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# End-of-life Decision-making and Religious Beliefs: Opinions and Attitudes towards Death and Euthanasia in Argentina*

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**Abstract:** This paper analyzes the opinions on and attitudes towards the end of life among the population residing in Argentina. The data presented are taken from the Second National Survey of Religious Beliefs and Attitudes in Argentina, which was conducted on a multi-stage sample of 2421 cases in 89 districts throughout the country. Opinions about the end of life include positions in favor of euthanasia, requesting life extension through life support technologies, and leaving death to God's will. Religious beliefs and affiliations prove to be determining variables in the positions taken by Argentine citizens regarding the end of life, death, and euthanasia. Furthermore, among those without any religious affiliation, some positions of autonomy over their bodies stand out: prolonging life and bringing life to an end, which means that their support for euthanasia can be assumed. The data presented here intend to contribute to planning health policies about the end-of-life process. The different views on this process or, in other words, the beliefs, values, and needs of patients and their families have a unique relevance that must be considered in the organization of care settings in end-of-life contexts.

**Keywords:** Surveys; questionnaires; religion; attitude towards death; euthanasia

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## *Toma de decisiones al final de la vida y Creencias Religiosas: opiniones y posturas en relación con la muerte y la eutanasia en Argentina*

**Resumen:** el presente documento analiza las opiniones y actitudes hacia el final de la vida entre la población residente en Argentina. Los datos presentados fueron tomados de la Segunda Encuesta Nacional de Creencias y Posturas Religiosas en Argentina, que se realizó en una muestra en varias etapas para 2421 casos en 89 distritos de todo el país. Las opiniones sobre el final de la vida incluyen posiciones a favor de la eutanasia, la solicitud de prolongación de la vida por medio de tecnologías de soporte vital y dejar la muerte a la voluntad de Dios. Las creencias y afiliaciones religiosas demuestran ser variables determinantes en las posiciones tomadas por los ciudadanos argentinos en relación con el fin de la vida, la muerte y la eutanasia. Además, entre los que no tienen ninguna afiliación religiosa, destacan algunas posiciones de autonomía sobre sus cuerpos: prolongar la vida y poner fin a la vida, lo que significa que se puede asumir su apoyo a la eutanasia. Los datos presentados aquí tienen la intención de contribuir a la planificación de las políticas de salud sobre el proceso del final de vida. Las diferentes opiniones sobre este proceso o, en otras palabras, las creencias, valores y necesidades de los pacientes y sus familias tienen una relevancia única que debe considerarse en la organización de entornos de atención en contextos del final de la vida.

**Palabras clave:** encuestas; cuestionarios; religión; actitud ante la muerte; eutanasia

## *Tomada de decisões no fim da vida e crenças religiosas: opiniões e posicionamentos quanto à morte e à eutanásia na Argentina*

**Resumo:** Neste documento, analisam-se as opiniões e as atitudes no fim da vida entre a população residente na Argentina. Os dados apresentados foram coletados da Segunda Pesquisa Nacional de Crenças e Posicionamentos Religiosos na Argentina, que foi realizada numa amostra em várias etapas para 2.421 casos em 89 distritos de todo o país. As opiniões sobre o fim da vida incluem posicionamentos a favor da eutanásia, a solicitação de prolongação da vida por meio de tecnologias de apoio vital e deixar a morte à vontade de Deus. As crenças e as afiliações religiosas demonstram ser variáveis determinantes nos posicionamentos tomados pelos cidadãos argentinos com relação ao fim da vida, à morte e à eutanásia. Além disso, entre os que não têm afiliação religiosa, destacam alguns posicionamentos de autonomia sobre seus corpos: prolongar a vida e dar fim à vida, o que significa que pode ser assumido seu apoio à eutanásia. Os dados apresentados aqui têm o objetivo de contribuir para planejar as políticas de saúde sobre o processo de fim da vida. As diferentes opiniões sobre esse processo ou, em outras palavras, as crenças, os valores e as necessidades dos pacientes e suas famílias têm uma relevância única que deve ser considerado na organização de contextos de entornos de atenção em contextos no fim da vida.

**Palavras-chave:** enquetes; questionários; religião; atitude ante a morte; eutanásia

## Introduction

In 2019, the Society, Culture and Religion Program, based in the National Scientific and Technical Research Council's Center for Labor Studies and Research (CEIL-CONICET), carried out the Second National Survey on Religious Beliefs and Attitudes in Argentina, coordinated by a team that included the authors of this paper. The survey addressed diverse aspects of religious beliefs and practices of varying degrees of institutionalization. It further explored citizens' attitudes towards several issues on the public agenda that have been historically influenced by confessional institutions (such as regulation of abortion, sex education, religious teaching in state schools, and state funding of religion).

One of such issues was that of personal decisions at the end of life. In this paper, we will try to establish the orientations of Argentine society about this topic, identify different positions according to age, educational level, gender, and place of residence, and analyze the relationship between religious affiliation and individual decisions in a terminal illness situation.

Regionally, regulations about the end-of-life process exist in Colombia, Brazil, Uruguay, and Argentina. In Colombia, euthanasia has been established by Court Ruling T-423.17. Brazil, Uruguay, and Argentina have legislation about the autonomy of individuals to decide whether to accept or reject medical treatment at the end of life. In the case of Argentina, Law 26,742, passed in 2012, amends Law 26,529 or the Patient's Rights Act (2009), granting individuals with a terminal illness the right to accept or reject medical treatment to prolong their lives. The 2009 law included the concepts of advance health directives, informed consent, and patient autonomy, which was a significant step forward in Argentine legislation since, before this patients' rights law, end-of-life issues were litigated or solved through consultations with clinical ethics committees whose recommendations are not legally binding.

