

Relationship Between Religion and Health on the Topic of Euthanasia

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Връзката между религията и здравето по темата за евтаназията

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Abstract

In 1963 Michel Foucault writes that his book “The Birth of the Clinic” is about space, language, and death, about perception. There is a shift of societal problems to the field of medicine, in other words, modernity formulates some social problems through medical categories. But in fact, questions that seem purely medical are often a product of social factors. In society, medicine is a conservative force that maintains the status quo and distracts from major threats to human health. The growth of individualism, the desire for autonomy, and the decline of religiosity allow discussions around death, tolerance of mystery, and euthanasia. For example, in Canada, 2021 marks five full years of access to medical assistance in dying. In 2021, there were 10 064 cases, bringing the total number to 31 664. Annual growth continues to increase steadily each year. Are the major religions capable of facing that challenge?

Keywords: religion, euthanasia, medicalization, right-to-die debate, right-to-health

Резюме

През 1963г Мишел Фуко описва книгата си „Раждането на клиниката“ като книга за пространството, езика и смъртта, за погледа. Защото се наблюдава едно изместване на социеталните проблеми към полето на медицината, с други думи – модерността формулира някои социални проблеми посредством медицински категории. Но всъщност някои въпроси, изглеждащи чисто медицински, често са продукт на социални фактори. В обществото медицината е консервативна сила, която поддържа статуквото и отвлича вниманието от големите заплахи за човешкото здраве. Засилването на индивидуализма, желанието за автономия и отслабването на религиозността, позволяват обсъждания относно смъртта, религиозните тайнства и евтаназията. Напр. през 2021 г. в Канада се навършват пет години практика на медицинско подпомагане на смъртта. От 2016 г. насам общият брой случаи е 31 664, като само за 2021 г. те са 10 064. Наблюдава се стабилно процентно нарастване на случаите всяка година. Способни ли са големите религии да се изправят срещу това предизвикателство?

Ключови думи: религия, евтаназия, медикализация, дебат за право на смърт, право на здраве

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The concept of euthanasia has been a controversial topic since its inception. The word is derived from Greek, it means "good death." It is defined as the hastening of the death of a patient to prevent further suffering. Active euthanasia refers to the physician's deliberate act, usually, the administration of lethal drugs, to end an incurably or terminally ill patient's life. There are three types of active euthanasia, concerning giving consent for it: voluntary euthanasia – at patient request, nonvoluntary – without patient consent, and involuntary euthanasia – the patient is not in a position to give consent. Other terminology like assisted suicide and physician-assisted suicide are not synonyms of euthanasia. Passive euthanasia refers to withholding or withdrawing treatment that is necessary for maintaining life, and it is generally accepted worldwide. (Annadurai et al., 2014; BBC, 2014).

While active involuntary euthanasia is legal in countries such as Netherlands, Belgium, and Luxembourg, assisted suicide is legal in Switzerland and the United States of Oregon, Washington, and Montana. In Belgium alone, there are 1 400 cases of euthanasia practiced. The concept of death tourism or euthanasia tourism is slowly increasing, Switzerland is known for death tourism, where every year patients primarily British, German, and French travel there to end their lives. In the Netherlands, euthanasia accounts for 2% of all deaths. Common conditions which make patients seek euthanasia are terminally ill cancer patients, acquired immune deficiency syndrome (AIDS), and other terminally ill conditions where there is no active treatment. Factors that are responsible for decision-making are classified into physical and psychological. Physical conditions that affect the quality of life in these patients are unbearable pain, nausea, and vomiting, difficulty in swallowing, paralysis, incontinence, and breathlessness. Psychological factors like depression, feeling a burden, fearing loss of control or dignity, dislike of being dependent, suicidal ideation, and inadequate palliative care might also be the underlying reasons for seeking euthanasia (Annadurai et al., 2014; BBC, 2014).

2021 marks five full years of access to medical assistance in dying (MAID) in Canada. In 2021, there were 10 064 MAID provisions in Canada, bringing the total number of medically assisted deaths in Canada since 2016 to 31 664. Annual growth in MAID provision continues to increase steadily each year. In 2021, the total number of MAID provisions increased by 32.4% (2021 over 2020), compared to 34.3% (2020 over 2019) and 26.4% (2019 over 2018) (Health Canada, 2022).

