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BIOETHICAL ACCEPTABILITY OF EUTHANASIA IN THE GREEK ORTHODOX RELIGIOUS CONTEXT

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Abstract: The paper analyzes the instances of social construction of the acceptability of euthanasia in the Greek Orthodox Christian religious context. A series of three focus groups and ten individual interviews were undertaken with people belonging to the Greek Orthodox Christian religion in north-eastern Romania. The interviews addressed how people make their decisions about the ethical acceptability of euthanasia and how religious beliefs inspired by Orthodox Christianity are reflected in the decision-making process regarding the acceptability or unacceptability of an extreme medical practice, including interrupting the course of life at the patient's request. Data analysis was performed using the Grounded Theory method. The emotional factor and discursive contingency of the reference group significantly contributes to nuancing religious beliefs. The bioethical discourse on euthanasia should be overtoned to take into account not only religious beliefs, but also the emotional context in which the acceptability of an extreme medical practice is socially constructed.

Key words: ethical acceptability; religious background; euthanasia; post-secular society; existential neighboring between man and the Divine.

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1. Introduction

Today's society has surpassed the stage of militant secularism (Habermas 2008), noting its failure, at least in terms of the complete separation of secular institutions from religious organizations, and placement of religious beliefs exclusively in the sphere of individual privacy and family life. The transition to a post-secular society brings a number of major changes in the perception and social acceptance of various practices – including those of an extreme medical nature, such as euthanasia – by recognizing the role of religious identity in the social construction of the idea of ethical acceptability.

Religious affiliation influences decisions about the ethical acceptance of euthanasia. The Greek Orthodox Christian Church expressly opposes the approval of euthanasia, so it is expected that believers should strongly oppose this practice.

The present paper aims to analyze the instances of social construction of the acceptability of euthanasia in the Greek Orthodox Christian religious context, especially in the north-eastern region of Romania.

2. Literature review

2.1. The social construction of ethical acceptability

The ontological and epistemic framework of this research is social constructionism (Gergen 2005), a theory on the process of how individuals come to describe, explain and take note of the world they live in and that includes them (Sandu and Unguru 2017). Constructs represent operational definitions applied to conceptualized aspects of reality. Among them, we include the idea of acceptability. In fact, any conceptualized idea that may suffer from an interpretive adrift – that is, to change its meaning by using it in different interpretive communities – is a social construct. In social sciences, we speak of a relativism of moral values, of a contextual dependence of constructs, of an interpretive adrift of concepts and of a deconstruction of the legitimate meta-stories of modernity.

In narrative constructionist sociology, the emphasis is placed on the construction of social stories, namely metanarratives, that generate local culture and strongly influence the individual, thus becoming a starting point for the individual to build his discourse and substantiate his own decisions (O'Donoghue 2010). The meanings that individuals attribute to the world differ from one social actor to another (Sandu and Unguru 2017), depending on the interpretive contexts, a process of deconstruction-reconstruction, stemmed from on the influences that the interpretive communities exert on individuals. Individuals assume their

own version of social reality in the process of a continuous interpretation (Butt and Burr 2004).

From a social ontological point of view, social constructionism pleads for avoiding to accept the idea of a social-objective reality, but this does not exclude the existence of social reality, that subjects perceive as objective and compelling, but this is only the result of a set of communicative actions (Habermas 1985) that have generated an interpretive consensus.

Starting from ontological theories regarding the existence of different levels of reality (Lupașcu 1982), Antonio Sandu (2016) built his own model of social constructionism, which he calls *fractal constructionism*. Any social phenomenon can be understood through a process of sensitization, that helps individuals attribute meanings to that phenomenon, resulting in a negotiation of the interpretations arising within their own interpretive communities. These meanings generate a series of ethical values, that require the emergence of norms and establishing various sociological institutions.