This law (26,529) sets down that patients have the essential rights to medical care, dignified and respectful treatment, intimacy and confidentiality, autonomous free will (rejection of specific therapies and treatments), complete medical information about their health situation, and informed consent (1,2). In 2012, Law 26,742 titled "Dignified Death. Protection of the Dignity of Terminally Ill or Dying Persons" was passed. This legislation explicitly states that, at the end of his or her life, a person can reject surgical procedures, reanimation, life support, as well as hydration and nutrition since these are means that would prolong dying (2,3). Besides, Sections 59 and 60 of the Civil and Commercial Code grant individuals the right to reject medical treatment in illness situations, provide informed consent, and formulate advance directives. Both pieces of legislation consider hydration and nutrition as a treatment that can be rejected in end-of-life situations and prohibit euthanasia practices (1,4).

The issue of nutrition and hydration and the definition of death concerning the notions of persistent vegetative state and minimally conscious state were the most debated topics, both in the legislative arena and in public opinion (5,6). The conceptions and notions included in the law have their origin in a broad tradition of litigating decisions about medical treatments at the end of life. According to Alonso (6), the first court ruling about the rejection of a blood transfusion due to religious reasons dates back to 1975. According to this author, From then on and until the 1990s, prominent court cases dealt with rejections of blood transfusions by Jehovah's Witnesses. In the mid-1990s, other controversies arose, *e.g.*, the rejection of amputations in diabetic patients, and as of 2000, the withdrawal of life support and the suspension of treatment (3,6). In 2012, the Argentine Supreme Court issued a ruling authorizing the suspension of treatment and the withdrawal of hydration and nutrition in a case of persistent vegetative state (4, 7). Thus, the provisions of the Patient's Rights Act, which was enacted in the same year, and the Civil Code provided a regulatory framework for practices that were already taking place in healthcare settings.

## Social Studies about the End of Life

The various angles of the end-of-life process, death, and dying were studied early on from the classical social sciences and humanities perspectives. Death,

occurring both naturally and through the intervention of others, suicide, grief, and the different forms in which modern societies face the end of life are recurrent themes (8). In particular, during the early 20th century, death studies became established as a specific field of knowledge (9,10). Historiography presents studies about changes in the mentalities about death and its meaning in the Middle Ages and Modernity. According to such studies, death in medieval times is a public and family moment, whereas, during the modern era, death goes through a privatization process and becomes subject to technology intervention (11-13).

Latin America has produced a vast amount of academic literature in the field of death and dying studies. Particularly worth mentioning are the study of the past and the symbolic production of the deceased, post-mortuary practices and history, and mortuary rituals and actions in urban and rural settings (14,15). The issues of the body, the embodiment of the deceased (16), as well as violent deaths, disappearances, and remembrance, have been the focus of academic research regionally (16,17) and established a field of study in the anthropology and sociology of death (15).

On an international scale, especially in the Anglo-Saxon world, courses, seminars, and publications about the sociology of death and dying have multiplied since the mid-1960s (18), which marks the beginning of a broad production of research centered on healthcare institutions and the interactions between patients and professionals during the end-of-life process. These works analyze the different death paths, hospital staff strategies to deal with patients at the end of life, and the organizational settings which shape dying, understood not only as a physiological phenomenon but also as a social construction (19,20). Along these lines, there has been a proliferation of studies focusing on expanding hospitalized death and intensive care rooms. Research has also studied the critical shifts towards the technification and medicalization of the dying process, leading to the expansion and consolidation of palliative care in hospital settings (21,22).

Various analysts claim that the emergence of the concept of "brain death" reveals the possibility of separating "social death" from "biologic death" (23). In this context, vitality shifts to the brain, displaying neocortical activity and consciousness. This gives rise to many complex ethical and legal reflections and new forms of relationship based on the possibilities of organ transplantation and body part or dead tissue donation (23). Death can be interpreted as the breaking of bonds and as a process of social and political communication and interaction (24). In general, the different approaches agree that the way in which the dying process is handled in contemporary societies points to their members' social and biological processes (17) and that the process of dying can be addressed as a *social problem*, that is, as the result of collective construction and definition that become visible and require responses from the state and communities (24).

The dignity of death in hospital settings concerning public policies and patients' rights has been studied by several authors in Latin America (14). Pessini (25) highlights the different debate topics in the region: the difficulties in making therapeutic decisions about patients' treatments, the definition of the state of reversibility, the administration of nutrition and hydration, the participation of families in decisions related to patients, the communication of bad news, legal decisions for the admission of patients into intensive care and the relationship of healthcare professionals with patients and relatives. The implementation of support measures, palliative care, sedation treatments, and healthcare professionals' attitudes have also been extensively studied (22,-26-30).

Menéndez (31) indicates that medical anthropology in Latin America is a source of wide-ranging developments and contributions. In this regard, Mexico is a pioneering country in the study of the health/illness/care-prevention process and has sparked off a theoretical and conceptual debate since 1930, before Europe and the United States (31). In Brazil and other Latin American countries, medical anthropology studies became established by the 1990s, focusing on the health/illness/care-prevention processes (31,45). According to Menéndez (31), a characteristic of regional studies was that they moved away from magical-religious

interpretations of healing and disease to focus on suffering and mortality. About death, Menéndez (31) claims that social studies have shown more interest in cultural and religious mortuary rituals and practices than in the causes of mortality affecting Latin American populations.