The Ethics of Euthanasia

Several key themes run through the subjects covered by bioethics. One is whether the quality of human life can be a reason for ending it or for deciding not to prolong it. Since medical science can now keep alive severely disabled infants who would otherwise die soon after birth, pediatricians are regularly faced with this question. A major controversy erupted in the United States in 1982 when a doctor agreed to follow the wishes of the parents of an infant with Dawn syndrome by not carrying out the surgery necessary to save the baby's life. The doctor's decision was upheld by the Supreme Court of Indiana, and the baby died before an appeal could be made to the U.S. Supreme Court (Singer, 2002).

Another central theme is that of patient autonomy. It was generally agreed that patients must give informed consent to any experimental procedures performed on them. The allocation of medical resources became a life-and-death issue in the late 1940s when hospitals in the United States first obtained dialysis machines and had to choose which of their patients suffering from kidney disease would be allowed to use them. Some bioethicists argued that the decision should be made on a "first come, first served" basis, whereas others thought it obvious that younger patients or patients with dependents should be given preference. Although dialysis machines are no longer so scarce, the availability of various other exotic, expensive lifesaving techniques is limited; hence, the search for rational principles of distribution continues (Singer, 2002).

In 1995, Hans Küng stirred controversy with his theory on assisted suicide in his book "Dying with Dignity."¹ In his book, "Dying Happily?" (2014) he wrote: "When the time to die has come, I may, on the condition that I am still capable of making such a decision, decide, of my responsibility, when and how I will die." He attacked basic elements of the Catholic Church. In his view, the Catholic Church had degenerated into a "power church" following its interests, but

¹ Hans Küng's (1928-2021) career began in 1948 when he went to Rome to study Catholic theology and philosophy at the Papal University of Gregoriana. After being ordained as a priest, he finished his doctorate at the Sorbonne in Paris in 1957. He became a professor of fundamental theology at the University of Tübingen in 1960. After rejecting the doctrine of papal infallibility, he was asked to leave the Catholic faculty in 1979 but remained at the University of Tübingen as a professor of ecumenical theology. Although Küng was not allowed to teach Catholic theology any longer, his priestly functions were not revoked. He started the Global Ethic Foundation in 1995 and became an emeritus professor in 1996. He was appointed as a synod theologian and came to participate in the Second Vatican Council (1962-1965). Joseph Ratzinger, later Pope Benedict XVI, had the same function there, sharing the same views on many issues concerning the modernization of the Catholic Church. But the council did not adopt some of Küng's views — reforming the papacy, abolishment of obligatory celibacy for priests, birth control, permitting women to serve as priests, and some of the objectives of the ecumenical movement (Krämer, 2021).

not the teachings of Jesus Christ. "Controversial fundamental questions like birth control or assisted suicide are not the main issue here, but rather basic rules that every society, even every office or company needs to function - ethical standards" (Krämer, 2021).

Moral Theology and General Christian View

Moral theology, also called Christian ethics, identifies the principles that determine the quality of human behavior in the light of Christian Revelation. The traditional Eastern Christian emphasizes the divinization of man through his association with Jesus Christ and in the Protestant concern with the moral power of justification. Medieval and post-Reformation Roman Catholic moral theology tended to separate moral teaching from dogmatic theology. In the light of Revelation, sin is seen as a deterioration of the fundamental disposition of a person toward God, rather than as a breaking of rules or laws (Britannica, 2020).

The moral teaching in Christian communities has varied in the different eras, regions, and confessional traditions in which Christianity has been professed. The Roman Catholic tradition has been inclined to emphasize the mediating role of ecclesiastical institutions in its approach to the moral authority of Revelation. Protestant churches have often put great emphasis on the direct, or immediate, moral responsibility of the individual before God. The influence of the spiritual director on the moral welfare of the individual Christian has been a significant aspect of Eastern Christianity. Contemporary moral theology must confront a variety of problems (Britannica, 2020).

