Luo, G. (2025). Religion, Ethics, and Medicine at End of Life: When It Is Acceptable for Physicians to Refuse Care? ***The Journal of Young Innovators, 1*****(1), 1–16.**

Abstract

In this article, the author considers physicians' right to refuse to participate in or offer end-of-life care that includes medically assisted death. The author argues that physicians, like patients, are guided by religious and more beliefs, and they do have a right to refuse medically assisted death services if they violate their religious beliefs or moral convictions. To make this case, the author reviews the historical relationship between religion and medicine, looking at how the modern medical system came to be. This helps set the stage for understanding how these two aspects of society affect end-of-life care. Landmark cases in the Right-to-Die movement are presented to further illustrate how religious beliefs affect the care that a person receives at the end of life. After reviewing possible reasons that a physician may object on religious grounds, the author then provides recommendations that honor both the free will of the patient and the physician.

Keywords: end of life, religion, medically assisted death, medicine

Author Summary

This article looks at whether doctors should be allowed to say no to helping with medically assisted death if it goes against their own personal or religious beliefs. The author claims that both doctors and patients have their own set of moral and religious views, and they should be allowed to follow them. The article explains how religion and medicine have been connected throughout history, and how they still are connected within end-of-life care today. It also

addresses important legal cases that show this interconnection. Finally, the author provides suggestions on how to respect both the patient's wishes and the doctor's beliefs.

Religion, Ethics, and Medicine at End of Life: When It Is Acceptable for Physicians to Refuse Care?

On April 20, 2025, Easter Sunday, *The New York Times* published an article entitled, "America Wants a God" (Jackson). The author of the article claims that "secularization is on pause" and that "religion is taking a more prominent role in public life." In other words, religion is becoming a more significant force in areas where it may have once been less so or entirely off-limits. As Jackson(2025) argues, public institutions that were largely secular in nature are, for better or worse, seeing the division between Church and State become less rigid. While the public institutions that Jackson(2025) refers to are primarily governmental offices, the present article centers its examinations of religion, ethics, and morality in the context of the medical institution.

This article investigates the role of religion in medicine, specifically as it relates to physicians' provision of end-of-life care. Yet, what distinguishes this discussion of religion and end-of-life care from other investigations, however, is its focus. Although the article does provide an overview of how medicine and religion are historically intertwined through the presentation of landmark case studies, it does not stop at detailing the influence of religion from the patient's perspective. There has been a substantial body of scholarship written about how religious commitments affect patients, from policy-level analyses of how religious ideology impacts the care options available to patients to reviews of how religious doctrine enters into the procedures patients elect to undergo (Curlin et al., 2005). Much of this discussion occurs against the

backdrop of end-of-life care, including medically assisted death (formerly referred to as "physician-assisted suicide"). While this body of literature has, admittedly, been instrumental in helping scholars better understand patients' decision making as complex and stemming from a variety of factors, it overlooks a key component: that the healthcare provider can be guided by their own religious convictions.

To fill this gap within the literature, this article considers in-depth how healthcare providers' (physicians, nurses, nurse practitioners, and so on) religious and moral commitments affect patients' end-of-life care. It poses the following research question: "Patients' religious beliefs are protected and respected (or at least they should be), so to what extent should providers be afforded the same privileges?" While there are many avenues available for exploring this question, particularly within the context of family planning and abortion laws, this article aims to examine how providers' religious beliefs may impact end-of-life care.

To better understand how religious beliefs enter the realm of medicine, however, it is necessary to first review how these two areas of public life have come together throughout history. The article begins by tracing the origins of early hospitals until the present day. It then proceeds to analyze landmark cases in end-of-life care and what is now popularly referred to as the "Right-to-Die" movement. After outlining how religious beliefs are weighed in this context, the discussion then moves to consider how it is not just patients and their moral values and belief systems that influence end-of-life care, but that of the healthcare provider as well. The article concludes by reflecting on the implications of providers' right to refuse care on religious grounds. Acknowledging that providers, like patients, are moral beings with religious convictions who face tough ethical quandaries, the article then offers recommendations for how

providers can still ensure that patients receive the care they need without compromising their own beliefs.