In connection with euthanasia as a specific topic of study, there is limited but growing literature. Research indicates that the euthanasia procedure involves not only health professionals and the dying person but also caregivers and relatives (32) and that the criteria for using euthanasia are different in the various countries where it is legal. According to recent studies (34), at least 2 out of 10 physicians are asked to hasten a patient's dying process in an end-of-life situation. Healthcare teams view euthanasia as a complex procedure that involves debates about what is considered a disabling, incurable, terminal, or painful illness or ailment (35). Studies have also been conducted based on patients who ask for euthanasia and their profiles. According to these studies, most people in end-of-life situations who request to die earlier suffer from depression and generalized anxiety disorder, in addition to the physical pain caused by their disease (29). These situations condition the preparation of advance directives (36).

The Colombian case, in particular, has been extensively discussed in the regional literature, which has addressed both legal issues (37-41) and bioethical ones (42,43) and has analyzed cases of patients suffering from chronic degenerative disease, cancer or in a coma (44,45). Conscientious objection and Colombian health professionals' rejection of requests to perform euthanasia have also been broadly debated (46). Discussions in other countries have revolved around ethical dilemmas regarding the limitation of therapeutic effort/sedation (29,36,43,44,47,49) and the conception of what a person is in terms of his or her vital functions. The Brazilian case has also been studied, especially after the country's Federal Medical Council issued resolutions that allowed suspending treatment in 2006 and one about advance directives in 2012 (25,50,51).

Research has also focused extensively on religious perspectives and how they relate to the dying process. Furthermore, how death has been influenced by the secularization process, a distinctive feature of Modernity, has been studied through the analysis of cemeteries and funeral rituals (7,19,53). The implications of these secular frameworks of death become more evident in the growing expectation that people will take responsibility for their own death, making autonomous decisions by preparing donor cards, living wills, and advance directives (23).

Studies that address the relationship between beliefs and the end-of-life process in biomedical settings have found that religiosity is associated with the desire to receive more aggressive treatment, rather than preparing advance directives or suspending treatment (52). These research perspectives also refer to the participation of religion in cases that have caused an impact on public opinion (53,54) and the contradictions between religious beliefs and biomedical system practices, such as the rejection of blood transfusions or surgeries by Jehovah's Witnesses (55). Social studies have also focused their interest on the end-of-life process and hospital care. Research has delved into how secular institutions negotiate patients' demands for medical and spiritual care, the establishment of chaplains and interreligious support services (56), and the influence of religious values over the regulation of terminal patients' rights (57). Besides, some regional studies indicate that life-prolonging or life-sustaining technology is one of the main discussion topics in which politics and religion intertwine (58). In connection with palliative sedation, euthanasia, and beliefs, discussions revolve around patients' autonomy when permeated by healthcare professionals' religious and moral values (30).

In general, we have found that studies carried out over the last few years have focused on people going through the end-of-life process and their relatives. However, the sociology of death and dying indicates that the focus on death must consider the interrelation among social systems, social change, historical processes, social institutions, and identities and that death and the dying process intersect with class, race, and gender issues (59). Our article intends to contribute in two ways. First,

we will analyze the general population's opinions about the end-of-life process based on a representative survey of Argentine society. Second, we will examine these opinions more deeply from an intersectional point of view, focusing on different dimensions: gender, age, educational level, religious affiliation, and the belief in God. By characterizing the various attitudes of Argentine citizens towards the end of life, death, and euthanasia, and by understanding their different positions in terms of these variables, we intend to add, as suggested by the specialized literature, to the study of social mediations in end-of-life decision-making (59).

Since death is present in all of these social domains (institutions, social systems, and personal identity), and its presence varies in form and purpose, it is possible to understand the countless and complex ways in which death is socially mediated (59). Following Matamoros Santos (61), we intend to highlight that the symbolic mediation produced by the concern about death brings together the social and religious fabric through traditions, practices, customs, and logics. In the particular case of euthanasia and the end of life in the context of terminal and irreversible illnesses, it is also believed that the situation depends on technology (prolonging or ending life), which is mediated by healthcare professionals (60).

## Method

Data have been analyzed from the "Mallimaci, Esquivel, Giménez Béliveau & Irrazábal (2019) Second National Survey on Religious Beliefs and Attitudes Argentina" dataset. This dataset results from a probabilistic survey carried out in Argentina (country total) during August-September 2019. The universe under study is the population of the Argentine Republic aged 18 or older, living in urban districts or agglomerations of at least 5,000 inhabitants according to the 2010 National Population, Households and Housing Census. A total of 2,421 cases were selected through multi-stage sampling. The primary sampling units were 89 districts/urban agglomerations.

In the first stage, the sample was stratified (considering the region and district size), and urban agglomerations within each stratum were selected in a systematic random fashion, according to the probability proportional to size (PPS) method. In the second stage, we chose the sampling units (sample block groups) in each selected district through systematic random sampling (the order is based on socioeconomic level indicators) with PPS (according to the population size) and equal allocation per census block group. In the third stage, once the working areas had been identified, a survey and systematic selection of individual houses were conducted. Finally, in the fourth stage, we selected the final sampling units according to sex and age quotas based on population parameters. Data were collected between August and September 2019. The margin of error used is +/- 2 % for a confidence interval of 95 %. The scope of the study is the Argentine Republic (Country Total). Since this is a multi-stage probability survey combining stratification by region and city size and systematic random sampling (with PPS), the data can be extrapolated to the general population, giving due consideration to the margin of error.