Although allusions to euthanasia are found in the literature from the Ancient Near East and the Greco-Roman world, the Bible itself is silent on euthanasia and physical-assisted suicide (EPAS). The Bible develops a theology of suffering early on. It describes the entrance of suffering into the world through the concept of sin, the act of deliberately turning away from God and his instructions. The Bible also demonstrates that we are often unable to explain the mystery of suffering. In offering these two contrasting views of suffering—that it is through human sin that suffering occurs, yet, that suffering cannot be understood fully, the Bible also describes two responses of God to our suffering. Firstly, God cares about human suffering, and secondly, God himself suffers, especially in the person of Jesus, God the Son. That places God in a position to understand our suffering but is part of God's redemptive plan for humanity. The book of Revelation describes the future of humanity as one without suffering. At the same time, the Bible acknowledges suffering and death are realities that will be part of the lives of all people in this

world. This description of suffering and death immersed in hope is complex. In this theological framework, living right in this life, following the path set out by God, and being obedient to his rules, is of more importance than avoiding temporary suffering (Grove et al., 2022).

Christians are mostly against euthanasia. The arguments are usually based on the belief that life is given by God and that human beings are made in God's image. Some churches also emphasize the importance of not interfering with the natural process of death. All life is God-given, birth and death are part of the life processes which God has created, so we should respect them, therefore no human being has the authority to take the life of any innocent person, even if that person wants to die. Human life possesses an intrinsic dignity and value because it is created by God in his image for the distinctive destiny of sharing in God's own life. Saying that God created humankind in his image does not mean that people look like God, but that people have a unique capacity for rational existence that enables them to see what is good and to want what is good. As people develop these abilities, they live a life that is as close as possible to God's life of love. To propose euthanasia for an individual is to judge that the current life of that individual is not worthwhile (Saint Joseph's University, 2011). Such a judgment is incompatible with recognizing the worth and dignity of the person to be killed. Therefore, arguments based on the quality of life are completely irrelevant. Christians believe that the intrinsic dignity and value of human lives means that the value of each human life is identical. They do not think that human dignity and value are measured by mobility, intelligence, or any achievements in life (BBC, 2009).

The Orthodox View

Eastern Orthodoxy sees a direct link between mercy and salvation as being fundamentally in contradiction with euthanasia. Furthermore, God's sovereignty is a strong theme of Orthodox theology. As such, an acceptance of illnesses that God has allowed in our lives is an important part of faithful living and opens the Orthodox Christian to spiritual growth (Grove et al., 2022). If the history of our changing grasp of death is old, the story of the contemporary problem starts in 1976 when a New Jersey Court ruled on the case of Karen Ann Quinlan that she could be removed from the respirator because we ought not to use medical technology to make dying even harder. The US Congress passed (Dec. 1, 1990) the Patient Self-determination Act which required institutions receiving government funding to advise patients that they had the right to indicate in advance how they wanted to be treated. Medicine is good, but medicine should not contribute to death without human dignity. We have great faith in technology, but should we expect medicine to underwrite

our demands to be in complete control? Some people try to control death by deterring when they will die. Euthanasia seems an almost inevitable consequence of their strategy of avoidance. The directives of "living wills", which are often combined with a "durable power of attorney", designate someone else to speak for you (living wills are legal documents that allow people to state their wishes for end-of-life medical care in case they are unable to communicate those wishes). The justices saw danger in undermining the trust we have that a physician will not harm us by blurring the line between healing and harming (Woodill, 2013).

In a materialistic society with a lack of faith or rejection of God, suffering and sickness are accepted as misery and injustice. In such a society, the concepts of sacrifice, patience, and anticipation are unknown, and the concepts of mercy, sympathy, and generosity are misinterpreted. Euthanasia, although defined as a dignified death, in its effective form is assisted suicide. Therefore, it is a decadent phenomenon of social disregard for man. The request of some patients for euthanasia is a matter of seeking our love and the desire to be next to them (Holy Synod of the Greek Orthodox Church, 2002).

The Roman Catholicism View

The Roman Catholic Church has developed official documents with a strong comment on the sanctity of life and expressly condemned euthanasia: Pastoral Constitution *Gaudium et Spes* and Declaration on Euthanasia (Sacred Congregation for the Doctrine of the Faith, 1980). It is specifically defined as an action undertaken with the express intention of causing death to alleviate all suffering, and it is described as sinful (Grove et al., 2022).

