. The pain consists of two different phenomena - acute or chronic. Medication such as opioids has much effect on the former, but latter is weakly influenced by

medication, it adapts more effectively psychosocial intervention or behavioral one.

When we think about medication, opioids are for symptom control but benzodiazepine or midazolam are for sedation. Some say deep sedation is a sort of euthanasia, other say it is a kind of palliative care. Their arguments are quite different concepts at all. According to The Oath of Hippocrates, it is said that 'I will give no deadly medicine to anyone if asked, nor suggest any such counsel.' When we respect Hippocrates as father of medicine, we should obey the Oath naturally. But there could be other thinking about it.

Another definition of euthanasia is 'A deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering.' From this point of view, euthanasia has been not allowing nature to take its course, stopping biologically futile treatment, stopping treatment when the burdens outweigh the benefits, using morphine and other drugs to relieve pain, and using sedatives to relieve intractable mental suffering in a dying patient.

In short, when we use euthanasia in ordinal palliative care practice, we neither grow nor increase palliative skills any more. If we have an ethics like The Oath of Hippocrates, we never permit such an intervention ethically or morally at all. We understand the concept of self-decision making, of course. However, we live socially, not isolated. The society is not a group of isolated individuals, rather it a complex network of relations – between children and parents, between partners, between relatives, colleagues, etc. We have to take into account the specifics of the community the person lives in.

1.Philosophical	That man has a right to die That the value of human life is measurable That human life can be dealt with in the same ways as animal life That suffering can have no beneficial function That an unmixed motive of compassion can be guaranteed
2.Medical	That medial diagnosis and prognosis are always certain That the degree of suffering of another person can always be realistically That effective alternative methods for the relief of suffering are not available That euthanasia is the justifiable duty of a doctor
3.Legal	That the legalization of euthanasia can control its abuse That euthanasia can be clearly distinguished from murder

Table 1: *shows assumptions of euthanasia 6)*

Conclusion

All we know we are being mortal.8) Yet we could forget these words at all. Simply because we live busy life to support ourselves. They had been said traditionally 'memento mori'. We should remember this Latin word from the middle.

Euthanasia, in another word as Physician Assisted death has been primally concept with twenty-first century of first and second decade. It is important to discuss openly and clearly the theme of euthanasia, simply because all we are to be mortal existence. Death comes everybody equally

REFERENCES:

1) The Asahi Shinbun, 25th. July 2020, in Japanese.
2) The Asahi Shinbun, 20th. July 2020, in Japanese.
3) The Asahi Shinbun, 22th. July 2020, in Japanese.
4) Yoichiro Murakami, A philosophy of era of never die, Bunshunshinsho, 2020, in Japanese.
5) David Clark, To Comfort Always: A History of Palliative Medicine Since the Nineteenth Century (Oxford Medical Histories), 2016.
6) Doyle D, Hanks G.S.C., Macdonald N, eds, Oxford Textbook of Palliative Medicine, first ed., Oxford Medical Publications, 1993.
7) Twycorss RG, Introducing Palliative Care, fourth eds. Radcliffe, 2003.
8) Atul Gawande, Being Mortal, Doubleday Canada, 2014.

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