The Scope of the Review

It is noteworthy that much, though not all, of the discussion of religion and end-of-life care presented here is within a Judeo-Christian framework. The U.S. is undoubtedly becoming an increasingly diverse nation, as immigrants from all nationalities and faiths are coming to call America home. In fact, Islam, a faith typically associated with the East, represents one of the fastest-growing religions in the U.S., according to the Pew Research Center. This raises a few questions, the first of which might ask, "Why focus exclusively on the U.S.?"

Globally speaking, U.S. healthcare is quite unique in that it adopts a privatized insurance system. In fact, many other Western countries, like Canada, the United Kingdom, Germany, France, and Sweden, among many others, offer universal healthcare systems that extend citizens health services regardless of their ability to pay (Clinton and Sindhar, 2017). This, coupled with medical training and licensure protocols that vary country by country, means that this review is not necessarily applicable to all cross-cultural contexts. While some may regard this as a shortcoming or limitation, this narrowed scope allows for a more in-depth analysis of religion and end-of-life care within the U.S., specifically.

Another question that has through this research asks, "Why focus primarily on how Judeo-Christian principles influence healthcare?" The answer to this question is twofold. One, despite the increasingly varied number of faiths represented in American society, a vast majority (62%) of American adults identify as Christian. After that, the next biggest religion is Judaism, with over 2% of American adults identifying as Jewish. Religions like Islam, Buddhism, and

Hinduism, while growing in their numbers, represent 1%, respectively (Pew Research Center, 2015). Because the Christian and Jewish faiths are more heavily represented in the social landscape, their influence may be more significant in other areas of public life, such as healthcare. The second reason may best be analyzed through a historical lens, and argues that the intertwining of the Judeo-Christian faiths and medicine spans millennia.

Religion and Medicine: From Ancient Egypt to the Present Day

Prior to the advent of modern medicine, faith leaders were performing medical procedures. In their article, "From shamans to priests of Sekhmet," Bestetti et al. note that it was priests who were performing medical procedures as far back as 3100 BC. The authors' review supports the point that the interconnection between medicine and religion is a longstanding one. Several centuries later, with the dawn of Christianity and its emphasis on caring for the sick (Gabriele), several church-sponsored hospitals appeared. Throughout the 4ththrough 6th centuries, churches like St. Basil of Caeseara (370 AD) founded a large healthcare complex known as the "Basiliad," which tended to the sick, the poor, and people with leprosy (Fengren). Scholars like Bynum describe the Basiliad as serving as an important early model guiding later Byzantine hospitals, which eventually served as prototypes for modern hospitals.

This intertwining of religion and medicine continued throughout the ages and is still prevalent today. Catholic hospitals presently comprise nearly 25% of the world's healthcare (Catholic News Agency,2010). In the U.S., religiously affiliated hospitals provide nearly 20% of hospital beds (Stulberg et al., 2010), suggesting that the relationship between religion and medicine has not waned over time.

The Right to Die

In the past few decades, however, the Catholic Church's involvement in healthcare has not only been limited to providing life-sustaining care, but advocating that it not be withheld from others. The 1975 case of Karen Ann Quinlan demonstrates this. Quinlan entered a persistent vegetative state following a drug overdose. Her parents petitioned the New Jersey Supreme Court to remove her ventilator while medical professionals advocated for keeping it in. Eventually, the courts ruled in the parents' favor. The Pope at the time, Pope Paul VI, emphasized that the Church's stance on such matters was that it supports ordinary life-sustaining measures, like intravenous nutrition, but not necessarily extraordinary ones, like ventilation (Center for Practical Bioethics).

This distinction between ordinary and extraordinary life-sustaining measures became a focal point in the two landmark cases in end-of-life care that came after: the Nancy Cruzan case and the Terri Schiavo case. Following a car accident, Cruzan entered a persistent vegetative state (Glover). Her parents wanted her feeding tube to be removed; however, the state of Missouri argued that its removal would amount to euthanasia. As the case was heard before the U.S. Supreme Court, the Vatican issued formal statements denouncing the decision to remove her feeding tube (Congregation for the Doctrine of Faith). In fact, the then-Pope, Pope John Paul II, wrote in the *Evangelicum Vitae* that removing nutrition provided by a feeding tube constituted passive euthanasia.