Pope John Paul II (*Evangelium Vitae*, 1995) has spoken out against what he calls a "culture of death" in modern society and said that human beings should always prefer the way of life to the way of death. "Nothing and no one can in any way permit the killing of an innocent human being, whether a fetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying." The Roman Catholic church does not accept that human beings have a right to die because it is a rejection of God's absolute sovereignty over life and death. The Church regards it as morally acceptable to refuse extraordinary and aggressive medical means to preserve life. Refusing such treatment is not euthanasia but a proper acceptance of the human condition in the face of death. The statement from the National Conference of Catholic Bishops (USA) in 1991 is: "As Catholic leaders and moral teachers, we believe that life

is the most basic gift of a loving God, a gift over which we have stewardship but not absolute dominion” (BBC, 2009).

The Evangelical Protestantism View

There is a strong emphasis in Protestant Christianity on Biblical authority on matters of faith, therefore, it naturally tends towards opposing EPAS. The Anglican Church, one of the largest branches, confirmed a resolution, affirming the intrinsic value of life and explicitly opposing EPAS (Lambeth Conference, 1998). Baptist churches have also released numerous statements, for example, the Resolution on Euthanasia and Assisted Suicide, confirming its belief in the connection between humans created in God's image and the sacredness of human life, incompatible with EPAS (Southern Baptist Convention, 1992). The world's largest association of Pentecostal churches, the Assemblies of God, has also released a specific document - Sanctity on Human Life Position Paper (2010) wherein EPAS is described as "mistaken, deceptive and evil", through the lenses of humankind's dignity, God's authority and hope for suffering humanity. Despite recognizing the sinful nature of EPAS, the document concludes with themes of mercy and grace, as defining elements of the Christian faith (Grove et al., 2022).

The Islam View

From ancient Sunni scholars such as Al-Ghazali in the 10th century to Islamic bodies and statements of the 20th century such as the Islamic Medical Code of Ethics (International Organization for Islamic Medicine, 1981), assisted suicide, and, more recently, euthanasia, remain condemned. Contemporary Sunni Islamic advisory and judicial bodies worldwide have issued fatwas (Dar al-Ifta al-Misriyyah in Egypt and the National Fatwa Committee of Malaysia), or non-binding legal guidance, prohibiting the practice of EPAS. The desire for relief and even praying for death may be acceptable in Islam, however, given Allah's supremacy over life and death. Current Sunni thought insists that a higher value be placed on the sanctity of life than on a person's quality of life. Sunni scholars have recognized differences between murder, suicide, and assisted suicide which are related to the severity of sin and the degree of punishment. As such, EPAS remains haram, or prohibited, in Sunni praxis. Although Shia religious jurists' legal views do vary, the highest-ranking Shia clerics have consistently taught against the practice of EPAS. On this specific question, for example, the Ayatollah Sayyid Ali Khamenei of Iran (Islamic Rulings: Medical Issues, Question 115, 2007) has confirmed Shia's prohibition on EPAS (Grove et al., 2022).

The Hinduism View

Despite this extensive diversity in Hinduism and lack of centralized authority, the shared cultural, scriptural, ritual, and conceptual connections allow for the development of Hindu philosophies for complex ethical issues. In the small amount of published literature about EPAS and Hinduism, it is apparent that Hindu philosophies both against and in favor of EPAS coexist. Thus, it is impossible to dogmatically state that Hinduism universally opposes or supports EPAS. Complex and nuanced threads of thought infuse the Hindu understanding of EPAS. Atman and karma, balance and justice, and non-violence and ahimsa indicate EPAS is not acceptable within Hindu thought. But Hinduism allows scope for religiously motivated suicide and, possibly, for compassionately motivated EPAS. Despite this, contemporary Indian culture and its legal system are clear in their rejection of EPAS (Grove et al., 2022).

The Buddhism View

Karma is central to the Buddhist worldview and has a significant logical influence on the understanding of EPAS. As suffering is part of the universe's natural order of balance and justice, EPAS is unable to alleviate suffering and will merely delay it to a subsequent life. The ending of a life is not the solution to suffering because life is seen through the prism of this cyclical existence of death and rebirth. This path includes living morally through the right action, which extends to avoiding killing, suicide, and assisting suicide. Likewise, suicide is considered wrong except in the case of the Buddhist who has finally removed all desires and has completed their work, and is ready to pass to Nirvana. Buddhism aims for its adherents to find liberation from suffering, but not through death. In line with this, Buddhist teaching seeks to comfort those suffering from illness, helping them find peace that transcends their suffering (Grove et al., 2022).