This research was carried out in compliance with CONICET's guidelines for ethical behavior in the Social Sciences and Humanities (Resolution 2857/2006), the Declaration of Helsinki (Fortaleza 2013), the UNESCO Declaration on Bioethics and Human Rights, and the Human Rights laws and covenants currently in force in Argentina. Participation in the survey was voluntary. Participants' informed consent was obtained once the goals and expected benefits of the study were explained to them. The data collected are used for statistical purposes, with confidentiality and anonymity guaranteed to respondents so that they cannot be identified (Table 1).

**Table 1.** Sample characteristics according to distribution by gender, age, and educational level

| | |
|---|---|
| Women | 1,274 |
| Men | 1,147 |
| Total | 2,421 |
| 18-29 | 714 |
| 30-44 | 752 |

| | |
|---|---|
| 45-64 | 635 |
| 65 and older | 620 |
| Total | 2,421 |
| No education | 141 |
| Elementary school | 788 |
| Secondary school | 1099 |
| Non-university institution | 205 |
| University | 188 |
| Total | 2,421 |

**Source:** own elaboration.

The "personal decision in an end-of-life situation" variable was surveyed based on a question with three mutually exclusive response options. Respondents were asked the following question: "If you had a terminal and irreversible disease, which decision would you make?" The questionnaire included the following choices: a) "I would let God's will be done"; b) "I would ask the doctors to do everything they could to prolong my life"; c) "I would ask the doctors to end my life." Our purpose with these categories was to inquire into attitudes towards dying without the intervention of others, an end-of-life process with life support, and, finally, euthanasia. The legislative debates around the end-of-life process held in 2011 in Argentina brought to the forefront the notions of a patients' right to decide on the healthcare process in terminal illnesses, advance directives, and the rejection of treatment. In this context, it becomes particularly relevant to explore citizens' attitudes towards death and the end-of-life process. Our working hypotheses predicted that individuals living in contemporary Argentina would reveal an ample predisposition towards the right to make their own decisions about the end-of-life process. Our hypotheses also considered religion a significant factor influencing the beliefs, perceptions, and attitudes related to health, disease, and death (61).

The analysis was carried out based on descriptive statistics using the SPSS software. We are interested in characterizing the general population's opinions about end-of-life decision-making. Bivariate tables are presented, where the dependent variable is "personal decision in an end-of-life situation" by gender, age, educational level, religious affiliation, relationship with God, type of belief, attendance at worship services, and variables that reveal positions of personal autonomy, such as opinions on abortion and drug use. We also included opinions about religious participation in public policies and religious teaching at schools to measure the respondents' degree of proximity to the religious institution and their attitude towards its behavior in other domains of social life.

Finally, we carried out a multiple correspondence analysis, a multivariate analysis technique that makes it possible to summarize information. This analysis confirms the association of the religious variables (religious affiliation, belief in God, and attendance at worship services) with the decision made in an end-of-life situation. It is then relevant to describe Argentine society's beliefs and attitudes regarding the variables mentioned to identify future lines of analysis.

## Results

Half of the population living in Argentina answered that, faced with terminal illness, they would let God's will be done. The rest of the respondents are divided between those who would ask doctors to do what they could to prolong their lives (22.6%) and those who would ask them to bring their lives to an end (18.9%) (Table 2).

**Table 2.** Personal decision-making in an end-of-life situation (%)

| | |
|---|---|
| I would let God's will be done | 49.9 |
| I would ask the doctors to do everything they could to prolong my life | 22.6 |
| I would ask the doctors to end my life | 18.9 |
| DK / NA | 8.6 |
| Total | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

Women lean towards leaving the end of their lives to God's will more than men (53.8 % vs. 45.6 %). This orientation increases in older people. While 42.8 % of younger respondents would let God determine the end of their lives in a terminal illness situation, this proportion is as high as 62.2 % among older respondents. Conversely, younger people show the highest percentage in choosing to have their lives extended: 29 % would ask doctors to do everything they could to prolong their lives in an irreversible situation (Table 3).

**Table 3.** Personal decision-making in an end-of-life situation by gender and age (%)

| Decision in an end-of-life situation | Gender | | Age | | | |
|---|---|---|---|---|---|---|
| | Women | Men | 18-29 | 30-44 | 45-64 | 65 or older |
| I would let God's will be done | 53.8 | 45.6 | 42.8 | 48.2 | 53.1 | 62.2 |
| I would ask the doctors to do everything they could to prolong my life | 20.3 | 25.2 | 29 | 24.7 | 17.6 | 14.8 |
| I would ask the doctors to end my life | 16.6 | 21.5 | 18.6 | 19.3 | 21.1 | 14.2 |
| DK / NA | 9.3 | 7.7 | 9.6 | 7.8 | 8.2 | 8.8 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

The distribution of personal decisions in an end-of-life situation is different according to the population's educational level. Among those with a lower educational level, accepting God's will reaches a percentage as high as 60 %. Regarding both prolonging and putting an end to life, individual decisions are more frequent among those with a higher educational level. In any case, it is interesting to note that the answers of respondents with a university education are divided into three thirds as to the decision they would make in a terminal illness situation (Table 4).

