

Article

Conscientious Objection and Religious Pluralism in the Implementation of Euthanasia in Spain: Legal Framework, Moral Diversity, and Practical Impact

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Abstract

The legalization of euthanasia in Spain through Organic Law 3/2021 has intensified debates concerning the relationship between patients' autonomy, the protection of life, and the freedom of conscience of healthcare professionals. In a context marked by increasing moral and religious pluralism, conscientious objection has emerged as a particularly sensitive issue in the practical implementation of assisted dying. This article adopts a legal and socio-religious approach to analyze the role of conscientious objection in the Spanish euthanasia framework. First, it examines the constitutional foundations of freedom of conscience and its specific regulation under Organic Law 3/2021, with particular attention to the guarantees and limits established for healthcare professionals. Second, it analyses the official positions of the main religious traditions present in Spain regarding euthanasia, assisted suicide, and end-of-life care, identifying both points of convergence and doctrinal diversity. Finally, the article assesses the practical impact of religious and moral convictions on the exercise of conscientious objection, drawing on the limited empirical evidence currently available. The analysis shows that, although most religious traditions oppose active euthanasia while accepting palliative care and the withdrawal of futile treatments, analysis of available empirical evidence suggests that objections are more often grounded in secular ethical or professional reasons than explicitly religious ones. The article concludes that conscientious objection should be understood as a structural feature of pluralist healthcare systems, requiring legal and organizational arrangements capable of safeguarding both freedom of conscience and effective access to legally recognized rights.

Keywords: conscientious objection; assisted dying; religious diversity; ecclesiastical law; end-of-life care



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1. Introduction

Euthanasia is one of the most intense debates in contemporary law, where legal, ethical, medical, and social arguments converge. The very term is controversial: while its etymological meaning refers to a “good death”, in the collective imagination it can also evoke historical episodes with an enormously negative connotation ([United States Holocaust Memorial Museum 2021](https://www.ushmm.org/learn/education/teaching-materials/lesson-plans/lesson-plan-1)), which further underscores the complexity of the debate.

In 2021, with the enactment of Organic Law 3/2021, Spain joined the small group of countries that decriminalize euthanasia and assisted suicide under strict conditions. This legislative recognition, however, has not brought the discussion to an end; rather, it has intensified it on the social, political, and religious planes. Emblematic cases such as those

of Ramón Sampredo (Sampredo 2004, p. 45) and María José Carrasco (El País 2021) helped to make visible the tensions between personal suffering, patient autonomy, and legal limits, fueling public reflection on the need for regulation.

Within this framework, conscientious objection by healthcare personnel emerges as one of the most delicate issues in the implementation of the law. Its exercise raises questions about the balance between patients' right to access the provision of assistance in dying and professionals' right to abstain on moral or religious grounds. Added to this is Spain's religious diversity, which introduces an additional element of plurality and shapes both the social perception of euthanasia and professionals' willingness to participate in it.

This paper aims to analyze this phenomenon from a legal and socio-religious perspective. To that end, first, it will examine the regulatory framework for euthanasia and conscientious objection in Spain. Second, it will address the positions of the main religious denominations regarding euthanasia, assessing their possible impact on the exercise of conscientious objection. Finally, it will assess the practical implications of conscientious objection for the implementation of euthanasia in Spain, situating the Spanish case within broader comparative debates on assisted dying, moral pluralism, and freedom of conscience.

Although the legal and ethical dimensions of euthanasia and conscientious objection have been extensively examined in both Spanish and comparative scholarship, the interaction between religious pluralism, freedom of conscience, and the practical implementation of euthanasia following the adoption of Organic Law 3/2021 has received comparatively limited attention. Existing studies have largely focused either on the constitutional basis of conscientious objection, on the regulation of euthanasia as an end-of-life practice, or on the doctrinal positions of particular religious traditions. By contrast, this article seeks to bring these strands of scholarship into dialogue by examining how religious diversity may shape conscience-based conflicts within a healthcare system that recognizes euthanasia as a legal entitlement. Spain provides a particularly relevant case study for this purpose. As one of the most recent European jurisdictions to legalize euthanasia, and as a society characterized by both a historically strong Catholic tradition and an ongoing process of secularization and religious diversification, Spain offers a valuable setting in which to analyze the relationship between moral pluralism, healthcare governance, and freedom of conscience. The article combines legal analysis, socio-religious inquiry, and the analysis of available empirical evidence in order to contribute to broader international debates concerning the accommodation of conscientious objection in pluralistic healthcare systems.

The primary focus of this article is euthanasia; nevertheless, references to assisted suicide are included where appropriate because both practices are regulated jointly under Organic Law 3/2021 on the regulation of Euthanasia as forms of "medical aid in dying". The article does not seek to provide a separate legal or ethical analysis of assisted suicide. Rather, references to this practice are limited to those contexts in which religious positions, conscientious objection, or regulatory frameworks address both forms of assisted dying simultaneously.

