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Foreword: Interactions Between Religion and Medicine in Eastern Europe During the SARS-COV-2 Pandemic: Social Context

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FOREWORD

INTERACTIONS BETWEEN RELIGION AND MEDICINE IN EASTERN EUROPE DURING THE SARS-COV-2 PANDEMIC: SOCIAL CONTEXT

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A special issue of OPREE, dedicated to the interaction of religion and medicine, is being released on the anniversary of the struggle of humankind against the SARS-CoV-2 pandemic. Unfortunately, hopes of overcoming the infection quickly proved futile. The outbreak of this infectious disease has caused chaos in the private and social lives of billions of people. It changed the usual rhythm and forced people to obey new rules. For many people, it caused job and income loss and changes in personal priorities. For most people, the question of reappraisal of values arose when the need for self-realization gave way to the need for personal security. Social institutions designed to combat the ills and fears posed by pandemics have also been challenged to confront these threats. Institutions of medicine, religion, and the state were, to different degrees, outposts of such resistance. How well and jointly coordinated they act today will depend on how quickly and reliably this deadly threat will be overcome.

For the countries geographically located "in/to the east of the Elbe and south of the Baltic Sea," the challenges of the COVID-19 pandemic are far greater than for the countries of

the Western world. Although they belong to the European civilization and enjoy its achievements, their financial resources are limited. Most of them have a crisis-vulnerable economy, a weak social security system, and an imperfect health-care reform system. On the other hand, they differ significantly from each other in terms of quality of life and level of health development, and most of them cannot compete with the countries of the Western world. Due to low living standards, social disturbances, and wars, their populations are not among the healthiest in the world. Despite powerful medical schools and a well-developed medical educational system, most of them suffer from a shortage of doctors. Because of humiliatingly low wages and difficult working conditions, medical specialists are forced to change professions or seek a better standard of life by going abroad.

As for the level and nature of religiosity, these countries share a common atheistic past. But for many of them, escaping from atheism has not resulted in freedom for religion. At present, the level of their religiosity is generally reflected in similar trends in post-secular Europe. Their citizens are free to believe or not believe in God or to remain indifferent to this issue. In some of them there is a religious uplift. For others, the religious sphere is not a visible priority. Although the analysis on this matter is not unanimous,[1] it is common to distinguish countries with a high level of religiosity: Poland, Romania, Ukraine, Bosnia & Herzegovina, Serbia, Croatia, etc., and the least religious: the Czech Republic, Estonia, Latvia,[2] Slovenia, and Belarus. And then there are countries with a mixed religious and atheistic culture, statistically in the middle of this conventional list.

The level of religiosity of the population is important for understanding our problem. A high level of religiosity coincides with a high level of trust in religious institutions and their leaders, which, as a result, are perceived by a large number of people as moral authorities. In the context of health, activities initiated by religious organizations affect the behavior and habits not only of those who belong to those organizations, but they also influence the greater

[1] See: "Eastern and Western Europeans Differ on Importance of Religion, Views of Minorities, and Key Social Issues." https://www.pewforum.org/2018/10/29/eastern-and-western-europeans-differ-on-importance-of-religion-views-of-minorities-and-key-social-issues/. Accessed 01.01.2021; "These are the European countries where young people are least religious." https://www.weforum.org/agenda/2018/05/the-european-countries-where-young-people-are-losing-their-religion/. Accessed 01.01.2021; "What Alabamians and Iranians Have in Common." https://news.gallup.com/poll/114211/Alabamians-Iranians-Common.aspx. Accessed 01.01.2021; "Названы самые религиозные страны мира." [The Most Religious Countries in the World Are Named]. https://regnum.ru/news/society/2725204.html. Accessed 01.05.2021; "Названы наиболее и наименее религиозные страны мира." [The Most and Least Religious Countries in the World Are Named]. https://delo.ua/econonomyandpoliticsinukraine/nazvany-naibolee-i-naimenee-religioznye-strany-mira-338097/. Accessed 01.05.2021.