Religious affiliation turns out to be a decisive variable in the position of Argentine citizens about the end of life. Evangelicals are more likely to accept God's will in case of a terminal condition: this option was chosen by 8 out of 10. A proportion of 6.3 % of this population supports euthanasia for themselves, shifting away from the prescriptions of their religious institutions on the matter. Conversely, most of those with no religious affiliation support preserving their autonomy over their bodies, whether by prolonging or putting an end to their lives. Even so, 16.7 % of the unaffiliated would leave the end of their lives in the hands of God, mainly those who reported that they have no religion although they consider themselves believers[4]. Catholics, in turn, are in an intermediate situation. They would accept God's will more than the unaffiliated but less than Evangelicals (Table 5).

4 The segment of the "unaffiliated" encompasses those who defined themselves as agnostic, atheist, and those who simply reported having no religion. It is the latter who would mostly let God decide about the end of their lives. They represent 9.7 % of Argentine society (the unaffiliated as a whole account for 18.9 % of the population). Although they are not affiliated to any religion, they generally consider themselves as believers in God. What differentiates them is that their beliefs are independent of institutionalized formats. They use a language that refers to the sacred but show a total lack of connection with any institutional, religious, or other kind of framework in their everyday lives.

**Table 4.** Personal decision-making in an end-of-life situation by educational level (%)

| Decision in an end-of-life situation | Educational level | | | | | |
|---|---|---|---|---|---|---|
| | Total | No education | Elementary school | Secondary school | Non-university institution | University |
| I would let God's will be done | 49.9 | 64.3 | 60.1 | 45.6 | 46 | 29.9 |
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 15.5 | 17.5 | 25.5 | 23.5 | 29.9 |
| I would ask the doctors to end my life | 18.9 | 17.1 | 14 | 20 | 22 | 29.4 |
| DK / NA | 8.6 | 3.1 | 8.4 | 8.9 | 8.5 | 10.8 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

**Table 5.** Personal decision-making in an end-of-life situation by religious affiliation (%)

| Decision in an end-of-life situation | Religious affiliation | | | |
|---|---|---|---|---|
| | Total | Catholics | Evangelicals | Unaffiliated |
| I would let God's will be done | 49.9 | 53.5 | 79.6 | 16.7 |
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 21.8 | 9.7 | 33.5 |
| I would ask the doctors to end my life | 18.9 | 16.8 | 6.3 | 35.6 |
| DK / NA | 8.6 | 7.9 | 4.4 | 14.2 |
| Total | 100 | 100 | 100 | 100 |

**Base:** 2,352 cases (only religious affiliations over 2 % were considered).

**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

According to the belief in God, the analysis of attitudes towards the end of life confirms that the religious factor is a conditioning variable. A proportion of 45.4 % of those who do not believe in God would ask doctors to end their lives. If we add those who would opt for asking health professionals to prolong their lives (35.5 %), 80.9 % of non-believers defend their autonomy in making decisions about the end of life. Only 5.3 % of that segment would accept God's will. In contrast, among believers, 58.9 % give God the power to determine the end of their lives, whereas 14.3 % would choose euthanasia (Table 6).

**Table 6.** Personal decision-making in an end-of-life situation by belief in God (%)

| Decision in an end-of-life situation | Belief in God | | | | |
|---|---|---|---|---|---|
| | Total | Yes | Sometimes | Doubtful | No |
| I would let God's will be done | 49.9 | 58.9 | 20.3 | 17.6 | 5.3 |

| | | | | | |
|---|---|---|---|---|---|
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 20.1 | 31.1 | 31.4 | 35.5 |
| I would ask the doctors to end my life | 18.9 | 14.3 | 24.3 | 31.4 | 45.4 |
| DK / NA | 8.6 | 6.7 | 24.3 | 19.6 | 13.8 |
| Total | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.

**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

The proportion of those who would let God determine when their life will end is even higher among those who are not only believers and identify with a religion but also relate to the transcendent through a church or temple. Most of that segment of Argentine society rejects the option of euthanasia. Institutional prescriptions prove to be a regulatory framework that remains influential on the most critical life decisions. As the relationship with God becomes less mediated by religious structures, autonomous decisions around the end of life show relative growth (Table 7).

**Table 7.** Personal decision-making in an end-of-life situation by relationship with God (%)

| Decision in an end-of-life situation | Relationship with God | | | | |
|---|---|---|---|---|---|
| | Total[5] | Through a church or temple | Through groups or communities | On one's own | No relationship at all |
| I would let God's will be done | 56.4 | 70.5 | 64.3 | 52.4 | 22.7 |
| I would ask the doctors to do everything they could to prolong my life | 20.7 | 18.3 | 11.4 | 21.1 | 34.1 |
| I would ask the doctors to end my life | 15.1 | 6.3 | 15.7 | 18 | 30.3 |
| DK / NA | 7.8 | 5 | 8.6 | 8.5 | 12.9 |
| Total | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,112 cases (non-believers not included).

**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

5 The distribution of the totals is different from other tables, as non-believers are not included here.

An association exists between the belief in the icons most identified with institutionalized religion (Jesus Christ, angels, the Holy Spirit, hell) and the disposition to accept God's will in case of a terminal illness. To a greater extent, those who have beliefs that are more distant from religious apparatuses (UFOs, astrology, luck, energy) adopt a relatively autonomous position towards the end of their lives (Tables 8a and 8b).