Methodologically, the article adopts a doctrinal legal analysis combined with a socio-religious and interpretive approach. It addresses three main research questions: first, how conscientious objection is constitutionally and legally configured within the Spanish euthanasia framework; second, how the main religious traditions present in Spain position themselves in relation to euthanasia, assisted dying, and end-of-life care; and third, whether the available empirical evidence supports the claim that religious convictions are a determinative factor in healthcare professionals' conscientious objection. The purpose of analyzing the positions of different religious traditions is not to assume a direct or deterministic relationship between religious affiliation and conscientious objection. Rather, the article

examines religious traditions as sources of moral reasoning that may contribute to the formation of conscience and to the ethical frameworks through which some healthcare professionals understand end-of-life decision-making. Consequently, the relevance of religious pluralism lies not in predicting individual behavior, but in identifying normative and cultural contexts that may help explain why conscience-based conflicts arise in the implementation of euthanasia.

The analysis is based on Spanish constitutional and statutory law, relevant case law, doctrinal legal scholarship, religious and institutional sources, and the limited empirical literature currently available on professional attitudes toward euthanasia and conscientious objection. This methodological combination makes it possible to distinguish between normative interpretation, doctrinal religious positions, and empirically supported findings.

2. Regulatory Framework for Euthanasia and Conscientious Objection in Spain

2.1. Constitutional Recognition of the Right to Freedom of Conscience

The starting point for the study of this issue is Article 15 of the Spanish Constitution, which proclaims that “everyone has the right to life and to physical and moral integrity, and may in no case be subjected to torture or to inhuman or degrading punishment or treatment”. This provision places the protection of life and physical and moral integrity among the core constitutional interests, although its scope has been subject to varying interpretations by the Constitutional Court.

In addition, the Constitution explicitly enshrines, in the following provision (Art. 16 CE), freedom of ideology, religion, and worship, which encompasses freedom of conscience. The right to freedom of conscience protects not only religious convictions, but also ethical or moral ones, and it constitutes the normative foundation of conscientious objection.

Accordingly, we may affirm that the right to freedom of conscience is protected by Article 15, insofar as it refers to moral integrity, and by Article 16, insofar as it expressly refers to freedom of thought.

The internal dimension of this right seeks to protect the individual from external indoctrination, since every person is free to hold, develop, or change their most intimate beliefs, religious or otherwise, thereby ensuring that the State does not interfere in the individual’s most private sphere (Lightart et al. 2022, pp. 38–39).

Freedom of conscience refers to that area of personal autonomy that guarantees an individual’s freedom to conduct their life in accordance with their own convictions. This freedom of conscience does not impose an imperative on the person to act according to their convictions; rather, it guarantees their freedom to do so—a freedom protected by law. The right to freedom of conscience is the right that protects the freedom to externalize, without external coercion, acts that are the product of internal reasoning, developed in intimacy and consistent with one’s own convictions. The formation and consolidation of one’s convictions ensures that they are expressed through concrete acts or manifestations, such as freedom of expression, education, or association (Souto Paz 1995, pp. 133–34). In this sense, and from an axiological standpoint, we may affirm that the right to freedom of conscience, as a projection of the principle of autonomy, is closely linked to human dignity, which makes it a higher value of the legal order that must guide the competences exercised by public authorities (Contreras Mazario 2014, p. 65).

Beyond its role in protecting individual autonomy, conscience also performs an important legal and institutional function within democratic constitutional systems. Its relevance should not be understood as meaning that legal responsibility depends on the individual’s subjective moral assessment of their own conduct: a person may consider an unlawful

act morally justified and nevertheless remain legally responsible for it. Rather, conscience is relevant because it reveals the existence of a morally accountable subject, capable of forming judgments about the meaning of their actions and of acting in accordance with or against legal norms. In this sense, conscience does not replace legality, nor does it exempt individuals from civil or criminal liability merely because they act on moral conviction. However, it helps to explain why the law attributes responsibility to persons as moral agents, and why conflicts between legal duties and deeply held convictions require particular constitutional attention. At the same time, conscience fulfills a broader institutional function by safeguarding the moral independence of individuals who exercise public authority. Although public officials are required to act within the framework of the law, they do not cease to be moral agents. The protection of freedom of conscience therefore contributes to preserving individual integrity and preventing the complete absorption of personal moral judgment by institutional or political structures, which constitutes an essential guarantee in pluralistic democratic societies.

In the healthcare context, the relationship between an individual's convictions and their autonomy is materialized primarily through informed consent (Llamazares Fernández 2011b, p. 21)¹, an instrument that ensures that medical action is carried out in accordance with the patient's convictions. Subjecting a person to treatment against their will, or without taking them into account, entails a violation of their physical and moral integrity and, consequently, of their right to freedom of conscience, unless such conduct has constitutional justification².