Discussion from a sociological perspective

Statistics about the acceptance of euthanasia in the USA are generalized by J. Jones (2020). In 1950 37% of Americans favor euthanasia, in 2020 they are 74%. In 1995 52% of Americans favor doctor-assisted suicide, in 2020 they are 61%. By subgroups 75% of men support euthanasia related to 73% of women; 77% of whites and 65% of nonwhites. 78% of Americans in the age cohort 18-54 support euthanasia and 68% in the 55+ subgroup; 79% of graduated from college related to 71% of Americans who did not graduate from college. 55% of Americans who attend church weekly support euthanasia, 76% of those who attend church monthly, and 82% of those who seldom or never attend church.

According to D. Masci (2013), views on proxy decision-making are as follows: 78% of adults say that the closest family member should be allowed to decide whether to continue medical treatment if a patient with a terminal disease is unable to communicate and has not made his/her wishes known. 16% of adults say family members should not be allowed to decide. Among the extremely important for a good quality of life in older age people from all age groups mention: being able to talk/communicate, feed and dress oneself, have long-term memory, live without severe/lasting pain, and get enjoyment out of life.

Table 1 (see Appendix) represents statistics about how much euthanasia is justifiable in different European countries according to the European Values Study (2017). Particularly, the value for Bulgaria is 31 and it can be seen that the differences by age, income, education, and religiosity are minimal. There is a difference in opinion about whether euthanasia is justifiable only by the indicator of church attendance.

The Right-to-Die Debate

In jurisprudence, fundamental rights are divided into three generations: 1. Civil and political; 2. Social and economic; 3. Environmental and information. Recently, the rights of a new generation began to be recognized in some countries: the right to dignified death (euthanasia), the right to same-sex marriage, the right to change gender, etc. They enter into a collision with centuries-old ethical and legal norms, acknowledging the individual freedom that was unthinkable in a previous historical age. Another common feature of these rights is that they arise as secondary or derived rights, based on pre-existing personal rights (right to life, right to private and family life, right to dignity and respect of the individual, and non-admission of inhuman treatment, etc.). These rights initially arise based on precedent, with the courts gradually expanding the content and scope of established rights or through the referendum process. Perhaps a fourth generation of rights is in the process, which put the individual interest in a different direction from the public interest (Todorov, 2017).

Opponents of EPAS are medical associations, disability rights advocates, and some religious groups. They contend that the safeguards contained in the laws, even if well-intentioned, miss the larger point: that suicide is a personal tragedy, not a personal choice. They say that in most cases, physician-assisted suicide was a result of the failure of our healthcare system or our families and communities. Opponents are also concerned about potential abuses and the "slippery slope" phenomenon of involuntary euthanasia (Masci, 2013).

Supporters of the practice are liberal religious denominations, civil rights groups, and organizations for the rights of patients. They argue that physician aid in dying is not about forcing or pressuring anyone but rather about giving people with no hope of recovery the choice to end their lives before their physical pain becomes unbearable or before they fully lose control of their mental faculties. "This is about compassion. A compassionate society does not allow people to suffer unnecessarily." It is also about personal autonomy. "This lets [people who are dying] make their own choices during the last stages of their lives." They argue that giving people the option to end their suffering does not devalue human life: on the contrary, it promotes human dignity by allowing those in the last stages of potentially painful illnesses to end their lives on their terms. For the terminally ill, life is often medicalized, centered around doctors and treatments. This frees up people in the final stages of life to focus on life and the meaning of life, rather than doctors and medicine (Masci, 2013).

Statistics about favoring euthanasia are represented in tables in the Appendix. Collected from the research centers data give different optics to the topic related to religious denomination, ethnicity, and age. Moreover, it could be seen the connection between particular Christian branches of Islam and the level of euthanasia approval (see Table 8). In most European countries euthanasia is justifiable according to young, highly educated, not religious, and never visited church people.