[2] Although Lithuania, Latvia and Estonia have been officially classified as Northern Europe since 2017, we mention them in view of their common post-atheistic past.

masses of the population. In crisis situations, a high level of trust in the churches and the personal example of their leaders are the basis of mobilization actions that can avert or minimize epidemic threats. On the contrary, negative examples can lead to catastrophic consequences. This is especially important because in some of these countries the level of trust in medical personnel is much lower than in priests. The situation is highlighted when the shortcomings of national health systems are extrapolated to its representatives. Thus, in times of epidemic threats, the authority of the church adds weight to medical strategies that may not be understood by the general public.

In the context of our problem, the confessional map of these countries, which mainly[3] belong to the Christian tradition,[4] is also important. The post-secular present time of the European civilization does not deny the significance of its Christian roots. Such Christian values as the sanctity of human life, the equality of all people before God, and the recognition of the dignity of the human person in medical discourse mean the indisputable right of every person to an adequate medical care. Moreover, it must be recognized under all circumstances, even when this assistance is expensive, difficult, and long. Still the social value and result of this medical care from the standpoint of pragmatic thinking are questionable. Ranking people according to finances, age, stratification, or other criteria on those who receive this assistance and those who do not is a gross violation of the principles of Christian humanism and can also be considered a sin.

At the same time, in none of the countries of Central and Eastern Europe do religion and medicine duplicate each other's functions. They are different forms of spiritual experience and knowledge with different areas of competence. The goal of modern scientific medicine is to take care of human health and quality of life, and the competence of the medical worker ends with the death of the patient. The purpose of religion is to care for the soul and the meaning of human life, which is not subject to death. For it, health is important, but not the only human need. The differences between medical treatment and religious healing are obvious. If religious healing mainly involves the supernatural restoration of human integrity, then the medical treatment deals with the restoration of the natural condition of a physical

[3] The numerical superiority of Christians over other religions does not negate the multi-religious nature of Europe, which is home to Muslims, Jews, Buddhists, New Age believers, etc., as well as people with unclear religious identities.

[4] Among them there are mostly Orthodox, Catholic and mixed (i.e. those that have different Christian denominations in their territory in approximately the same proportions). The predominantly Orthodox countries include Ukraine, Belarus, Moldova, Serbia, Romania, Bulgaria, Macedonia, Greece, Montenegro, Georgia, and Armenia; the predominantly Catholic countries are Poland, Croatia, Slovenia, Slovakia, Lithuania; the countries with a "mixed Christian tradition" are Hungary, the Czech Republic, Latvia, Bosnia, Estonia. Albania is predominantly Muslim but with Orthodox and Catholic minorities.

human body through therapeutic or surgical manipulations. Although medical science has some cases of miraculous healings, they are mostly explained through the internal reserves of the human body. The commonality between both religion and medicine is the fact that the tool of their work with the human is a word that can both heal and cause irreparable harm. In the context of our problem, they are united by the fact that in times of epidemics, society had the highest hopes for doctors and clergy. However, they were also under the greatest pressure, socially stigmatized,[5] and sometimes suffered from open aggression of some people.[6]

Although there are still all sorts of healers, psychics, and sorcerers in these countries, their quasi-medical activities are illegal. According to the laws of the European countries, only professional doctors have the right to practice medicine and are responsible for its outcome. The religious beliefs of either the doctor or the patient do not affect treatment protocols. But from time to time there are cases when a patient, due to religious beliefs, refuses certain medical procedures, such as blood transfusions or surgery, and so on.

Regarding the influence of religious beliefs on the formation of a doctor's personality, we partially agree with the conclusions of Ludwik Fleck that the worldview has very little influence on the formation of a specialist, giving them only certain features of a thinking style. It is partly because the mind and soul constitute the indivisible unity of the human person. Belief in God significantly strengthens the motivational component of the doctor's activity. This is well-illustrated by the example of some organizations of Christian physicians and psychologists, which act on the territory of these countries and combine their profession and mission, faith and public service.[7] This combination has a double effect, providing examples of true Christian love and self-sacrifice, it contributes to the evangelization of society.