In order to understand a social phenomenon, we must first identify the norms and behaviors that reflect how interpretive communities, when faced with a window of ethical acceptability, put into practice a set of values that were considered necessary. The establishment of these values required the establishment of appropriate institutions. These values have been called constitutive values (Frunză and Sandu 2018). Once a series of constitutive values obtain the consensus of an interpretive community, they generate, through institutionalization, a level of social reality. For the institutions that act within the respective level of reality, a series of other values emerge, as important and concrete guiding rules for accomplishing the social practice of constitutive values. We call these values *operational* (Frunză and Sandu 2018), but their emergence generates an interpretive adrift from the discursive focus on constitutive values to operational values. The achievement of operational values, in return, requires a new social construction, through new normative institutions and a new interpretive consensus on these operational values, which become constitutive for the new institutions, thus generating a secondary level of social reality.

For example, the concept of human dignity becomes a constitutive value, which, when interpreted in secular interpretive communities, generates a series of sociological institutions that guarantee rights, including expressive autonomy. By exercising these rights and expressive autonomy, the following level of reality becomes apparent: the right to cease one's existence when it is considered that a particular context infringes on human dignity and a person's expressive autonomy reaches an extreme point that makes euthanasia ethically and socially acceptable, within a specific interpretive context.

From another perspective, which emphasizes the sacredness of life as a spiritually originated value, which asserts itself in a post-secular - and at the same time a post-religious - interpretive context, expressive autonomy must be limited to the point where it contradicts the sacredness of life. From that point forward, euthanasia becomes ethically unacceptable.

This conflict of values occurs only at the intersection of the two interpretive models, when one interpretation or the other is placed in a window of opportunity – the *overtone* window (Greer, Bekker, Azzopardi-Muscat, and McKee 2018; Talbot 2019) –, determining the transition from completely unacceptable, through successive interpretive adrifts, to acceptable from an ethical point of view, or, vice versa, from socially acceptable to socially undesirable.

2.2. The sacredness of life from an Orthodox Christian perspective

Christian bioethics speaks of the sacredness of human life, because of the presence of the divine within, and, as such, none of the practices that breach this sacredness can be accepted, including euthanasia, that interrupts life before its natural end.

Christian bioethics is different from secular bioethics, not in the sense of a difference in professional standards, but in the sense of a total involvement of the Christian therapist in the act of care. Professional detachment should not be excluded, but compassion is added to it, as a form of spiritual encounter with the Other, namely with the divine dwelling within the person who is in need of care.

A series of elements related to respecting the sacredness of life should be added to the fundamental values of the medical profession, the spiritual value of providing help and the spiritual value of loving your neighbour. These additional values should make the distinction between a practice infused with Christian values and a secular professional practice.

The restriction of life before the end of its natural course contradicts the sacrificial approach by martyrdom. According to Christian beliefs, martyrdom is sanctifying when it represents a continuity of life alongside God, but not as an exit from suffering "through the back door", as in the case of euthanasia. The person should accept their condition of health because it is allowed by God. Suffering is seen as a trial useful for one's spiritual growth. The contemporary, postmodern society is one that escapes pain a society where people are rather selfish and individualistic and have a minimalist ethic (Lipovetsky 1996).

2.3. Ethical context of post-secular values in the north-eastern region of Romania

The failure of the total separation between state and religion becomes obvious especially when analizing mentalities, a level where ethical values originated in faith, although secular at this point (Nistor 2018a, 2018b, 2019a, 2019b), are visibly influencing the ethical conduct of

individuals (Sandu, Huidu, and Frunză 2020), such as human dignity, love, understanding, dialogue and mutual respect (Habermas 2008).

A perspective stemming from the sociology of religions is that today we are at the point of overcoming secular modernity and individualistic postmodernity, and we are moving towards a post-secular society (Parsons 1984), as a recognition of the role that religious communities have socially, in the sense of mobilizing energies towards implementing ethical values. Such values have a Christian origin, even if they have suffered an interpretive adrift in the sense of secularization (Dinham and Lowndes 2008).

Sider and Unruh (2004) talk about faith-based organizations that, in the process of providing services, may undergo various secularizing processes that cause them to change their characteristics. This produces the phenomenon known as the professionalization of charity (Nistor 2018a). Religious ethical values recovered in post-secular society could infuse various practices, at least at the level of their social acceptability component.

Previous research shows that the north-east of Romania, the area where this research was conducted, could represent a model of a post-secular society in which religious values are received by individuals through cultural filters (Sandu, Frunză, and Huidu 2020). The cited study draws attention to the fact that the family remains the main source of information on ethical values, as well as the Church. As such, we speak of a type of ethics originated in faith.