The protection of the legal interest of "integrity" constitutes one of the guiding principles of the rights recognized in the Oviedo Convention, as reflected in Article 1 thereof. Consistently, the European Convention on Human Rights places physical and psychological integrity within Article 3, in close connection with the right to informed consent. It should be emphasized that this legal interest encompasses both the physical dimension and the moral or spiritual one (De Esteban and González Trevijano 1992–1994, p. 44), and therefore protects the person and their personal identity in its entirety (Llamazares Fernández 2011b, pp. 27–28; Tarodo Soria 2005, p. 231).

Spanish case law has reinforced this connection between integrity and patients' rights. The Supreme Court has stated that interference with physical and moral integrity is legitimate only when informed consent exists, which it defines as "one of the latest contributions made to the theory of human rights, a necessary consequence or explicit articulation of the classic rights to life, to physical integrity, and to freedom of conscience" (Spanish Supreme Court 2001a, FJ 4; Spanish Supreme Court 2001b, FJ 2). Along the same lines, the Constitutional Court has held that imposing medical care against the patient's will "would constitute an infringing limitation of the fundamental right—to physical and moral integrity (Art. 15 CE)—unless it has constitutional justification" (Spanish Constitutional Court 1990, FJ 3).

From a broader perspective, the free development of personality, in Romeo Casabona's words, can be understood as "the enrichment of the personality through one's own experiences and intimate lived realities, and through one's own conceptions regarding one's vital development" (Romeo Casabona 1994, p. 112). At this point, the philosophical and legal debate emerges regarding the limits of individual freedom: if autonomy allows decisions that affect the legal interest of integrity, and even life itself, does freedom also legitimize the disposal of one's own existence?

This question has regained currency following the adoption in 2021 of the Organic Law Regulating Euthanasia (LORE), through which Spain decriminalizes the conduct provided for in Article 143.4 of the Criminal Code—euthanasia and assisted suicide³—when the circumstances set out in Article 5⁴ of the law are present. The legislator thus confirms the

thesis that “the law may protect the value of life from attacks by third parties, but not from those of its holder” (Llamazares Fernández 2011a, p. 387)⁵.

Consistently, the Constitutional Court’s doctrine has maintained that a person may in fact end their life, since this act falls within their sphere of freedom (*agere licere*), though not as the exercise of a fundamental right recognized under Article 15 CE (Spanish Constitutional Court 1990, FJ 5). The interpretation of this provision has been the subject of lively doctrinal and jurisprudential debate, without any unanimous criterion having been reached⁶. Indeed, following Rey Martínez (Rey Martínez 2008, pp. 84–88), four possible readings of Article 15 CE in relation to euthanasia can be identified: (1) considering euthanasia constitutionally prohibited; (2) recognizing it as a fundamental right; (3) understanding it as a constitutional freedom that may be limited by the legislator; or (4) accepting it as a legitimate exception, under certain conditions, to the State’s protection of life. Doctrine has not reached consensus on these interpretations, although there is general agreement that what Article 15 CE does guarantee is the right to a dignified life (Llamazares Fernández 2011a, p. 388; Herranz Rodríguez 2002, p. 187; Parejo Guzmán and Atienza Macías 2014, p. 297).

2.2. Specific Development Under Organic Law 3/2021

The starting point for understanding the regulation of euthanasia in Spain lies in the very preamble of Organic Law 3/2021, which justifies its enactment as a response to a sustained social demand over recent decades. The statute is presented as a legal, systematic, and rights-based solution to a growing debate on end-of-life matters, in which social, healthcare, ethical, and legal factors converge.

The Law begins from a clear definition of euthanasia as the deliberate act of ending a person’s life, at that person’s express and repeated request, with the aim of preventing intolerable suffering. At the same time, it excludes from this concept both so-called passive euthanasia—i.e., the withdrawal or non-initiation of disproportionate treatments—and situations involving palliative care or palliative sedation, where symptom relief may be accompanied by a possible shortening of life as a foreseen but unintended effect. The purpose of palliative care is not to hasten death, but to provide holistic care and symptom management without either accelerating death or artificially prolonging the dying process (Radbruch et al. 2009, p. 284).

The rationale for this law lies in the need to reconcile constitutional rights and principles in tension: on the one hand, life and physical and moral integrity; on the other, dignity, freedom, autonomy, privacy, and freedom of conscience. It is not merely a matter of decriminalizing euthanasic conduct—which would leave the patient unprotected—but rather of articulating a legal framework that simultaneously guarantees the applicant’s autonomy and the legal certainty required for the healthcare professionals involved.

However, the reference to patient autonomy should not be understood in purely abstract or individualistic terms. In end-of-life decision-making, autonomy is closely connected to agency, understood as the person’s capacity to articulate, negotiate, and sustain a decision within concrete relational, clinical, and institutional contexts (Buchbinder 2018, p. 754). The request for assistance in dying is therefore not merely the expression of an isolated individual preference, but the result of a deliberative process shaped by medical information, vulnerability, dependence, suffering, and interaction with healthcare professionals and family members. For this reason, the legal recognition of autonomy in Organic Law 3/2021 must be read together with the procedural safeguards designed to verify that the applicant’s agency is effectively preserved throughout the process.

