How can religious values intersect with healthcare decision-making?

**Dietary Restrictions**: All other things being equal, the dietary laws that apply to the daily lives of members of certain religions will also apply when these members are sick and/or hospitalized. The most notable of these restrictions are for Jews and Muslims, who are likely to request vegetarian meals when institutionalized in order to comply with their religious commitments regarding the procurement and preparation of meat. There are other traditions that have less well-known restrictions: groups that will consume no caffeine, for example. A great many hospitals are familiar with these restrictions and often have provisions in their dietary support systems for these purposes (e.g. by having kosher meals available for Jews or certified halal meat for Muslims). Alternatively, individuals from within the patient’s religious community may bring food to the hospital for the patient. This action is considered a religious obligation for members of several religious traditions.

Certain times of year may pose particular challenges for the observant patient. During Ramadan, Muslims will not consume food or beverage during daylight hours. During Passover, Jews will not eat anything made with a leavening agent. And during Lent, Roman Catholics abstain from meat on Fridays. Because these events follow lunar calendars, the dates will not correspond exactly from year to year with the secular calendar. The health care provider must rely on the patient to disclose this information, and then be willing to discuss the implications of this observance for his or her treatment regimen.

There are some who worry that the religious prohibitions on ingesting certain kinds of foods (pork, for example) extend to other products made from these animals: pig valves for hearts or porcine-derived insulin, for example. In at least one religious tradition, the prohibition extends only to those things ingested by mouth. Therefore, products derived from prohibited sources are permitted, although there is a preference for products derived from other sources when available and effective (synthetic insulin, for example).

This is one area where the duty to preserve life and health may take precedence over a religious restriction. The ingestion of prohibited substances, when required to save a life, is often either sanctioned or specifically required by religious authorities. Whether or not a particular instance of food or beverage intake qualifies under this provision must be negotiated with the patient, family and often with religious representatives.

**Modesty and Personal Space**: Certain religious traditions, such as some conservative Christian faiths, Hinduism, Islam, and some forms of Judaism, include provisions for maintaining personal modesty, especially for women. As a result, there is a preference for a provider who is the same sex as the patient if possible. Additionally, while ensuring that a patient’s body is appropriately covered is an important feature of respect for patients, it takes on particular importance in these contexts. Considerations of modesty are sometimes related to notions of bodily integrity, which has implications for the care of the body regarding surgery or after death (see below).

For some religious traditions, physically touching someone can have negative connotations (for positive aspects of touching, see below). Generally, touching that is necessary for an intervention to preserve the life or health of an individual is sanctioned;

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however, additional touching may raise concerns. For a Muslim man, being touched by a woman, especially a non-Muslim woman, after he has performed the ablutions necessary for prayer is problematic. Similar problems arise when members of other religious traditions are touched by non-members, particularly when the patient is near death. These problems are sometimes exacerbated when the touching is done by a member of the opposite sex. As a result, it is wise to inquire about the permissibility of touching with the patient and his or her family.

Pain and Suffering: The extent to which pain and suffering should be alleviated may rest on the patient’s religious values. Some traditions find meaning in suffering as a transformative process or as a means to pursuing the understanding that leads to salvation. Some see pain and suffering as a divine punishment for wrongdoing or on account of transgressions in a past life. A few traditions view suffering as not only beneficial but necessary in order to approximate Christ’s suffering for His people. However, these attempts to find meaning in suffering may work collaboratively with, rather than instead of, medical interventions geared toward the alleviation of pain and suffering. Some, like Buddhists or Hindus, may reject pain medication that dulls the senses and interferes with their ability to be “mindful” of their situation or actively involved in the dying process. Other traditions, by contrast, regard suffering as unnecessary and undesirable and something to be overcome at all costs.

These differences, while marked, are not at all obvious, and may vary from location to location. Given that these values may significantly impact the treatment alternatives that a patient and his or her family may consider, it is incumbent upon the provider to assess for the patient’s understanding of the value or disvalue of pain and suffering.

Even for those traditions that sanction the relief of pain and suffering, there may be limits. In chronic conditions where pain is significant, adequate pain relief may come with the added element of unconsciousness or decreased respiration. The possibility of pain management hastening death is problematic for some religious traditions, and as a result patients and families may set boundaries for what is or is not acceptable regarding pain relief. Providers are also often encouraged to seek non-pharmacological remedies for pain. Additionally, psychological comforts, such as the laying on of hands, may have spiritual significance as well as provide emotional support for patients and families.

Medications: As mentioned previously, the dietary prohibitions against certain animal products may extend to anything ingested orally. A patient may ask about the origins of a particular product in order to ascertain its permissibility according to his or her religious values. One religious tradition in particular, Seventh Day Adventists, will not take any over-the-counter medication.