The Right-to-Health Debate

In medicine from the 18th century, M. Foucault writes, the approach of nosography arranges diseases in a table, according to the ideal natural order. It is preached the medicine of waiting, home care, and direct interactions between the family doctor and the patient. During the epidemics, it became clear that the classification approach was already untenable, so the image of the supervisor-educator is introduced, who supervises the health of the population and teaches how to protect from possible epidemics. Thus, two myths were built at that time: first, the doctors became from craftsmen to clergy-like, which selflessly served society and improved infinitely. The second is that in the world of equality, wealth and freedom civilization will gradually free itself from all diseases, and man will become virtuous, healthy, and happy; accordingly, medicine will be knowledge not of suffering and disabilities, but of a model person with blossoming health. In the 19th century, this model changed – medicine is already set to the norm, with not only individuals and society but also ontological periods being considered according to the norm. With the development of pathology, death is relativized and deprived of its out-of-time status. Thus, in the

organic destruction at its end, life finds its positive truth. It turns out that death is the constructing fact of the positive science, therefore the scientific explanation for the individual starts from death. Enlightenment has made it possible to realize the "original extreme" of a man shaking the idea of God (Foucault, 1994).

In every society, the dominant image of death determines the prevalent concept of health: culturally conditioned anticipation of a certain event at an uncertain date. It is shaped by institutional structures, deep-seated myths, and the predominant social character. It reveals the level of independence of people, their relatedness, self-reliance, and aliveness. Wherever the metropolitan medical civilization has penetrated, a novel image of death has been imported. The white man's image of death has been a major force in cultural colonization. The "natural death" which comes under medical care and finds us in good health and old age is a quite recent ideal. In five hundred years it has evolved through five distinct stages. Their iconographic expressions are: 1. The fifteenth-century "dance of the death"; 2. The Renaissance dance at the bidding of the skeleton man, the so-called "Dance of Death"; 3. The bedroom scene of the aging lecher under the Ancient Regime; 4. The nineteenth-century doctor in his struggle against the roaming phantoms of consumption and pestilence; 5. The mid-twentieth-century doctor who steps between the patient and his death; and the next 6. Death under intensive hospital care (Illich, 2020).

At each stage of its evolution, the image of natural death has elicited a new set of responses that increasingly acquired a medical character. The history of natural death is the history of the medicalization of the struggle against death². At the fifth stage, lifelong institutional medical care had become a service that society owed all its members. abnormal death is opposed to natural death because it results from sickness, violence, or mechanical or chronic disturbances. This new image endorses new levels of social control. Society has become responsible for preventing each man's death: treatment, effective or not, can be made into a duty. Any fatality occurring without medical treatment is liable to become a coroner's case. This new image of death also befits the industrial ethos: medical consumption became a device to alleviate unhealthy work, dirty cities, and nerve-racking transportation (Illich, 2020).

Finally, "death under compulsory care" encourages the re-emergence of the most primitive delusions about the causes of death. As in primitive cultures, somebody can again be blamed, but

² Medicalization is a term, created in the USA, that means an expansion process in which more and more areas of life are subject to the jurisdiction of medicine (Ivkov, 2014, p. 48).

it is no longer the witch, the ancestor, or the god, but the enemy in the shape of a social force. It might be the class enemy who deprives the worker of sufficient medical care, the doctor, who refuses to make a night visit, the multinational concern that rises the price of medicine, or the capitalist or revisionist government that has lost control over its medicine men, etc. the witch-hunt that was traditional at the death of a tribal chief is being modernized: for every premature or clinically unnecessary death, somebody or somebody can be found for delaying or not preventing a medical intervention (Illich, 2020).

After the mid-fifties of the 20th century comes the sixth image of death: under intensive hospital care. Malinowski (1949) has argued that death among primitive people threatens the cohesion and therefore the survival of the whole group. It triggers an explosion of fear and irrational expressions of defense. Group solidarity is saved by making out of the natural event a social ritual: an exceptional celebration. The dominance of industry has disrupted and dissolved most traditional bonds of solidarity. The impersonal rituals of industrialized medicine create an ersatz of humankind. They tie all its members into a pattern of “desirable” death by proposing hospital death as the goal of economic development. The myth of progress of all people towards the same kind of death diminishes the feeling of guilt on the part of the “haves” by transforming the ugly deaths of the “have-nots” as a result of underdevelopment, which should be remedied by further expansion of medical institutions (Illich, 2020).

Modern medicine creates completely new situations, which change a person's attitude towards himself, disease, suffering, and death. It produces, temporarily or permanently, disease conditions that, as new risk life positions, cross the previous system of social inequalities: from the beginning of the 20th century to 1980 the proportion of chronic diseases increased from 46% to 80%. Moreover, the end is preceded by long-suffering. The diagnostic toolkit increases, and new diagnoses and pathological conditions are defined, but all this leads to delays in treatments. It can be said that medicine abandons people of the disease, technically takes away their suffering, monopolizes it professionally, and administers it. The disease is generalized because of the successes in diagnostics. Everything “gets sick” currently or potentially, everyone is currently or potentially “ill”, no matter how he/she feels. The image of the “active patient” is constructed, from whom “cooperation” is expected (Beck, 2013, p. 355).