[5] By social stigmatization we mean the negative isolation by society of an individual or a certain social group on some grounds that do not meet certain collective stereotypes or expectations. In the event of pandemic threats, individuals or social groups are exposed to stigma, which, according to most, are a source of infection, or in some way (even mystical) contribute to the spread of the disease. As well as those communities in which the incidence rate is lower than in the population as a whole, this seems suspicious to most of them. The stigmatized social groups and risk groups are not the same though in a number of cases certain coincidences happen.

[6] During the epidemics of past centuries, the causes of human aggression were fear, despair, and helplessness due to the disease. But these emotions were transformed into an aggression towards priests and doctors. The church and its representatives were accused of deviating from faith and sinfulness, which was considered the cause of God's wrath. Doctors were accused of getting rich during epidemics, and sometimes of conspiring with the wealthy to exterminate the poor.

[7] These organizations are one of the variants of the Christian professional movement whose purpose is the Christian service of the world through the profession. The activities of Christian physicians are characterized by a great variety of forms. They set up medical centers, hold charitable medical events, and provide material, social, and psychological assistance to sick and injured people. Operating on the model of the relevant world centers, they communicate with them, as well as with international charities.

Our hypothesis is that difficult times can shed light on hidden things. These things, which in ordinary conditions remain almost unnoticed, are manifested in times of acute social crises, such as the COVID-19 pandemic. Our sensitivity to them is the key to a positive change in the future.

The first wave of the COVID-19 pandemic, which hit Central and Eastern European countries last winter, *revealed* vulnerabilities in their healthcare systems. But it also showed a paradoxical fact: disadvantages may become "advantages." And timely awareness of one's weaknesses can prevent a catastrophe. Thus, a much lower life expectancy in the Central-Eastern European region than in the Western world means there are fewer vulnerable and elderly people, there is lower population and density-less contact, and due to poverty, there is less opportunity to visit other countries (including China, which was the main source of infection at the time). The main reason for the more or less easy passage of the first wave of the pandemic by these countries was the rapid introduction of rather strict quarantine measures issued by the governments of all the countries in the region. The only exception was Belarus, whose president persistently ignored the coronavirus until he fell ill himself.

The "first" wave of SARS-CoV-2 also *revealed* the peculiarities of religious reactions to the pandemic in these countries. The quarantine measures affected events that make up the "fabric" of religious life. They complicated offerings of the liturgy, sacraments, and holidays. Direct *koinonia* communication became a luxury, and the financial situation of religious organizations deteriorated.

To the credit of their leaders, almost all of them took a constructive stance on the forced restrictions. Worship activities in small groups or online worship began to be practiced everywhere. The speed of reactions and the willingness to accept restrictions in various denominations were different, and the path to consensus between them and the state was not always easy. However, religious humanism and the priority of the value of human life proved to be more important than ritual rigorism.

At the beginning of the pandemic, atheistic fears, not yet forgotten by the older generations of the population of these countries, became apparent. The anti-pandemic quarantine measures became the first restrictions on religious life over the period of 30 years, which caused some believers to feel "déjà vu." Here and there, voices began to be heard about the return of "persecution" of religion. Surprisingly, this rhetoric was combined with the anti-

Western context, most often the conspiracies of the Western secular civilization against Christianity, especially Orthodoxy. Thus, coronavirus dissidence arose, which was based on the denial of the very fact of the existence of the causative agent of this disease. Coronavirus dissidence exhausted itself and declined with the onset of mass outbreaks of the coronavirus disease in the very monasteries and temples where it was denied. Specific to the countries of the Central and Eastern European region was the fact that although COVID-19 dissidents were present in various denominations, most of them appeared among the clergy of the Russian Orthodox Church, in Russia and its foreign dioceses.

Over time, COVID-19 fundamentalism took other forms. Its followers still insist on the impossibility of getting infected with the coronavirus during their stay in the sacred space of the houses of worship, or during the Eucharistic communion and kissing of icons. They deny the need for vaccinations due to the threat of "chipping" and so on. All these warnings are not purely religious reactions. They have anti-globalization motives and Malthusian fears.[8] In fact, they are attempts by individual religious communities and people to protect themselves from a large and complex world.