The Spanish legislator has opted for a detailed regulatory framework that combines the recognition of individual autonomy with a series of procedural and medical safeguards

governing access to euthanasia. Unlike legal systems in which the legal treatment of assisted dying has developed primarily through judicial decisions or limited decriminalization measures (Pereira 2011, p. 38), Organic Law 3/2021 establishes a comprehensive statutory procedure that defines eligibility criteria, review mechanisms, and professional responsibilities. Thus, the law delineates the so-called euthanasia context, referring to situations of serious and incurable illness or severe, chronic, and disabling conditions that cause unbearable physical or psychological suffering for the person. To these substantive conditions, the Law adds procedural safeguards designed to ensure that the decision is adopted freely, with full information, and without external pressure.

The preamble also underscores the need to introduce institutional counterweights: on the one hand, external oversight bodies—the Guarantee and Evaluation Commissions—tasked with supervising the correctness of the procedure; on the other, the express recognition of healthcare professionals’ right to conscientious objection, which ensures respect for their freedom of conscience without undermining patients’ effective access to the provision of assistance in dying.

Ultimately, the debate on euthanasia reflects a conflict between two fundamental values: life and autonomy. Historically, much of the Western legal and moral tradition has tended to regard human life as a particularly valuable and generally non-disposable good, an understanding shaped by philosophical, religious, and legal traditions that have influenced the development of modern constitutional systems (Dworkin 1993). Organic Law 3/2021 should be understood precisely as a further step in this evolution: by recognizing the right to receive assistance in dying under strict conditions, the value of life is not denied, but the idea is reinforced that respect for human dignity and individual freedom requires acknowledging a person’s capacity to decide how life ends (Gracia Guillén 2022, p. 245).

Having set out the purpose of the Law, it is necessary to examine the concrete safeguards that the text establishes in order to ensure, in a balanced manner, both patients’ right to request and receive assistance in dying and healthcare professionals’ right to refrain from participating in it on grounds of conscience.

With regard to patients, Organic Law 3/2021 frames euthanasia as an enforceable individual right under strictly regulated conditions. Article 1 defines the object of the statute as “to regulate the right of any person who meets the required conditions to request and receive the necessary help to die, the procedure to be followed, and the safeguards to be observed.” In this respect, Articles 4 and 5 set out the substantive requirements: being of legal age, having legal capacity, Spanish nationality or residence in Spain, and the presence of either a serious and incurable illness or a severe, chronic, and disabling condition that causes intolerable suffering. In addition, the decision must be free, informed, and reiterated over time, with express record in the medical file.

The Law also provides for the possibility that the request may be made through an advance directives document, thereby extending the guarantee of patient autonomy even in situations of de facto incapacity. The procedure includes deliberative phases, the involvement of an independent consulting physician, and external verification by the Guarantee and Evaluation Commissions, ensuring both prior and subsequent review of compliance with legal requirements. The aim is thus to safeguard the freedom of the decision and to rule out external pressures, whether familial, social, or economic.

As for healthcare professionals, Article 16 expressly recognizes the right to conscientious objection, understood as “an individual decision of the healthcare professional directly involved in carrying out the provision.” Its exercise must be stated in writing and in advance, and it is guaranteed through the creation of registers of objectors within each health administration. These registers, subject to confidentiality, make it possible both to

respect professionals' freedom of conscience and to ensure that the service can be effectively organized across all centers of the National Health System.

That said, Organic Law 3/2021 contains significant gaps in defining who may invoke the right to conscientious objection and under what conditions. While Article 16 limits its exercise to professionals "directly involved" in the assistance-in-dying provision—i.e., in the prescription or administration of the substance—Article 3 formulates a much broader definition that could encompass multiple healthcare actions contemplated by the statute. This ambiguity has been reinforced by the Good Practice Manual on Euthanasia, which extends the scope of objection to consulting physicians, clinical psychologists, or pharmacists, and even excludes objectors from the Guarantee and Evaluation Commissions, despite the fact that such scenarios do not entail direct participation in the performance of euthanasia. These interpretations blur the restrictive criterion provided by the Law and create an evident risk of legal uncertainty. Moreover, the absence of clear regulation on scenarios such as partial objection or subsequent objection, together with the refusal to admit any form of collective or institutional objection, highlights the tension between protecting professionals' freedom of conscience and ensuring the effectiveness of patients' rights (Tarodo et al. 2022).

The balance between rights is reinforced through two additional mechanisms: first, the inclusion of assistance in dying in the common portfolio of services of the National Health System, with public funding, so that patients' access cannot be conditioned by their economic capacity or by the facility in which they are treated; second, the obligation of health administrations to ensure that conscientious objection does not constitute a real obstacle for those who wish to exercise their right.