According to Talkott Parsons, the “sick role” requires the patient to cooperate with the physician, to allow access to his body, to fulfill the prescriptions, etc. The one who refuses to follow the

recommendations questions his sick status. But Parsons' structural-functionalist model nowadays fails to explanation for phenomena such as health consumption, or the conduct of patients with chronic diseases (diabetes, osteoporosis, asthma, hypertension), etc. The theory model of symbolic interactionism determines three options for the sick role, taken from the structural-functionalism theory. The chronically ill people perform the "unconditional sick role". They get the recognition that they do not bear the blame for their suffering, but society expects them to "unconditionally" take on their role (Dokova & Rangelova, 2017).

According to the conflict theory, Elliot Freidson brought out the conflict (instead of Parsons' consensus) guiding the patient-physician relationship. It is a consequence of the fact that they represent different social and cultural groups. Difficulties in professional-non-professional relationships are a result of structural conflict, not a poorly executed social role. Parsons' legitimate authority and credibility in this theory are interpreted as medical dominance and oppressed conflict. While the patient is excited about his suffering, and about the difficulties professionally and personally, the physician is interested in the diagnosis and qualification of the individual to prescribe therapy. Other authors define a source of potential conflict as the contradictory expectation for the patient's conduct. On the one hand, he is expected to be a "well-informed citizen" who knows when to seek a medical consult. But on the other hand, after entering the cabinet, he should get rid of his knowledge and adopt the physician's prescriptions unequivocally. At first, the patient was stimulated to show activity but later excluded from the treatment process (Dokova & Rangelova, 2017).

Medicalization also brings individualization of societal problems. There is a shift of societal problems to the field of medicine, but also psychologists or social workers. Therefore, it is typical for modernity to formulate social problems through medical categories. But in fact, questions that seem purely medical and are within the competence of medical professionals are often the product of social factors. In society, medicine is a conservative force that maintains the status quo and distracts from major threats to human health (Ivkov, 2014, p. 50-51).

The technical and the nontechnical consequences of institutional medicine generate a new kind of suffering: anesthetized, impotent, and solitary survival in a world turn into a hospital ward. "Medical nemesis is the experience of people who are largely deprived of any autonomous ability to cope with nature, neighbors, and dreams, and who are technically maintained within environmental, social, and symbolic systems" (Illich, 2020, p. 162). The term is taken from Honoré

Daumier's drawing "Nemesis Medical" where Nemesis is "the inevitable punishment upon mortals for attempts to be heroes rather than human beings." The reversal of nemesis can come only from within man and not from yet another managed (heteronomous) source depending once again on presumptuous expertise and subsequent mystification (Illich, 2020, p. 14).

Conclusion

The fundamental worldviews of the world's major religions are against the moral acceptability of EPAS. Not only do these beliefs represent thousands of years of combined human wisdom, but also the views of billions of people living today. Some commentators indicate profound changes in contemporary postmodern, secular, and Western societies. These include the growth of individualism and the desire for autonomy, and the decline of religiosity with its vocabulary that allows for discussion around death and tolerance of mystery (Grove et al., 2022).

Christianity requires us to respect every human being. If we respect a person, we should respect his/her decision about the end of life. Perhaps we should accept his/her rational decision to refuse excessively burdensome treatment even if it may provide several weeks more of life. But the community should care for people who are dying, and for those who are close to them. The community should provide the best possible palliative care. The community should face death and dying with honesty and support. The community should recognize that when people suffer death on earth, they entrust their future to the risen Christ. Religious people should help the terminally ill prepare for death (BBC, 2009).