2.4. Approaches to euthanasia in the post-secular society

The study by Verulava, Mamulashvili, Kachkachishvili, and Jorbenadze (2019), who questioned Georgian Orthodox priests about euthanasia and its Christian-Orthodox acceptability, showed that 81% of respondents consider euthanasia to be "the consent to life termination during illness, when there is no way out and recovery is impossible". The priests who participated in the survey said that the Orthodox Church bans euthanasia, but 39% of them believe that euthanasia can be justified in extreme medical conditions. The article also discusses the difference between voluntary and involuntary euthanasia, both of which are considered killings - although in some cases we can speak of "mercy killing". The article emphasizes the difference between active and passive euthanasia, showing that the latter – which means disconnecting a patient from life-support devices – is considered less appalling from an Orthodox perspective.

Another study by Banović and Turanjanin (2014) compares the acceptability of euthanasia from the perspective of Orthodox Christians, Catholics, and followers of Islam, and draws attention to the fact that although the Catholic Church strongly opposes euthanasia, studies show that a large majority of Catholic believers from the Netherlands, for

example, are in favour of this practice (Leenen 2001). In the countries of former Yugoslavia, cross-cultural influence leads to a lower rate of acceptability of euthanasia. This is probably due to Islamic influence, as followers of Islam are wholly against this practice.

Regarding the social construction of acceptability of medical practices, the post-secular society is divergent, accepting that the religious factor may be one of the instances of social construction of ethical acceptability, but also that the interpretive adrift of ethical values may influence the social construction of euthanasia in a post-religious context.

Ana Iltis (2006) points out that Catholic hospitals in Belgium are involved in carrying out euthanasia, which is religiously unacceptable. The organization is faith-originated, but after undergoing a process of secularization, which occurs as a result of a need for social integration and access to funds, it loses its spiritual dimension, in the sense that its medical practice not only is no longer based on Christian values, but even contradicts them.

3. Research methodology

3.1. Data collection

A series of 3 focus groups and 10 individual interviews were applied to individuals with Christian-Orthodox beliefs in North-Eastern Romania. The interviews addressed how people make decisions about the ethical acceptability of euthanasia and how Christian-Orthodox-inspired religious beliefs are reflected in the decision-making process about the acceptability or unacceptability of an extreme medical practice, euthanasia.

3.2. Data analysis

Data analysis was performed through the Grounded Theory method, which presupposes that participants in the process of social construction are brought together in various interpretive contexts, called "instances" of social construction. In other words, we cannot understand social reality in its entirety, but only contextually, and only certain levels of it, which may or may not communicate with each other (Sandu 2018).

The purpose of Grounded Theory is to generate a theory on a social phenomenon and not to verify an existing theory or hypothesis. GT is a method that is generally used in exploratory researches of social phenomena (Sandu 2018) that are not explained satisfactory by a previous theory (that can suggest hypotheses for future confirmation through empirical research), for studying completely new social phenomena, or when it is assumed that the explored phenomenon is so different from previous social phenomena, even seemingly similar, that one can no

longer apply existing theories. In these situations, the construction of a new theory is pursued, starting inductively from the data obtained in the field (Urquhart, Lehmann, and Myers 2010).

The induction cycles are successive, until the construction of a theoretical model with the highest possible degree of generality is achieved (Chen and Boore 2009). A qualitative methodological design is followed in the construction of the research approach, based on the elaboration of some theme axes for the interview or the focus group. The interrogative process of data collection will be repeated until new interviews no longer generate additional significant information. As data is collected, it is subjected to the interpretation process. The first stage is called open or initial coding (Cheer, MacLaren, and Tsey 2015). In this first stage, the researcher divides the data into semantic categories, which are considered to be the same semantic units because they refer to the same thing, in approximately the same terms. The other stages of coding, called axial coding and selective coding, aim at establishing the preponderant semantic categories in the discourse of the persons interviewed, respectively the relationships between these categories, possibly revised, and the construction of the interpretive model. By using this process of data analysis, the generated theory would have an increasingly higher degree of generality, which would no longer be a regional, local one, but would have the potential for generalization and replication (Sandu 2018).