The debate about what kind of care should or should not be provided at the end of life based on religious grounds set an important precedent for the 2005 case of Terri Schiavo. Similar to the cases that came before, Schiavo entered a persistent vegetative state following cardiac arrest. Similar to the Cruzan case, the debate centered around ordinary and extraordinary measures.

This time, however, the Catholic Church was much more vocal in its objections. The United States Conference of Catholic Bishops (USCCB) issued a statement that argued that Schiavo "was not in a coma" and "that she was not on 'life support.'" The USCCB further argued that "She only needs basic care and assistance in obtaining food and water" (Keeler, 2005).

Part of what made Schiavo's case complicated was the number of parties that were involved. In addition to the Catholic Church and the extensive media coverage her case received, the Florida state government passed "The Terri Schiavo Bill." This bill provided Schiavo's parents with another avenue for challenging the decision to remove her feeding tube, even though her husband, Michael Schiavo, stated that this was in line with Terri's wishes (Annas, 2005). Ultimately, however, the Florida Supreme Court upheld the decision to remove Schiavo's feeding tube, and she died 13 days later.

In each of these cases (Quinlan, Cruzan, and Schiavo), the patient was unable to articulate their wishes regarding end-of-life care, but that changed with Brittany Maynard's 2014 case. After being diagnosed with terminal brain cancer, Maynard decided to pursue medically assisted avenues for ending her own life. Maynard became the face of the Right-to-Die movement, which advocated for legislation that legalized medically assisted death administered by a physician, such as Oregon's 1994 Death with Dignity Act (Hendin and Foley, 2007). Maynard became the face of the Right-to-Die movement, as it raised questions about the role of physicians in facilitating patients' deaths. Unlike the cases previously mentioned, which may be classified by some as "passive euthanasia," since Maynard was not looking to remove life-sustaining treatment, but seeking treatment to hasten her own death, it was framed by some as active euthanasia (Gostin and Roberts, 2016).

“First, Do No Harm”

Around this same time, the language surrounding these practices seemed to shift. Whereas before, “physician-assisted suicide” was the common terminology used to refer to such practices, “medically aid in dying” was quickly becoming the preferred alternative (Lawry, 2023). On the one hand, this shift may indicate that the public was becoming more accepting of these

matters. One could also argue, however, that some healthcare providers felt uncomfortable by terminology like “physician-assisted suicide,” which places the focus on physicians as deliverers of death. “Medically assisted death,” by contrast, directs attention to the medication being used to bring about death, not the individual. Today, the most widely used term is medical aid in dying (MAiD), a term that takes the responsibility off physicians in bringing forth death and instead focuses attention on the method for initiating it (i.e., through medication) (Downie et al., 2021).

To better understand physicians’ discomfort with both the language used to describe medically assisted death and the practice itself, one can turn to the Hippocratic Oath. The Hippocratic Oath is a pledge that many medical schools require aspiring physicians to recite prior to embarking on their medical careers. Even though several scholars, such as Hajar point out that the instruction to “first do no harm” is mistakenly attributed to the Hippocratic Oath and actually appears elsewhere in Hippocrates’ writing, the association with this principle and the Hippocratic Oath nonetheless endures. Therefore, providers who object to end-of-life care measures that involve medically assisted death may see these practices as a violation of this sacred principle within medicine.