As Ivan Illich (2020) wrote, in industrial societies it is imposed a sociopolitical image of death and people are deprived of their traditional vision of what constitutes health and death. The self-image that gives cohesion to their culture is dissolved, and atomized individuals can now be incorporated into an international mass of highly "socialized" health consumers. Medicine in practice takes the form of a game, and the physician is the agent of the social body with the duty to make sure that everyone plays the game according to the rules. The rules forbid leaving the game and dying in any fashion that has not been specified by the umpire. Death no longer occurs except as the self-fulfilling prophecy of the medicine man. Through the medicalization of death, health care has become a monolithic world religion whose ethical rules are applied to a bureaucratic restructuring of the environment and people's conduct. Traditionally the person best protected from death was the one whom society had condemned to die. Society felt challenged and threatened if someone

took his/her life before the appointed hour. With the medicalization of society Western man has lost the right to preside at his act of dying.

In the words of Angel Tsvetkov (2017), the Church should not remain silent on the modernization of societies, and it should find the necessary formula to face the changed expectations of people. And because it is aimed at the practical mind – morality, and the practical cognitive attitudes, it should overcome the so-called Pierre Bourdieu "crisis of ritual". Because in the past the individual was not understood outside the community, symbolic manipulations were directed to community attitudes, where through dogmas chaos is controlled. And because of modern individualization, the boundaries are blurred secularly and religiously: "inconspicuous gradations of the once-spirituals" appear to martial arts teachers, psychoanalysts, doctors, and social workers. All of them use in their practices competitive, antagonistic definitions of healing, and treatment of the body and soul. They all manipulate worldviews by manipulating words, and therefore, the principles of creating the social reality. If ever attention was paid to the treatment of the soul, then today it goes through the treatment of the body. What was once entrusted to the cleric – the soul, and the body – to the wizard, is now redefined: to talk about the body is a way to get to the soul.

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Appendix

Table 1

Justifiable: euthanasia (opinion on a scale of 0 to 100: euthanasia can be justified; 0 = never, 100 = always; for some countries, there is no data)

European country	Total, ≈	Elderly	Young	Never visited church	Visited church often	High education	Low education	High income	Low income	Religious	Not religious
Denmark	73	67	74	76	41	71	72	72	72	74	71
Netherlands	72	69	72	79	42	75	68	73	67	59	80
Germany	70	65	72	77	51	73	63	70	67	64	79
Finland	68	59	70	80	36	70	63	66	63	64	79
Sweden	63	63	61	73	39	62	59	62	61	61	67
France	63	64	56	68	38	70	57	64	57	54	70
Iceland	63	54	67	69	45	65	59	61	59	61	72
Great Britain	62	60	58	67	37	64	58	62	58	53	67
Norway	59	47	66	67	29	58	56	59	57	54	68
Czechia	59	53	58	62	32	60	56	58	59	49	62
Slovenia	59	51	63	71	44	67	48	59	54	53	70
Switzerland	58	52	60	65	40	58	57	58	56	55	65
Austria	57	50	66	69	39	58	54	58	60	52	68
Spain	57	47	65	68	38	65	50	54	53	49	70
Estonia	56	54	53	61	30	63	43	54	53	41	60
Italy	53	46	58	71	43	63	47	51	46	47	74
Lithuania	47	40	51	53	41	49	43	46	42	45	60
Belarus	45	38	51	53	35	43	44	43	40	40	53
Portugal	43	27	55	53	25	55	36	44	-	38	58
Hungary	43	40	50	49	31	49	33	41	41	38	47
Slovakia	43	34	48	56	31	45	36	41	42	37	55
Russian Federation	43	36	47	44	27	47	38	43	37	41	45
Ukraine	41	33	42	49	32	43	31	39	43	38	-
Poland	37	29	40	66	25	44	31	36	33	34	65
Croatia	37	33	38	57	24	49	31	34	32	34	52
Serbia	33	31	38	37	23	38	32	33	27	34	31
Bulgaria	31	29	32	37	22	33	25	31	31	30	32
Bosnia and Herzegovina	28	21	31	37	21	44	19	27	22	27	48
Romania	23	16	28	32	18	29	21	24	19	23	28

Montenegro	23	24	25	43	16	30	22	23	20	24	22
Georgia	22	22	24	26	16	23	19	21	22	21	32
Armenia	19	18	18	26	20	-	19	19	18	18	25
Albania	19	14	26	25	12	21	17	18	18	18	32
Macedonia	19	13	26	30	12	30	7	18	11	18	30
Turkey	17	14	18	19	15	19	15	17	13	17	-
Azerbaijan	15	11	16	14	12	16	11	14	14	14	24

Note: European Values Study (2017)