Finally, the establishment of Guarantee and Evaluation Commissions in all autonomous communities provides institutional oversight aimed at conferring legal certainty on the process. These commissions, with a multidisciplinary composition (lawyers and healthcare professionals), verify requests both before and after the provision, resolve complaints in cases of denial, and produce annual evaluation reports.

In sum, Organic Law 3/2021 embodies a system of cross-cutting safeguards: it protects patients by recognizing euthanasia as a subjective right under precise conditions and by reinforcing their autonomy through strict procedures, while simultaneously protecting professionals by recognizing their freedom of conscience. This normative architecture seeks, in practical terms, to reconcile the tension between competing fundamental rights.

Ultimately, Organic Law 3/2021 has configured a legal framework that recognizes euthanasia as an individual right and establishes procedural guarantees for both patients and healthcare professionals. However, as doctrine warns, the statute merely sets a "minimum common moral baseline" and leaves the ultimate decision about the end of life to individual conscience. The ethical dimension, therefore, is not resolved by regulation but rather relocated to each person's internal forum. In this context, the role of professionals becomes decisive: the exercise of conscientious objection—including the possibility of subsequent objections in specific cases—and the need for robust ethical training become key elements for ensuring that the practical application of the law unfolds with full respect for the dignity, autonomy, and freedom of all those involved (Gracia Guillén 2022, pp. 245, 247).

3. Religious Diversity and Positions on Euthanasia and Assisted Suicide

Before examining the available evidence concerning conscientious objection in healthcare practice, it is necessary to consider the principal religious traditions present in Spain and their approaches to euthanasia and assisted dying. The objective of this section is not to establish a causal relationship between religious affiliation and conscientious objection, but to identify the moral and normative frameworks that may inform individual conscience

in a religiously plural society. Understanding these frameworks is essential for assessing the potential role of religious diversity in shaping attitudes towards euthanasia and the conflicts of conscience that may emerge during its implementation.

The religious dimension is unavoidable in the debate on euthanasia because confessional traditions have historically provided normative and symbolic frameworks for interpreting existential questions of the highest significance—the beginning and end of life, the meaning of suffering, death, and human dignity—shaping not only intimate convictions but also social and institutional practices. In pluralistic societies such as Spain, this diversity of worldviews does not remain confined to the private sphere: it influences public deliberation and may be projected onto clinical practice, insofar as professionals incorporate into their moral identity criteria derived from their beliefs (religious or ethical) when facing decisions that are clinically lawful but morally controversial.

For this reason, understanding the positions of the main religious denominations present in Spain makes it possible to better grasp the axiological substratum from which some professionals may ground conscientious objection and to anticipate, at least as a working hypothesis, that in certain territorial or institutional contexts—with higher religious density or more cohesive community networks—the prevalence of resistance to participating in the provision of assistance in dying could increase. This potential impact should not be interpreted as a “cultural” obstacle in a generic sense, but rather as a structural feature of moral pluralism: when a healthcare practice lies at the intersection of individual autonomy and ultimate values, the social distribution of convictions—and their capacity to translate into professional conduct—may, *de facto*, shape the availability of personnel willing to intervene and, consequently, the real accessibility of the right recognized by law.

Within this framework, a comparative analysis of religious positions does not seek to reduce the debate to confessional determinants, but to provide an indispensable interpretive key for assessing how freedom of conscience, religious diversity, and guarantees of effective access intertwine in the practical implementation of euthanasia.

3.1. Catholicism

Within Christianity, Catholicism maintains a categorical opposition to euthanasia and assisted suicide, on the understanding that human life is a gift from God over which the person does not have absolute power of disposal. Since the Declaration on Euthanasia (*Iura et bona*) of the [Congregación para la Doctrina de la Fe](#) (1980), the Magisterium has held that such practices constitute a “violation of divine law” and are incompatible with the dignity of the human person ([Congregación para la Doctrina de la Fe](#) 1980). Subsequently, John Paul II’s encyclical *Evangelium vitae* (1995) reaffirmed this condemnation, describing euthanasia as a form of “false compassion” in contrast to the genuine obligation to respect life at every stage. More recently, the letter *Samaritanus bonus* (2020) updated this teaching, rejecting both euthanasia and assisted suicide and emphasizing the importance of palliative care as an ethical and Christian response to suffering ([Juan Pablo II](#) 1995).

The Church nonetheless distinguishes between euthanasia and the withdrawal of disproportionate treatments or palliative sedation, which it considers morally permissible provided that the aim is to relieve pain and not to bring about death directly ([Congregación para la Doctrina de la Fe](#) 2020). In the Spanish context, the Spanish Episcopal Conference has repeatedly expressed its opposition to Organic Law 3/2021, in documents such as *Sembradores de esperanza* (2019) and the Declaration on the parliamentary processing of the euthanasia law (2020), in which it reaffirms the dignity of every human life, promotes holistic accompaniment of the sick, and advocates strengthening palliative care rather than legalizing assistance in dying.