These reactions would not be so sharp if they did not reflect the relevant trends in society. Their external catalyst was the fact that since the beginning of the pandemic, the countries of the world began to separate from each other by closing borders. In the information space, a loud discussion began about the curtailment of globalization. Vaccination biases[9] for Europe's population are also not new and have their own explanation, particularly in the case of the countries that were a part of the Soviet Union 30 years ago. At one time, mass compulsory immunization was carried out in the Soviet republics. Although it was quite effective, the statistics of deaths from vaccinations were carefully hidden from the people. This factor, as well as distrust in the safety and quality of vaccines, among other fears, is still a catalyst for vaccine hesitancy in the post-Soviet countries.

[8] Malthusianism (derived from the name of the founder of the concept, Thomas Robert Malthus) is a general name for various concepts based on the idea of the existence of global strategies to contain or reduce the population of the Earth. Various social practices, including biological ones, are recognized as a means of deterrence. Combined with various conspiracy theories, this gave rise to the idea of the world government's planned spread of infectious diseases and subsequent compulsory vaccination against them. The purpose of these actions is to depopulate the world's poor and to establish total control over the world's population.

[9] This is about a fairly wide range of prejudices. Among them, the main ones are distrust in the effectiveness of vaccination, as well as the belief that immunization can be a catalyst and even the cause of some diseases. The latter prejudice is occasionally fueled by pseudo-scientific theories that raise concerns about this problem in society. For example, as in the case of the infamous article published in one of the authoritative medical publications in the late twentieth century on the interrelation between immunization with measles-mumps-rubella vaccine and autism and intestinal diseases.

The sad "benefits" that led to the more or less smooth passage of the Central and Eastern European countries (see p. 4 above) were offset during the second wave of the disease, which began in the autumn of 2020. During this period, an imbalance between the spread of the disease and the capabilities of medical institutions became apparent. After all, medical institutions could not provide assistance to all of the people who needed it. This was especially true of the catastrophic shortage of doctors and special medical equipment. Under such conditions, the dilemma of fair distribution of limited resources among suffering people arose. The usual clinical ethics, focused on helping everyone by all means possible, gradually began to reorient towards the requirements of clinical triage.

Clinical triage, used in medical practice in exceptional conditions, is aimed both at saving more lives and improving their span after treatment. According to its criteria, priority assistance should be provided to people with a better chance of survival, to those who have a chance to live longer after treatment (namely, the younger or healthier), or to those who are more useful to society (for example, doctors or people who support the functioning of the critical infrastructure of society), etc. Under such conditions, even a sortition is allowed due to limited time. The allocation of resources among patients with the same prognosis should be provided by a random selection.[10] In practice it is most often the age requirement, as in some European countries the preference for medical care is given to people not older than 50 or even 40 years.

It is obvious that the practice of clinical sorting contradicts basic Christian values: the sanctity of human life, the equality of people before God, and the principles of human dignity. Its forced use in the 21st century in Europe became a humanitarian catastrophe and a shocking fact that left some national health systems unprepared for challenges of this magnitude.

Against the background of such harsh realities, people's reluctance towards quarantine measures intensified. Unfortunately, it was not only fatigue with the restrictions, but also sometimes the impossibility of meeting basic vital needs. There were a large number of socially vulnerable groups in these countries who were pushed below the poverty line by the quarantine measures. Under such conditions, a tragic dilemma arose because for a large part of the people the economic consequences of the coronavirus quarantine were more terrible than the threat of getting sick.

[10] Людмила Петрашко. Про практику і етику медичних рішень під час пандемії COVID-19. [On the Practice and Ethics of Medical Solutions During the COVID-19 Pandemic]. *ZN,UA.* https://zn.ua/ukr/HEALTH/skladni-rishennja.html. Accessed 01.17.2021.