**Table 8a.** Personal decision-making in an end-of-life situation by type of belief (%)

| Decision in an end-of-life situation | Believes in Jesus Christ | | Believes in angels | | Believes in the Holy Spirit | | Believes in hell | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| I would let God's will be done | 58.3 | 9.5 | 59.6 | 30.8 | 60.5 | 15.8 | 61.8 | 39.9 |
| I would ask the doctors to do everything they could to prolong my life | 19.7 | 36.7 | 18.8 | 29.9 | 19.3 | 34.4 | 18.3 | 26.5 |
| I would ask the doctors to end my life | 14.7 | 39.4 | 14.7 | 28.3 | 13.9 | 35.5 | 14.2 | 23 |
| DK / NA | 7.3 | 14.4 | 6.9 | 11 | 6.3 | 14.3 | 5.7 | 10.6 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

**Table 8b.** Personal decision-making in an end-of-life situation by type of belief (%)

| Decision in an end-of-life situation | Believes in UFOs | | Believes in astrology | | Believes in luck | | Believes in energy | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| I would let God's will be done | 40.2 | 54.6 | 44.5 | 53.1 | 48.8 | 51 | 48.5 | 54 |
| I would ask the doctors to do everything they could to prolong my life | 25.9 | 21.3 | 26 | 20.8 | 23.7 | 21.1 | 22.6 | 22.7 |
| I would ask the doctors to end my life | 25.1 | 16.1 | 20.1 | 18.1 | 18.5 | 20.1 | 19.9 | 16.6 |
| DK / NA | 8.8 | 8 | 9.4 | 8 | 9 | 7.8 | 9 | 6.7 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

Contrasting attitudes towards the end of life are also noted in the classical rites of religious socialization, such as baptism or other initiation ceremonies and religious marriage. Whereas 55.7 % of those who baptized or would baptize their children would let God's will be done, the same alternative would be chosen by 21.3 % of those who did not and would not baptize them. Conversely, 69.9 % of those who did not and would not baptize their children lean towards greater autonomy regarding the end of life, whether by requesting to have it prolonged (34.7 %) or by choosing to end it (32.2 %). In turn, 58.5 % of those who got or would get married in a church or temple would accept God's will in case of irreversible disease. By contrast, 54.5 % of those who did not and would not get married in a religious setting would rather make their own decisions in case of a terminal illness.

The clearest indicator of the correlation between the religious ethos and the disposition to leave the end of one's life in God's hands is regular attendance at worship services. This attitude is reported by 81.8 % of those who attend religious services every day or several times per week. This percentage decreases as attendance become less frequent. In turn, among those who never attend religious services, 6 out of 10 choose not to delegate such a momentous decision (Table 9).

**Table 9.** Personal decision-making in an end-of-life situation by attendance at worship services (%)

| Decision in an end-of-life situation | Attendance at worship services | | | | | |
|---|---|---|---|---|---|---|
| | Total | Every day / Several times a week | Once a week | Once or twice a month | Only on special occasions | Never |
| I would let God's will be done | 49.9 | 81.8 | 73.1 | 64.8 | 51.4 | 27.7 |
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 11.5 | 17 | 19.3 | 20.7 | 30.9 |
| I would ask the doctors to end my life | 18.9 | 4.1 | 7 | 11.2 | 18.7 | 29.2 |
| DK / NA | 8.6 | 2.6 | 2.9 | 4.7 | 9.2 | 12.2 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

The intensity of some aspects associated with everyday religious practice is also related to a preference to submit to God's will at the end of life, the option chosen by 69.7 % of those who pray every day. For those who read the Bible or other sacred books daily, that percentage is even higher: 80.5 %.

Respondents' decisions in the case of an irreversible disease are different depending on their position about issues that have stirred public debate and in which religious institutions have played a prominent role. Those who defend a woman's right to terminate her pregnancy also claim their autonomy to decide on the end of their lives. On the contrary, most of those who oppose abortion in any situation are willing to accept God's will at the end of their lives. These associations, though meaningful, are not to be interpreted too simplistically. Indeed, among those who consider that a woman must have the right of abortion, 23.1 % would let God's will be done if faced with a terminal health problem (Table 10).

**Table 10.** Personal decision-making in an end-of-life situation by opinion on abortion (%)

| Decision in an end-of-life situation | Opinion on abortion | | | |
|---|---|---|---|---|
| | Total | A woman must have the right to have an abortion whenever she wants | Abortion should be allowed in some circumstances | Abortion must be prohibited in all cases |
| I would let God's will be done | 49.9 | 23.1 | 55.8 | 72.1 |
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 31.5 | 20.2 | 16.9 |
| I would ask the doctors to end my life | 18.9 | 32.1 | 16.7 | 6.9 |
| DK / NA | 8.6 | 13.3 | 7.3 | 4.1 |
| Total | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

The same associations exist between respondents' attitudes towards the end of life and how they perceive drug use, whether it should be permitted or prohibited, and whether they consider it an individual decision or as a spiritual problem/moral weakness. Different profiles emerge from the data: some respondents recognize an individual's autonomy to choose what to consume and make significant decisions about his/her life, whereas others believe in spiritual and divine forces that regulate human life, which translates into restrictive positions towards certain behaviors (Tables 11a and 11b).