3.3. Qualitative sampling

We applied theoretical sampling, by including new respondents in the sample after analysing the discourse of previous respondents, and new participants were included in the sample until we reached the saturation of the model. To ensure data saturation, in order to build the theoretical model, a saturation grid was used according to the methodology presented by Fusch and Ness (2015), that contains the categories listed vertically, and the respondents listed horizontally. To ascertain saturation, the contribution of the last respondents to the table of categories does not exceed the categories already obtained for n-2 respondents.

3.4. Triangulation of researchers

In order to ensure increased veracity of the analysis, the process of elaborating the categories and establishing the relationships between them was performed by all authors of this study independently. The interpretations obtained were then mediated in such a way as to outline a commonly accepted analysis of data and an interpretative consensus between all three researchers.

4. Analysis of the categories obtained in the axial coding stage

4.1. Category 1: Meaning of the term euthanasia

The answers were that euthanasia is a right, namely the right to die on the part of a person who is in an incurable, terminal health condition, who suffers excruciating pain, or is in a condition that can be considered incompatible with the dignity of the human being.

Unfortunately, we have few definitions of this term that can be deduced from the focus groups as operational definitions of euthanasia. This indicates that there was no ethical reflection among participants regarding euthanasia prior to that resulting from participation in the focus groups, which leads us to conclude that the topic of euthanasia has not yet been emphasized enough as a topic on the public agenda. This omission can be correlated with the influence of faith-originated values, which are currently part of common morality nationwide. We consider this as an indicator for a taken for granted attitude that euthanasia is unacceptable in a secular Romania, a country that, at the same time, is still deeply influenced by religion. In the process of secularization, the value of human life transforms from an ontological value into a legal value, secular in nature, and the value of human dignity shifts from individual dignity to the dignity of the human species.

4.2. Category 2: Euthanasia as an alternative

When talking about considering euthanasia as a solution to ending suffering, it is considered by some interviewees that, even if such people recover from their illness, their quality of life would be greatly diminished, and perhaps such a person might consider such a life to be below their dignity.

Participants believe that euthanasia can be acceptable in the last days of life, when death is imminent, and when a person is suffering from excruciating pain which can no longer be alleviated with painkillers, a view influenced by compassion, when euthanasia would mean a dignified end (Fernandes 2010), relieving them of suffering when their expressive autonomy is almost non-existent. The relative congruence of responses provided by participants and the existing literature highlight the influence of the general cultural context on the religious beliefs of the interviewees.

4.3. Category 3: Involvement of physicians in euthanasia

The participants have divided opinions, the general emphasis being that doctors should not participate in such a practice because they have taken the Hippocratic oath.

Emphasis is also placed on the need for specialized clinics where euthanasia could be legally performed, and on the fact that there should be qualified medical staff to perform such practices. Focus group

participants believe that taking the lives of people repeatedly can in some cases be a sign of imbalance or even mental illness, and therefore underline the importance of psychological training for these profesionals.

It can be concluded that, in a society where euthanasia would be very easily allowed, an interpretive adrift might occur on a social level, from the acceptability of euthanasia to the acceptability of selective eugenics, including euthanasia of people suffering from various disabilities. We believe that the concern for the mental state of doctors hides an anxiety about possible unethical medical practices, specific to either totalitarian societies (which was the case of communist Romania before 1989) or to societies that are hyperpermissive in terms of individual freedoms.

4.4. Category 4: Decisions on euthanasia

Most people believe that the right to decide on euthanasia should belong exclusively to the person concerned, only after consulting the doctors of a clinic that is exclusively specialized in euthanasia, confirming or refuting whether there is a medical course of action that can lead to an improvement in the person's health condition or if that person is indeed in a terminal situation. There should be an ethical, medical and legal analysis.

The family should not have a decisive say and, as a consequence, at least euthanasia of minors and / or legally incapable persons should not be permitted. Otherwise the delegated consent would be the equivalent of a killing agreement (Banović and Turanjanin 2014). In addition, the decision of the person who provides the delegated consent could be challenged anytime, and not necessarily only from a legal point of view. Legally, though, the act of the doctor performing euthanasia, in an unclear context, could be labelled as manslaughter.

The point was made that families do not have medical education, nor do the Courts have such expertise and then it was suggested that the need for the consent of third parties should be as limited as possible.