As for religious organizations, during this period the restrictions on their activities remained at the level of an adaptive quarantine, by which are meant observance of general rules of social distancing during worship, wearing masks in the church, bans on crowded gatherings, restrictions on pilgrimage, and so on. Throughout the pandemic, religious leaders called on the church not to be isolated from society. Religious organizations expressed their readiness to take care of sick people and provide their own premises for the quarantine needs. However, in practice the public ministry of the church took on somewhat different forms. Due to the high virulence of the virus, attracting unprepared people and premises to help patients overcome the coronavirus would be a wrong step, which could lead to the expansion of the contamination area. Therefore, the quarantine measures were carried out by doctors who are prepared and protected by the appropriate equipment. The representatives of religious organizations focused mainly on the pastoral care of sick people, as well as providing various segments of people with special means of protection, diagnosis, and treatment.

During the "second wave," there appeared a phenomenon named cryptocoronafundamentalism.[11] The term means the hidden disregard for necessary safety measures during worship services under the pretext that "it is better to get sick with God than without God." Because it is quite difficult to hold a liturgy in a mask, some priests ignore this quarantine requirement. The services themselves last a long time and take place with large crowds, not all of whom are healthy. It is obvious that all these issues belong to the sphere of personal responsibility, which is difficult to control by administrative means, except by the people's own conscience.

The year 2020 has shown that, except in rare cases, the pandemic has no clear signs of social stigma on religious grounds. Confrontation involving religious groups is not religious discrimination. The pressure in these cases is not due to certain religious ideas or groups, but to people whose behavior can be a catalyst for an outbreak. Such was the case, for example, in Uman (in Ukraine), when the local population protested against the mass pilgrimage of the Hasidim to their town for fear of infection. Calls to refrain from pilgrimage were issued by both of the governments of Ukraine and Israel.[12] However, there is sometimes an "internal" stigma among priests. It refers to a prejudice when the disease of COVID-19 is associated with

[11] The term is given by the authors of this article.

[12] "Спільна українсько-ізраїльська урядова заява щодо паломництва хасидів до м. Умань з нагоди святкування Рош га-Шана." [Joint Ukrainian-Israeli Government Statement on the Hasidic Pilgrimage to Uman on the Occasion of Rosh Hashanah]. https://www.kmu.gov.ua/news/spilna-ukrayinsko-izrayilska-uryadova-zayava-shchodo-palomnictva-hasidiv-do-m-uman-z-nagodi-svyatkuvannya-rosh-ga-shana. Accessed 01.15. 2021.

a person's spiritual weakness or sinfulness. For the clergy, such explanations of the cause of the disease are particularly sensitive.

Currently, there are not so many stigmatized groups of the general public and their borders are unclear and flexible. During this pandemic, social stigma is not localized by ethnic, racial, professional, or ethical criteria—it is situational. If at the beginning of the pandemic the coronavirus was associated with the "people who look Chinese,"[13] and then as it spread, the regional dimension (belonging to the "red," "green," or other security zones) began to play an important role. Over time, it became clear that this disease can affect absolutely anyone. When mass vaccinations take place, it is possible that the population of the countries where it will be delayed might be stigmatized.

The pandemic is ongoing. Winter lockdowns have been announced. Some governments are talking about the continuation of the second wave, and others the beginning of the third wave of the pandemic. Although the world is entangled in numerous "waves," today we are in a more encouraging situation than a year ago. The invented vaccines and the beginning of mass vaccination give to all the hope to return to a normal life.

It is obvious that although the pandemic crisis is not over, it will be an impetus for the further development of medicine. Throughout human history, post-epidemic times have been characterized by the development of medical research, technology, the invention of new drugs, and so on. During this time, the social status of the medical profession was raised, local health care systems were strengthened, and coordination of medical structures at the global level was strengthened. Similar processes are expected now.

Possible changes in the lives of religious organizations are not yet so obvious. In the most general form, the question is being discussed among theologians and religious scholars: will religious life return to the "pre-pandemic forms" or are we on the threshold of a new Reformation? This implies the probable virtualization of a religious denomination, the further development of digital theology, and so on.