**Table 11a.** Personal decision-making in an end-of-life situation by opinion on drug use (%)

| Decision in an end-of-life situation | Opinion on drug use | | | | |
|---|---|---|---|---|---|
| | Total | All drugs should be allowed | Marijuana should be legalized in all cases | Marijuana should be legalized for medicinal purposes | Drugs should always be prohibited |
| I would let God's will be done | 49.9 | 34.8 | 24 | 51.7 | 65.6 |

| | | | | | |
|---|---|---|---|---|---|
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 27.7 | 28.2 | 23.3 | 16.8 |
| I would ask the doctors to end my life | 18.9 | 29.9 | 35.6 | 16.8 | 11.1 |
| DK / NA | 8.6 | 7.6 | 12.2 | 8.2 | 6.5 |
| Total | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

**Table 11b.** Personal decision-making in an end-of-life situation by opinion on drug use (%)

| Decision in an end-of-life situation | Opinion on drug use | | | | | |
|---|---|---|---|---|---|---|
| | Total | It is an individual decision | It is an illness | It is a moral weakness | It is a spiritual problem | It is a crime |
| I would let God's will be done | 49.9 | 39.2 | 51.8 | 60.7 | 68.3 | 55.5 |
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 28.7 | 20.5 | 18.6 | 12.5 | 14.3 |
| I would ask the doctors to end my life | 18.9 | 22.7 | 18 | 14.9 | 8.7 | 22.7 |
| DK / NA | 8.6 | 9.4 | 9.7 | 5.8 | 10.5 | 7.5 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

Personal positions in an end-of-life situation are also associated with the different representations that citizens have about the regulatory framework that must ideally govern the relationship between the state and religious institutions. However, some observations are necessary. In Table 12, it should be noted that the most significant percentage of respondents who support the participation of religious groups in public policies are also the majority of those who accord a decisive role to God at the end of their lives. In this case, there is no clear association between those who advocate greater laicization of the state and reject religious presence in state-run schools and those who demand autonomy in deciding about a terminal illness situation in their lives.

**Table 12.** Personal decision-making in an end-of-life situation by opinion on religious participation in social policies (%)

| Decision in an end-of-life situation | Opinion on religious participation in social policies | | | |
|---|---|---|---|---|
| | Total | The State must implement them jointly with the Catholic Church | The State must implement them jointly with all religions | The State must implement them without participation from any religion |
| I would let God's will be done | 49.9 | 64.4 | 61.5 | 40.2 |
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 17.2 | 19.3 | 25.7 |
| I would ask the doctors to end my life | 18.9 | 8.6 | 14.6 | 23.7 |
| DK / NA | 8.6 | 9.8 | 4.6 | 10.4 |
| Total | 100 | 100 | 100 | 100 |

Base: 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

In this regard, respondents who approve of religious teaching in general, and Catholic in particular, in state schools are also willing to accept God's will if faced with a terminal disease. Those who support keeping education non-confessional do not evidence a well-defined profile concerning the decision at the end of their lives (Table 13).

**Table 13.** Personal decision-making at the end of life by opinion on the teaching of religion in state schools (%)

| Decision in an end-of-life situation | Opinion on the teaching of religion in state schools | | | |
|---|---|---|---|---|
| | Total | Only the Catholic religion must be taught | There must be a general subject about religions | Religion must not be taught at state schools |
| I would let God's will be done | 49.9 | 65 | 59.4 | 39 |
| I would ask the doctors to do everything they could to prolong my life | 22.6 | 15.8 | 21 | 25.3 |
| I would ask the doctors to end my life | 18.9 | 16.4 | 14.6 | 23.5 |

| | | | | |
|---|---|---|---|---|
| DK / NA | 8.6 | 2.8 | 5 | 12.2 |
| Total | 100 | 100 | 100 | 100 |

**Base:** 2,421 cases.
**Source:** Own elaboration according to the Second National Survey on Religious Beliefs and Attitudes in Argentina. CEIL CONICET Society, Culture and Religion Program, 2019.

## Conclusions

This article presents the opinions of the Argentine population about the end-of-life process by examining data from a representative national survey. This work is one of the few that explores how attitudes towards the end of life relate to religious beliefs considering the population at large, thus being more encompassing than surveys that center on hospitalized individuals and their families (29). Based on the evidence gathered, we analyze how beliefs and religious affiliations reveal different attitudes towards the end of life.

Multiple correspondence analysis confirms the association between the religious variables (religious affiliation, belief in God, and attendance at worship services) and the decision in an end-of-life situation. Believing in God, attending worship services weekly, and identifying as an Evangelical define a social segment that leans towards leaving the end of one's life in the hands of God (Table 14).

**Table 14.** Multiple correspondence analysis

| | Religious affiliation | Belief in God | Attendance at worship services | Opinion on abortion | Opinion on drug use | Opinion on the teaching of religion in state schools |
|---|---|---|---|---|---|---|
| Decision in an end-of-life situation | .308 | .335 | .281 | .298 | .164 | .133 |

**Source:** Own elaboration

Besides, the value assigned to individual decisions in other issues, mainly abortion and, to a lesser extent, drug use, coincides with a greater predisposition towards autonomy to make decisions at the end of life. Unlike those works which show that in the context of a terminal illness it is the most religious individuals that show a greater predisposition to request life-support treatments to prolong their lives, even if aggressive (20), here we see that the majority of the answers indicates that, in the case of a terminal and irreversible illness, people would expect "God's will to be done."