A patient may also have religious objections to using medications on other grounds. Some patients refuse routine vaccinations for their children on the grounds that the serum was developed through immoral means. Typically, the patients for whom this is a concern will be well-versed in these areas and come prepared to discuss these values and their implication with the health care provider. Given that these considerations have import for public health, some professional organizations have taken positions against this practice. Even these groups, however, recommend respecting parents’ refusal “…after adequate discussion …unless the child is put at significant risk of serious harm” (Diekema and The Committee on Bioethics 2005, 1430)
**Childbearing:** Rituals surrounding pregnancy and birth are varied and plentiful, as many religious traditions have some way to sanctify bringing new life into the world. Religious considerations factor into the equation throughout the continuum of conception to birth.

**Contraception:** Restrictions on contraceptive measures are well known for some religious traditions. Roman Catholics, for example, seek to make every procreative act open to the possibility of conception (all things being equal). As a result, contraceptive measures are generally rejected. Similarly, Orthodox Jews understand the religious precept to “be fruitful and multiply” to encourage a couple to welcome any product of a procreative act. In both of these cases, however, some exceptions have been made for the health – both physical and psychological – of the mother. Some forms of birth control are more palatable to observant individuals than others based on other religious values. In the case of contraception, as with many decisions in health care, decision-making is a balancing act of competing interests and conflicting commitments. The way in which such a weighing of options is resolved will likely differ case-by-case.

**Conception:** In an era when many individuals seek assistance in conceiving a child, the once private realm of conception has entered the public domain. As a result, health care providers should be aware of religious values that influence notions of infertility and assisted reproduction. In no religious tradition is it required to seek reproductive assistance for infertility, but it is permitted in many. For some traditions, especially those with an emphasis on procreation, most currently-available forms of assisted reproductive technologies are sanctioned. For others, religious values may impose some limits on a couple, relating to the ways in which the gametes are retrieved and the method and location of their joining. These limits may either prohibit certain forms of assisted reproduction all together, or they may require an alteration in the customary procedure for procuring the components of conception. Regardless, an increased sensitivity to the needs of patients to both adhere to their religious commitments and also to have a child is warranted.

**Prenatal Genetic Counseling:** The purpose of prenatal genetic counseling is to obtain additional information about a pregnancy and about the condition of the fetus. Whether or not such counseling is permitted by various religions depends on (1) how the information is obtained, and (2) the purpose for which the information is requested. For those traditions that staunchly oppose pregnancy termination for any reason, there may be prohibitions against such counseling with the understanding that this additional information may lead couples to seek termination services. Other traditions, even those who oppose pregnancy termination, may sanction such counseling as a way for parents to prepare, both physically and psychologically, for a child with special needs.

**Birth:** Rather than requiring health care providers to perform an action, birth rituals often require the health care providers to refrain from performing an action that is part of standard care. For example, because of Jews’ desire to have their male children circumcised in a religious ceremony outside the hospital, parents will request that their provider not perform the routine circumcision that is otherwise part of standard postnatal care. In other traditions, like the Hmong, the placenta has religious significance and parents may request that the placenta not be discarded with other extraneous birth products but rather returned to them for sacred burial. Given the idiosyncratic nature of these values, health care providers should simply be open to these discussions and accommodating whenever possible.
Pregnancy Termination: Religious values are often brought to bear on the status of the developing fetus and the implications for pregnancy termination. Many, but not all, traditions sanction the termination of a pregnancy whose continuation threatens the life of the mother. This position is defended in a myriad of ways, including through the traditionally Catholic notion of the Doctrine of Double Effect and through the rabbinic view that in such circumstances the fetus is a *rodef*, or pursuer, against whom the woman is required to defend herself. For some traditions, the understanding of the moral standing of the fetus is a developmental one, where the closer to viability, the more moral weight is attached to the fetus.

While many religious traditions have guidelines regarding the acceptability of pregnancy termination, others do not. Patients themselves may be misinformed about their tradition’s stance on the issue and may instead be influenced by the divisive rhetoric of popular culture. As a result, inquiring into the patient’s spiritual concerns regarding pregnancy termination may engender contacting additional resources for assistance in facilitating the conversation.

Donor Organs or Tissues: All major (recognized) organized religions permit cadaveric organ or tissue donation. In fact, some religious traditions require such donation on the grounds that they serve to preserve the life of another individual. Even those religions with resurrection theologies do not prohibit the donation of organs or tissues. These faiths hold that either (1) one’s organs or tissues will not be needed at the time of resurrection, as our existence will be other-worldly, or (2) that if one does need particular organs or tissues, God will restore them just as He restored our life force.

Despite the general permissiveness of religious traditions regarding organ and tissue donation, many families are unaware of the official stance of their tradition’s governing body and as a result question these teachings at the point of decision. Most organ recovery personnel are well-versed in these religious teachings and can help a family work through these issues. Additionally, considering these issues in advance, either in conjunction with the creation of an advance directive or when obtaining a driver’s license, can help patients and families navigate this terrain before an emotionally complex situation arises.