3.2. Evangelical Churches

From an evangelical theological perspective, human life is sacred because it comes from God and remains under His sovereignty; consequently, only God has ultimate authority over life and death. Although evangelical Protestantism lacks a centralized doctrinal authority and displays considerable denominational diversity, there is broad consensus that active euthanasia is morally unacceptable, as it is regarded as incompatible with the biblical commandment not to kill and with the intrinsic dignity of the human being as created in the image of God ([Alianza Evangélica Española 2020](#)). In this framework, the value of life is not determined by autonomy, utility, or quality of life, but by its divine origin and moral inviolability.

Evangelical ethics therefore tends to reject the deliberate ending of life as a response to suffering, emphasizing instead medical, familial, and community-based care for seriously ill persons. The appropriate response to pain, vulnerability, or despair is understood to be palliative care, spiritual accompaniment, and social support, rather than the intentional causation of death ([Shirrmacher 2003](#), pp. 229–30). At the same time, evangelical churches commonly distinguish between actively causing death and allowing the natural process of dying to unfold. Accordingly, the withdrawal or non-initiation of futile or disproportionate treatments may be ethically acceptable when such measures merely prolong biological life without reasonable prospects of recovery, since Christian care does not require preserving life at any price ([Bioethical Committee of the Baptist, Methodist and Waldensian Churches in Italy 2017](#)).

In the contemporary Spanish and European debate, evangelical organizations have therefore opposed the legalization of euthanasia while calling for stronger palliative care and spiritual accompaniment at the end of life. The Spanish Evangelical Alliance, for example, has rejected euthanasia as an inadequate response to suffering and vulnerability, warning of the risks it may pose for the most fragile persons. Although some liberal Protestant perspectives may give greater weight to individual autonomy in extreme cases, the predominant evangelical position remains the defense of life and opposition to active euthanasia, grounded in biblical understandings of human dignity and moral responsibility before God ([Alianza Evangélica Española 2020](#)).

3.3. Orthodox Churches

Although the practical conclusions partially coincide with those of other Christian denominations, Orthodoxy offers a distinctive understanding of suffering, death, and spiritual care that is relevant to conscientious objection in clinical settings. The Orthodox Churches reject both active euthanasia and assisted suicide, grounding this position in a theological anthropology that understands human life as participation in divine life and as oriented toward the process of theosis, or deification ([Hatzinikolaou 2003](#), p. 196). From this perspective, life is not an object of absolute individual disposal, but a gift received from God; consequently, intentionally causing death, even for compassionate reasons, is considered incompatible with the ontological dignity of the person ([Ladas 2025](#), p. 149).

At the same time, Orthodox ethics distinguishes between actively causing death and allowing the natural process of dying to unfold. The withdrawal or non-initiation of disproportionate or futile treatments may be ethically legitimate when such measures offer no reasonable prospect of cure and merely prolong the dying process. This position is not based on utilitarian judgments about quality of life, but on a pastoral understanding of suffering and human finitude that rejects therapeutic obstinacy as a form of violence against the sick person ([Hatzinikolaou 2003](#), p. 191). Accordingly, Orthodox Christianity values spiritual accompaniment, prayer, reconciliation, holistic care, and palliative treatment when their purpose is to relieve suffering without deliberately hastening death. In this

sense, it adopts an intermediate position between absolute vitalism and approaches that subordinate life to autonomy or utility, emphasizing compassionate care rather than the elimination of the person who suffers (Joseph 2008).

3.4. *The Church of Jesus Christ of Latter-Day Saints*

The Church of Jesus Christ of Latter-day Saints adopts a clearly adverse position toward active euthanasia and assisted suicide, viewing human life as a sacred gift from God and as part of an eternal plan of salvation. From this perspective, human beings are not the absolute owners of their lives, and only God has ultimate authority over the beginning and end of life; consequently, deliberately causing death, even for compassionate reasons, is considered morally illegitimate (Hastings et al. 2011, p. 21).

At the same time, this tradition distinguishes between actively causing death and allowing the natural dying process to unfold. The withdrawal or non-initiation of disproportionate or futile treatments may be ethically permissible when such measures merely prolong dying without reasonable prospects of recovery, since there is no moral duty to preserve biological life at any cost (The Church of Jesus Christ of Latter-day Saints 2024). The Church also values palliative care, pain relief, and familial, communal, and spiritual accompaniment at the end of life, provided that the purpose is not deliberately to hasten death. Within this framework, the ethical response to extreme suffering is compassionate care rather than the direct elimination of life (Pond 2023, p. 213).