As in previos categories, the perspective was also secular in nature. The arguments of the interviewees are similar to those discussed in the literature, which leads us to think that the opinions presented by the participants are rather culturally formed in involuntary interpretive adrift processes, without a direct awareness or interest in euthanasia as a bioethical issue. The arguments were taken over from public debates and remained unfiltered by the participants' own opinions, who agree with these arguments without being able to argue why.

4.5. Category 5: Legalization of euthanasia

Regarding the legalization of euthanasia, it is shown that this practice is legal in countries that have a democratic tradition and, consequently, they would be able to set an example for Romania. It is interesting to note the cosmopolitan perspective on the legalization of

euthanasia and on social acceptance. We are practically talking about a phenomenon of anticipatory socialization.

On the other hand, references to the idea of legalizing euthanasia are not common between participants, which strengthens our belief that, although the issue is under discussion in the public space, it has not yet emerged as part of the public agenda.

It has also been discussed that in Romania euthanasia is not only illegal, but also unconstitutional, because it would violate a number of other fundamental rights, including the right to decide on his or her own health condition. The constitutional argument actually opens a broader discussion on the correlation of the right to end life with the right to life itself and the possible legal continuity between the two subjective rights (Chetwynd 2004).

4.6. Category 6: Religious perspective on euthanasia

We received few effective references from participants. Duiring focus groups we were only told that the Church considers suicide to be a sin, that life can only be taken by God, and that religious factors, among others, intervene in the decision to accept or not accept euthanasia as a legal practice. Again, the lack of previous moments of reflection can be observed in participants.

Many of the respondents seemed to reject the religious idea that euthanasia is totally unacceptable, because there could be unequivocal chronic, incurable, deeply painful conditions, when, only with the consent of the person, euthanasia would be justified, and not be seen as a murder out of compassion (Zdenkowski 1996), and, thus, be implicitly legalized. Orthodoxy emphasizes on suffering and its spiritual role, but the idea of suffering as personal martyrdom was not discussed during the focus groups or interviews.

The critique of the acceptability of euthanasia from a religious perspective is rather a series of somewhat a priori ideas, aimed at the fact that there are people in terminal stages who have hope until the last moment, therefore those who give up are to be blamed, but this argument is also rather a plea for the freedom to choose when euthanasia is a legal option, but not a moral or spiritual one.

4.7. Category 7: Euthanasia and the problem of disconnecting the patient from life support devices

We identified a confusion between active and passive euthanasia, including the action to disconnect a patient from life-supporting devices, which is included by most speakers in the sphere of euthanasia, and the arguments against euthanasia extend to the latter.

The possibility of a miraculous recovery of the person is also discussed here. If such a person would have been euthanized, his/her right to life would have been violated. Disconnection from life-support devices

is discussed as an attitude against medical obstinacy (Ameneiros-Lago, Rico, and Garrido Sanjuán 2006).

The reference to possible miracles stems from folk religiosity, where artificial life support techniques became a part of everyday mythology, but the perspective is not necessarily a religious one in the dogmatic sense, but is rather related to the narrative construction of the medicalization of social life, by including the phenomenon of technological miracles.

4.8. Category 8: Euthanasia of persons with impaired discernment

One of the interviewees tells us that, people who resort to euthanasia are considered cowards. The possibility that these people are in a state of altered consciousness precisely due to the disease is also invoked, which involves a state of increased anxiety and disappointment, As a result, the request for euthanasia is not fully justified by a mature and complex reflection on this final decision. Again, we note the increased concern in terms of flawed or altered consent, thus euthanasia should not be allowed to those incapable to provide informed consent in any situation. It is necessary to emphasize the existence of multiple filters, including psychiatric and psychological assessment, until the moment when euthanasia can be allowed to a person.

4.9. Category 9: The psychological perspective on people who want to perform euthanasia

The focus group participants consider that the medical staff involved in the procedure must be evaluated psychologically, not just permanently counseled, in order to analyze the level of post-traumatic stress that such a practice can bring to people who perform euthanasia.