Mechanical Ventilation: The ability to sustain ventilation mechanically presented a challenge to religious traditions that historically viewed the cessation of heartbeat and respiration as indicators of death. As a result, the transition to a brain-centered definition of death caused religious leaders to consider what this would mean for members of their community. Some traditions, such as Roman Catholicism, have applied the ordinary/extraordinary distinction to technologies such as these. That is, we are morally required to provide care that the patient or his or her family judges has a reasonable hope of benefit and is not unduly burdensome. In some cases, such as mechanical ventilation during or after surgery or for temporary purposes, mechanical ventilation clearly falls into the “ordinary” category. In other, more long-term cases, its use may indeed be, in the judgment of

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† The Doctrine of Double Effect differentiates between actions and omissions that are intended and those that are merely foreseen. The morality of the action or omission rests on what is intended, not on those consequences that are merely foreseen. This principle is often used in just war theory, where the unintended (but foreseen) consequence of the deaths of noncombatants is justified by the acceptable intent of toppling an unjust regime, for example.
the patient or his or her family, disproportionately burdensome. In that case, the technology may be removed.

Often, the move to mechanical ventilation, especially long-term, engenders a conversation about the goals of care, specifically regarding quality and quantity of life. These concepts have moral significance in many religious traditions. Islam, for example, values good works and service to God: purposes that can only be exercised if a certain quality of life is maintained. This understanding leads to the position that mechanical ventilation as a temporary measure to restore someone to health or functioning is permissible. However, mechanical ventilation that simply prolongs a person’s life without improving his or her ability to fulfill life’s purpose would not be sanctioned in Islam.

**Artificial Nutrition or Hydration:** Some of the most stark differences between religious traditions can be seen in the discussion of the permissibility of starting and, more importantly, stopping, artificial nutrition and hydration. The (im)permissibility of withholding artificial nutrition and hydration rests on a fundamental distinction in how this technology is viewed. Those religious traditions that view artificial nutrition and hydration as basic sustenance and analogous to food or water that is normally taken by mouth are much less likely to sanction discontinuation of this care for patients. Those traditions that view artificial nutrition and hydration as a form of medicine or mechanical intervention, similar to other interventions like mechanical ventilation, may view the removal of this care acceptable on the grounds that interventions that are not improving the patient’s condition may be stopped or withheld. Some traditions maintain a moral distinction between withholding and withdrawing care, which impacts medical decision-making.

**End-of-Life Issues:** Appropriate care for the dying presupposes that we can identify when a patient has reached this point – something that is not always medically possible. Regardless, religious values may become particularly salient at such times.

**Special Practices:** Roman Catholics and some other Christian traditions may desire the sacrament of Anointing of the Sick. Formerly known as “Last Rites,” this ritual has more recently been offered not just to those who are dying, but rather to anyone suffering a grave illness. It is thought both that the sacrament itself has healing powers and that spiritual conviction can be strengthened as the body weakens. Some traditions will require or request baptism, especially for a newborn or child, at the time of death, and many hospital chaplains have the ability and authority to provide this service for patients and their families. Additionally, some patients may prefer to be surrounded by members of their faith community at the time of death. These individuals may read from Scripture, pray, or meditate with and for the patient.

**Care for Dying Patients:** Some traditions establish the permissibility of actions based on intent, as was discussed previously in relation to the Doctrine of Double Effect. Another example comes from the Anglican tradition, where there is a distinction between those actions that intend care for the dying (through the palliation of symptoms), as compared with those actions whose intent is to actively intend death. A related distinction can be found in Judaism. There, one is not required to provide care that prolongs the dying process. Some sanction the removal of mechanical ventilation in certain circumstances according to this principle. However, one is prohibited from engaging in action that hastens a person’s death. Therefore, pain medication that decreases respiration and may hasten death, even though all that is
intended is relief from suffering, is not permissible. Finally, not all religious traditions value autonomy equally; end-of-life decisions may relate to family or community concerns as well.

**Care for the Body After Death:** Many religious traditions have rituals and practices regarding the care for the body after death. Some traditions, like Judaism, reject autopsies unless absolutely required for medical reasons or unless they are required by law. Many faith communities have their own systems for preparing the body for burial. Some require that whenever possible, the body only be touched by members of the faith community. However, if no one is available in the hospital, for example, then hospital personnel may remove tubes, close the eyes of the body, etc. until a member of the faith community arrives. Many traditions, such as Islam and Judaism, require the burial of the body with all possible haste. Cremation is prohibited by certain faiths – Judaism and Islam, for example – but is desired by others, like Buddhism, Sikhism, and Hinduism.