3.5. *Jehovah's Witnesses*

Jehovah's Witnesses maintain a firm opposition to active euthanasia and assisted suicide, regarding human life as a sacred gift from God and holding that only He has authority over its beginning and end. From this doctrinal perspective, any action deliberately aimed at causing death, even when justified by compassion or relief of suffering, is morally unacceptable and contrary to the biblical principles that govern their faith (Mattei 2023, p. 221).

At the same time, Jehovah's Witnesses distinguish between actively causing death and allowing the natural course of illness to unfold. Accordingly, the withdrawal or non-initiation of disproportionate or futile treatments may be ethically acceptable when such measures offer no reasonable prospect of recovery and merely prolong the dying process; this is understood as acceptance of the natural course of disease, not as euthanasia (Elger and Harding 2002, p. 479). Palliative care, pain relief, and familial or spiritual accompaniment are also valued positively, provided that they are not intended to hasten death. Within this framework, the response to extreme suffering is compassionate care and respect for conscience, rather than the deliberate elimination of life (Testigos de Jehová 2011).

3.6. *Islam*

In Islam, euthanasia and assisted suicide are generally prohibited, in accordance with the theological view that life is a gift from Allah and that only He has authority over its beginning and end. The Qur'an condemns the unlawful taking of life, and the Prophetic tradition reinforces the spiritual value of enduring pain and hardship. Accordingly, euthanasia and assisted suicide are usually considered unlawful (haram), since they involve an intentional intervention in the divinely ordained course of life and death (Garzón Borgoñoz and Guillaumet i Olives 2014, p. 23).

Islamic law nevertheless distinguishes between actively causing death, which remains prohibited, and withdrawing futile or disproportionate treatment when there is no reasonable hope of recovery. The latter may be permissible when the aim is to avoid therapeutic obstinacy and alleviate suffering, rather than to cause death directly (Zahedi et al. 2007, p. 11). In this decision-making process, family involvement and consultation with reli-

gious scholars are particularly relevant, given the importance of shura, or consultation and consensus, in Islamic ethics (Hedayat 2001, p. 117). In Spain, the Islamic Commission has expressed opposition to Organic Law 3/2021, while also recognizing the importance of strengthening palliative care and respecting patients' dignity (Zenit 2020).

3.7. Hinduism

Hinduism does not have a unified doctrine or a central religious authority establishing a single position on euthanasia, which results in a plural and contextual ethical approach. Nevertheless, several principles are particularly relevant to end-of-life decision-making, including the sanctity of life, ahimsa (non-violence), karma, and reincarnation. From this perspective, the intentional causing of death is often associated with a "bad death" (akal mrtyu), understood as violent, premature, or artificially induced. For this reason, suicide and active euthanasia tend to be rejected insofar as they interfere with the natural course of life and may generate negative karmic consequences (Grove et al. 2022).

This assessment, however, is neither absolute nor homogeneous. Hindu tradition may distinguish between actively causing death and allowing the natural dying process to take its course. Accepting death when it occurs naturally, without resorting to disproportionate measures that artificially prolong life, can be compatible with an ethic oriented toward dharma; accordingly, withdrawing or not initiating futile treatments may be considered morally legitimate when the aim is to avoid unnecessary prolongation of suffering (Avci 2019, pp. 1782–85). Palliative care and pain relief are generally valued positively as expressions of compassion toward the suffering person. Some interpretations, especially those inspired by a Gandhian reading of ahimsa, exceptionally allow for the justification of euthanasia in cases of unbearable suffering, provided that the motivation is exclusively compassionate and all therapeutic options have been exhausted (Gielen 2012, pp. 432–33). This remains, however, a minority and non-consolidated position within Hinduism, which continues to be marked by a tension between preserving life, accepting suffering, and seeking a spiritually appropriate death (Avci 2019, p. 1786; Srivastava 2014, p. 81).

3.8. Judaism

Judaism maintains an almost absolute valuation of human life (pikuach nefesh), understood as a gift from God entrusted to human beings, which entails a normative duty to care for and preserve it. This theological and legal outlook, reflected in Halakha, emphasizes that the dignity and value of life do not diminish because of suffering, disability, or extreme frailty (Probst 2023, p. 152). Within this framework, the commandment "You shall not murder" (Exodus 20:13) and the belief that only God has authority over the timing of death provide the basis for a general rejection of active euthanasia.

Jewish approaches to euthanasia are nevertheless marked by interpretive plurality. Traditional sources concerning the gose, or dying person, prohibit actions that would directly shorten life, while later rabbinic discussions allow for distinctions between actively causing death and removing obstacles that artificially prolong the dying process. Accordingly, although Orthodox Judaism tends to adopt a strongly vitalist position and rejects active euthanasia, Conservative and Reform perspectives more clearly accept the withdrawal of futile treatments in certain circumstances. Some minority interpretations go further, suggesting that in extreme cases of intolerable suffering a "good death" (mitah yafah) may be compatible with dignity and compassion. Overall, the dominant position in Judaism rejects active euthanasia, but there is broad consensus in permitting the withdrawal of futile treatments, alongside a minority doctrinal view that allows for exceptions in extreme situations of suffering (Baeke et al. 2011, pp. 784–86).