We believe that such a perspective defines normalcy as the prohibition of euthanasia, and requests for this practice to be automatically marked as unnatural, even if socially acceptable, but questionable both morally and from the perspective of the mental integrity of the person requesting or performing it, an opinion which originates in pre-religious morality, but is expressed in a post-secular society, where the transition from stigmatization of suicide (Durkheim 1993) to euthanasia is made.

4.10. Category 10: Performing euthanasia as an act of killing

The moral capacity of euthanasia practitioners to take on such a task is questioned, but again the possibility is highlighted that a professional will suffer from behavioral disorders, even mental disorders – a passion about killing, masked under the noble intention compassionate killing.

Of course, here we see a predominance of faith-originated ethical values (Sider and Unruh 2004) - in terms of the ethical foundation of

personality, given that participants in the focus groups consider it abnormal to contribute to the end of a person's life.

4.11. Category 11: Difficult / limited access to euthanasia

Access to euthanasia should, according to focus group participants, particularly difficult and limited. There should be more filters and the concrete application of euthanasia must be considered responsibly, to determine whether or not it meets a number of criteria for the acceptability of such a practice.

4.12. Category 12: The burden of life

The acceptability of euthanasia also comes from the fact that sick people, who are in an incurable state, consider themselves a burden to others. In fact, suicide itself is often associated with the burden of life.

The burden of life for the person suffering and for those caring for such a person was brought up as an argument in favor of legalizing euthanasia, especially if there are also other severe chronic conditions that place the person in a state of permanent discomfort, pain, and utimately of an unacceptability of life.

5. Generated Theoretical Model

Religious affiliation influences ethical decisions - including those regarding the acceptability or unacceptability of euthanasia. The Christian Orthodox Church expresses its disagreement with euthanasia and therefore those who are faithful are expected to consistently oppose such practice, because the individual was created in the image and likeness of God, and only the Divine should intervene to end human life.

The analysis of the focus groups shows that only few participants place the rejection of euthanasia in a religious context, a context which is only marginally considered and is not acknowledged as a source for the participants' beliefs on the ethical unacceptability of euthanasia. This rejection of euthanasia is rather placed in the context of concern for those individuals who might be subjected to such a practice, perhaps without their consent. This might happen in the terminal stages of a disease, when the patient is no longer able to consent, terminal states being considered psychological situations that would diminish the individuals' ability to consent. Other particular cases that were discussed referred to the euthanasia of people suffering from severe depression and the euthanasia of minors - which requires delegated consent.

Regarding the ethical acceptance of euthanasia – this is influenced by the general cultural context on the given local context and less by the religious beliefs of the interviewees. The perspective of a possible decision to perform euthanasia is secular in nature.

The religious perspective on the sacredness of life, in Orthodoxy, comes from the idea of human being's existential neighboring (closeness) with the Divine, which has its origin in the co-substantiality between the Divine Persons. The presence of Christ within the human nature elevates the latter to a continuity with the divine nature, opening up the perspective of deification - both of the human person, as well as of the entire creation.

The human being is the only one who can be aware of his existential neighboring – familiarity - to the divine nature. From the Orthodox-Christian perspective, the task is not only to deify oneself by accepting the sanctifying grace of the Holy Spirit, but also to lead to the deification of the whole nature through the deification of the human being.

The idea of accepting the human condition, which also includes suffering, once secularized, loses the dimension of continuity of the being between man and the Divine and in the same time the idea of the sacredness of life.

Arguments regarding the possible legalization of euthanasia should take into account the level of ethical acceptability of such practices, including those related to the religious specificity of local interpretive communities.

6. Some conclusions of this analysis:

Contrary to expectations, the religious element was less present at the discursive level. It was rather present as a continuous substrate that unconsciously motivates the decision to reject legalizing euthanasia. The participants are rather inclined to accept it as a practice, however after asserting strict limitations regarding the categories of persons who could benefit from this practice or could be involved in performing euthanasia, so extremely strict conditions must be put into practice in order for euthanasia to be legal.

Euthanasia should be totally forbidden to people without discernmen or impaired discernment, because delegated consent regarding euthanasia is unacceptable.

Even if participants are aware that from the point of view of the religion they adhere to, the practice is totally unacceptable, personally they would admit to cases of euthanasia when human dignity is subjected to the ultimate test, namely if there is unbearable pain involved.

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