In the meanwhile, most clergy and many lay people are skeptical about online worship. It is not just a matter of seeking direct *koinonia* communication, but also, as Herbert Marshall McLuhan, a representative of modern communicative philosophy, rightly pointed out that a means of communication is also a message. It means that the way of information transmission

[13] *Interfaith Dialogue in Action: A Guide for Dealing with COVID-19. (The International Dialogue Centre (KAICIID))*. https://jliflc.com/resources/interfaith-dialogue-in-action-a-guide-for-dealing-with-covid-19. p.13. Accessed 01.15.2021.

can influence its content. The form of mediation of the word of God is important for the future of religion. In the case of Christianity, the last revolution in this form took place with the spread of printing in Europe in the 16th century. Printing made reading the Bible accessible to many people, and thus allowed them to rely not only on preachers, but also on their own opinions in matters of faith. This contributed to the democratization of the faith and the emergence of Protestantism. The Gutenberg's Book Galaxy has now been replaced by the Internet Galaxy. Whether it entails any revolutionary changes in religion is an open question—the answer to which we will receive only with the lapse of time.

Most likely, as in previous centuries, the decisive cause in combating a pandemic will be socio-economic factors. It happened in the case of the Spanish flu pandemic, which engulfed the world a century ago. That flu, often compared to SARS-CoV-2, became a terrible disaster for humanity, taking more lives than the First World War, at the end of which it broke out.[14] Then it became clear that in the face of epidemic threats, whether a person would survive or not depended not only on his or her age or state of health, but also on his or her social status and country of residence. This is not surprising. Socio-economic factors play a key role in the spread of infectious diseases, such as poverty, overcrowding, and lack of quality medical care.[15] A century ago, more affluent countries coped with the Spanish flu with fewer human losses. For the United States, for example, in Alfred Crosby's words,[16] it became a "forgotten pandemic" in general.

The level of development of medicine and the financial capacity of states will be decisive factors in the elimination of its consequences. So far, the first steps have been taken. Mass immunization has started first in the most developed countries and is being carried out with vaccines of good quality.

The question of *how religious organizations should act in the face of modern challenges* is extremely important. We believe they should not duplicate the functions of the health care system. In times of infectious threats, this is unwise and dangerous. But their response needs to be spiritual, ethical, and social.

[14] Although data on the number of deaths from the flu vary, the World Health Organization estimated the death toll at 40-50 million. By comparison, 10 million people died on the fronts of World War I, and another 7 million disappeared.

[15] K.D. Patterson, G.F. Pyle. "The Geography and Mortality of the 1918 Influenza Epidemic." *Bulletin of the History of Medicine.* 1991. Vol.65 (1). pp. 4-21; S.M. Tomkins. "Colonial Administrations in British Africa during the Influenza Epidemic of 1918-19." *Canadian Journal of African Studies*. 1994. Vol.28 (1). pp. 60-83.

[16] Alfred W. Crosby. *America's Forgotten Pandemic: The Influenza of 1918*. (Cambridge: University Press, 2003).

The spiritual consequences of this pandemic are no less devastating than the medical ones. Compared to the epidemics of the past centuries, which were pandemics of hatred, the current one can be called *a pandemic of alienation*. Hatred is the result of panic and the inability to see the "face" of the real enemy, which contributes to the practice of finding culprits among other people. The current "enemy" is known, and the means of combating it are defined. However, purely human reactions have remained unchanged. Among them are increased fear, suspicion, and distrust of people. Social deprivation caused by prolonged and large-scale stressful circumstances has reached alarming proportions. All these phenomena are mediated by the factor of indirect virtual communication, which cannot replace direct human communication. Under such circumstances, the dominant social mood becomes alienation, which synthesizes a feeling of powerlessness or weakness in the face of circumstances and indifference not only to the Other, and sometimes even to his or her own self.

But no person can live without other people. Humanity, which for many decades has moved through openness and global dialogue, cannot return to the practice of isolationism without significant costs.