Admittedly, more medical education programs are discarding the Hippocratic Oath, seeing it as

outdated, and instead inviting their medical students to recite their own pledges, tailored to the issues of today's society and patient populations (Shmerling, 2020). Although this document dating back to 5th Century BCE Greece may no longer wholly apply to global medicine in the 21st century, it bears a striking resemblance to a religious commandment still widely circulated today: "Thou Shall Not Kill." This rule, attributed to the Ten Commandments, is a core principle of the Judeo-Christian faiths; however, it has clear parallels with several other religions. For instance, the Qur'an instructs followers of Islam to refrain from the killing of others, stating, "Whoever kills a soul unless for a soul or for corruption [done] in the land—it is as if he had slain mankind entirely" (Surah Al-Ma'idah). In Hinduism, the concept of *Ahimsa*, or non-violence, is a core principle (Brittanica), and in Buddhism, one of the five precepts is "I abstain from taking a life" (Buddhist Nuns of Mahamevnawa). All of this is to say that the notion of not taking a life is deeply intertwined with religious beliefs.

It is therefore not surprising that many physicians ground their objections to participate in medically assisted death in religious beliefs. Myskja and Magelssen argue that physicians are entitled to "conscientious objection" to participating in certain medical procedures (e.g., assisted dying) based on their own moral and religious beliefs. The authors call for tolerance and moral pluralism, meaning that they advocate for a healthcare system where providers are able to hold and act upon differing moral and religious beliefs without having to compromise their personal moral integrity.

The topic of conscientious objection is further explored by Martins-Vale et al., who reflect on how a physician's refusal to provide contentious care like assisted death may violate the patient's ability to exercise their own free will. In another article examining conscientious

objection, Żuradzki draws connections between individuals refusing to participate in military combat due to religious beliefs (the example of Quakers' pacifist beliefs is given as an example) and healthcare providers refusing to provide procedures (like assisted death) that violate their religious convictions. The author argues that if refusal is acceptable in one context, such as the military, the same should apply in healthcare contexts as well.

Balancing Physicians' Beliefs with Patient Safety

Following the discussion on conscientious objection, a question arises: If a physician objects to participating in end-of-life procedures like medically assisted death, what happens to

the patient? History has shown that when medical procedures are banned or inaccessible, it does not prevent patients pursuing a similar outcome. In other words, patients will often take matters into their own hands. Take the example of abortion, in societies or situations where abortion is banned or inaccessible, women do not stop having abortions. They just stop having safe abortions (Sedgh et al., 2012). One may therefore argue that if physicians do not offer medically assisted death procedures, those suffering from the pain and debilitation of a terminal diagnosis may turn to other means, which could be more traumatic for both the patient and their loved ones.

What this article therefore recommends is that if physicians object to certain end-of-life procedures designed to bring about death, they do have the right to refuse to provide such services. However, what a healthcare provider should do in this case is refer the patient to someone who is willing to do these things. In this way, the free will of the patient and provider are upheld. As Clarke(2016) notes, "In many institutions and jurisdictions healthcare

professionals who conscientiously refuse to perform a particular procedure are expected to refer a patient, who requests that procedure, to another healthcare professional who is willing to perform it" (220). Clarke(2016) continues that the motivation behind this practice is to avoid something called "systemic abandonment," where the needs of certain patient populations (like the terminally ill) are left continuously unmet by healthcare systems. Systemic abandonment can make already vulnerable patient populations even more vulnerable.

Towards Greater Tolerance of Moral Convictions in Medicine

Through its explorations of how medicine and religion have become intermingled throughout the ages, this review article set the stage for one area of medicine that is often discussed within contemporary society: end-of-life care. It then turned to consider landmark cases in end-of-life care, including the "Right-to-Die" movement, which advocates for medically assisted death. The article then proceeded to consider why physicians may refuse to participate in medically assisted death procedures based on their own religious and moral beliefs. It concluded that both physician and patient free will can be respected if physicians refer patients seeking a medically assisted death to providers who are willing to provide such service. This presentation of religion and medicine does portray the relationship between these two in a negative light, or as stirring up ethical and moral dilemmas. But it is important to acknowledge that the partnership between these two domains has led to a better quality of life for millions. Medical mission trips, where religious organizations sponsor healthcare providers to travel to under-served areas to provide free medical care, are a case in point about how the intermingling of these two areas can bring a significant benefit to the general public. However, the key to ensuring that this relationship continues to be a fruitful one involves also ensuring that healthcare providers be

recognized as individuals with their own religious beliefs and moral compass, one which they ideally use to guide the patient towards improved quality of life.

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