These data allow us to describe different profiles regarding end-of-life decisions. The profile of those inclined to surrender to God's will at the end of life seems more determined by an idiosyncrasy imbued with religious components in all domains of personal and social life. These individuals are not simply more related to confessional institutions, but their universe of values and attitudes is permeated by the regulatory principles of those religious settings. Almost 7 out of 10 of those who oppose gay or lesbian couples adopting children and uphold that the only valid marriage is that between a man and a woman gives God the power to determine the end of their lives. Also, 6 out of 10 respondents from that segment support a political party headed by religious leaders.

The profile of those in favor of euthanasia, that is, the disposition to request that their lives be

brought to an end in case of irreversible disease, seems to include more significant proportions of males, aged up to 64 years old, living in the Metropolitan Area of Buenos Aires, with the highest educational level, no religion (fundamentally atheist or agnostic) and a minimum level of religious beliefs and practices. They seem more likely to defend their children's autonomy to choose their religion or beliefs and refuse to force them to undergo a religious initiation ceremony such as baptism.

Their family socialization was indifferent to the religious, so they express secular attitudes to safeguard individuals' autonomy over their lives and advocate a lay state regarding its relationship with religious institutions. Thus, most of this segment supports a woman's right to terminate her pregnancy, gender equality, recognition of diverse sexual identities, and the legalization of drug use. Along these lines, they consider that the state should not authorize religious teaching at state schools and has the primary responsibility to provide sex education as part of the school curriculum. They would be content if the state implemented social policies without any involvement from churches and stopped financing religions and would also like to see crucifixes removed from government buildings.

Such a worldview contrasts with that of those who would submit to God's will at the end of their lives. The preservation of individual decision-making in the face of a terminal illness is associated with a set of values and ideas about the regulation of social life in which individual autonomy is represented as one of the guiding principles that must not only govern legal and state regulations but also pervade the fundamentals of living together in a secular world. These two contrasting profiles or worldviews make it possible to open future lines of research and analysis, not only about end-of-life decisions but also in connection with personal autonomy in health and body-related issues.

The data presented in this article follow the tradition of the social science and humanities studies about the end-of-life process, death and dying, understood not only as physiological processes but also as social constructs which respond to transformations in mindsets and meanings (9,19). In these traditions, patients' interactions with healthcare professionals in the end-of-life process have been a central topic (62,63). Consequently, as already mentioned, research works focus mainly on healthcare institutions' strategies to deal with patients, the expansion of hospitalized death, and the critical shifts towards the technification and medicalization of the dying process, resulting in the expansion and consolidation of palliative care in hospital settings (21,22).

The empirical material analyzed here, related to decisions about personal death in the face of a terminal and irreversible illness, becomes particularly relevant in the context of the COVID-19 pandemic. In Argentina, the healthcare protocols that required keeping patients completely isolated caused people to die alone during this period. Besides, the healthcare policy concerning corpses (31,64) made it impossible for relatives to carry out the funeral rites that they would perform in non-exceptional situations to go through the grieving process (17,65-67). As social anthropology has claimed (66), several rituals to honor the memory of the deceased usually exist in different cultures (68). These rituals vary according to social, cultural, and religious affiliation. During the pandemic, such rituals were suspended, while patients were subjected to triage according to their chances of survival. In this context, new questions were posed about the ways to die. Although particular institutional protocols were developed to privilege patients' needs, aspects related to the technification and medicalization of the dying process prevailed over a comprehensive approach to healthcare that would consider patients' psycho-social, cultural and religious needs (21,67).

These problems as a whole constitute a critical concern of bioethics. This discipline emerged to respond to technology development in the field of life sciences and medicine and took upon itself to monitor biomedicine on behalf of society in order to secure its well-being. Its origins are also related to the civil, political, cultural, economic, women's, and health rights movements of the 1960s. These exchange forums include the participation of religious actors, along with physicians and scientists, as religions are considered to be an authoritative voice in health-related matters (5,69). From this

perspective, bioethics takes a position that advocates patients' rights and focuses on finding common ground that can serve to justify shared decisions in matters of health and biomedical research.[6]

Issues related to the health-illness-patient care process in hospital settings, such as the rejection of treatment due to different reasons —including religious ones—, and the end-of-life process,—including dignified death, assisted suicide, and euthanasia—, are central concerns of bioethics (26,70). Reflections in this field have addressed patients' different conceptions about death and the decisions made in practice by healthcare teams in the end-of-life process (38,71). Concerning clinical care in health institutions, analyses have focused on justice problems and social inequalities in different populations' access to health services (72). Accordingly, our article also intends to contribute to the forms and management of the end-of-life process, centering on the perceptions and conceptions of death and euthanasia in contemporary society. We believe that it will be essential for healthcare professional teams to become aware of individuals' opinions, positions, and worldviews about the end-of-life process to ensure that healthcare settings will be compatible with the needs, beliefs and values of patients and their families.

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6 UNESCO, whose bioethics network is one of the main bioethicists' training schools, has contributed to developing international ethical standards by issuing declarations (Human Genome and Human Rights, 1997; Genetic Data, 2003; Bioethics and Human Rights, 2005); the establishment of international bioethics committees (International Bioethics Committee, 1993; Intergovernmental Bioethics Committee, 1998) and the creation of a world program for ethics education and assistance to bioethics committees (2004).

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