Positive strategies need to be renewed, and the role of religious organizations in this regard is invaluable. The world's most influential religious leaders insist on it. Their consolidated position is reflected in documents that provide examples of the public service of religion in the post-pandemic era. Among them are the guidelines of "The International Dialogue Center (KAICIID)," as well as collective and individual statements and decisions adopted within the G20 Interfaith Forum during 2020.[17]

[17] *Interfaith Dialogue in Action: A Guide for Dealing with COVID-19*. (*The International Dialogue Centre (KAICIID*)). https://jliflc.com/resources/interfaith-dialogue-in-action-a-guide-for-dealing-with-covid-19. Accessed 01.18.2021;
G20 Interfaith Forum. Statement Urging G20 Action. Interfaith networks support G20 action across sectors and communities to respond to the COVID-19 crisis. 25 April 2020. https://www.g20interfaith.org/wp-content/uploads/2020/04/G20-IF20-COVID19-Statement-2020.04.25.pdf. Accessed 01.18.2021; *Interfaith networks support G20 action across sectors and communities to respond to the COVID-19 crisis.* https://www.g20interfaith.org/statement-urging-g20-action-on-covid-19/. Accessed 01.18.2021; *G20i Regional Recommendations COVID – 19 Pandemic.* https://www.g20interfaith.org/wp-content/uploads/2020/09/2020_g20i_regional_recommendations_covid_19.pdf. Accessed 01.18.2021; *Remarks by The High Representative for the United Nations Alliance of Civilizations at the Opening Plenary of 2020 G20 Interfaith Forum Riyadh, 13-17 October 2020*. https://www.unaoc.org/2020/10/remarks-opening-plenary-2020-g20-interfaith-forum/. Accessed 01.18.2021; Οικουμενικός Πατριάρχης: Καλούμε σε μηδενική ανοχή απέναντι στην αδικία και σε οποιαδήποτε άλλη μορφή και πρακτική διακρίσεων. Οκτωβρίου 14, 2020. (Video). https://romalewfronimati.blogspot.com/2020/10/video.html?fbclid=IwAR0Z57sPfDA7ipo7oBunrnPGPjWYTLAbz9IZfaEmVQKcBaj_KCDAzxczvWE. Accessed 01.18.2021.

The social significance of these documents is difficult to overestimate. They declare the vital role of religious organizations in meeting acute humanitarian needs during the pandemic. Emphasis is placed on the need for special security measures to balance the requirements of health and religious freedom. This requires a certain flexibility of the parties for the dialogue, which is important for achieving socially useful decisions.

Human life and dignity are recognized as constant values that do not depend on racial, sexual, national, or any other human characteristics. At present, they are shaken and need protection by religious figures. This protection is a public duty of religious organizations, which, together with the state, must take care of the optimal redistribution of various resources among people in need. Under such conditions, the role of religious organizations is observational and coordinating. It should be aimed at avoiding discrimination, ensuring the right to equal access to diagnosis, treatment, and vaccination for the population of different countries. This is absolutely necessary in the context of growing economic inequality between different countries and social strata.

It is emphasized that *the integrity of the human community must be restored at all levels*: from the closest circles of human communication to the return of humanity to "unity in diversity." In the long run, religious voices must play a significant role in returning the world from its current state of fragmentation and isolation to a normal state of global cooperation.

Summing up the introduction, we note that the problem of interaction between religion and medicine is much deeper in content, and chronologically, much broader than their interaction during the COVID-19 pandemic. To comprehend it, it would be necessary to write a great number of books, covering the period from antiquity to the present. This is, in fact, the whole history of humankind, during which religion and medicine have always been close but not always together. Their coexistence created many complex problems. In this issue, we deal with only some of them. However, there are others which, being "in the shadow of the pandemic," have not lost their relevance.

The main idea of our issue is that *religion and medicine are different, but not antagonistic forms of spiritual experience and knowledge*. In today's world, they should not duplicate each other, but *must interact on the principles of complementarity and synergy*. The laws of this synergy are not always clear to humans. They are most vividly illustrated by the allegory of the "golden ratio." A person who contemplates the beauty of the shapes created by this intersection does not always know the proportions of the structure. But the viewer's ignorance of those proportions does not deny the artist's knowledge of them. By analogy, the various forms of human spiritual experience constitute integrity through a combination of

seemingly random configurations. The truth is that coincidences do not create integrity but testify to our ignorance of the Creator's plan.