3.9. Buddhism

Buddhism generally rejects euthanasia and assisted suicide because the principle of *ahimsā* prohibits the intentional taking of life. However, this does not imply a duty to preserve life at all costs. Buddhist ethics distinguishes between actively causing death and allowing the natural process of dying to unfold without disproportionate medical intervention. Accordingly, there is no obligation to maintain biological life through futile or extraordinary means.

Particular importance is attached to facing death with serenity, mindfulness, and appropriate accompaniment. For this reason, Buddhism tends to value palliative care and hospice models that relieve suffering while respecting the natural course of life. It thus occupies a middle position between absolute vitalism and approaches that prioritize individual autonomy or utility, maintaining that life has intrinsic value but need not be prolonged artificially once death becomes imminent (Keown 1998, pp. 404–5).

3.10. The Bahá'í Faith

The Bahá'í Faith does not contain a specific doctrinal regulation on euthanasia, but it offers an ethical and spiritual framework for end-of-life decision-making. Human life is understood as a sacred gift from God and as a stage in the soul's spiritual development, whose existence continues beyond bodily death. From this perspective, life and death are not fully subject to individual disposal, but form part of a divine process that transcends human will (Sharon 2003).

Accordingly, deliberately causing death, whether through active euthanasia or assisted suicide, is generally incompatible with Bahá'í teaching. At the same time, Bahá'í sources recognize that there is no explicit sacred text governing every clinical situation, so end-of-life decisions should be guided by conscience, compassion, and respect for life (BahaiTeachings.org n.d.). This approach allows a distinction between actively causing death and accepting the natural process of dying: death should neither be deliberately hastened nor unduly prolonged, and foregoing interventions that merely prolong the dying process without real benefit may be ethically considered (Sharon 2003).

The comparative overview of religious positions presented in this section is relevant to the central argument of the article not merely because it describes doctrinal stances on euthanasia, but because these traditions provide moral frameworks that may shape how healthcare professionals understand their role in end-of-life decision-making. Across the traditions examined, a broad convergence can be observed in the rejection of intentionally causing death, while many of them accept the withdrawal of disproportionate or futile treatments and the provision of palliative care. This distinction is directly relevant to professional practice: a healthcare professional whose moral identity is informed by one of these traditions may perceive participation in euthanasia not simply as the performance of a legally authorized clinical act, but as cooperation in an act that conflicts with deeply held convictions about life, suffering, and death. At the same time, the diversity and internal plurality of these traditions caution against assuming an automatic relationship between religious affiliation and conscientious objection. The practical significance of religious pluralism in the Spanish healthcare system therefore lies not in establishing deterministic links between faith and objection, but in showing why conflicts of conscience are foreseeable in the implementation of euthanasia and why legal and organizational frameworks must be capable of managing them without undermining patients' access to the legally recognized service.

4. Conscientious Objection by Healthcare Professionals: Legal Basis, Public Function, and Structural Character

Organic Law 3/2021 regulating euthanasia (LORE) expressly recognizes the right to conscientious objection for healthcare personnel involved in the provision of assistance in dying. Specifically, Article 16 provides that healthcare professionals directly involved in the procedure may exercise this right, provided that they do so individually, in advance, and in writing, and it establishes the creation of regional registers of objectors. This statutory recognition fits within the Spanish constitutional tradition, which has regarded conscientious objection as a specific manifestation of the fundamental right to ideological and religious freedom enshrined in Article 16 of the Spanish Constitution.

From a constitutional perspective, the Constitutional Court has repeatedly held that conscientious objection does not constitute an autonomous fundamental right, but rather a projection of the right to freedom of conscience, whose scope and limits may be shaped by the legislator in light of other constitutionally protected interests ([Spanish Constitutional Court 1985](#), [Spanish Constitutional Court 1987](#)) This configuration has been widely examined in the scholarly literature, which emphasizes that conscientious objection operates as a mechanism for protecting moral pluralism in democratic societies, especially in fields characterized by a strong ethical charge, such as healthcare ([Llamazares Fernández 2011a](#), p. 387).

The specific interpretation of conscientious objection in the LORE reflects this understanding ([Spanish Constitutional Court 2023a](#), [2023b](#)). Article 16 establishes, first, that it is a strictly individual right, exercisable only by healthcare professionals directly involved in the provision of assistance in dying. Second, it excludes any form of collective or institutional objection. Third, it imposes a formal requirement of prior written declaration, operationalized through registers of objectors subject to strict confidentiality safeguards. The purpose of this normative design is not only to protect the professional's conscience, but also to enable the health administration to plan the service appropriately and to guarantee patients' effective access to the right recognized by law.

This normative balance forms part of a broader doctrinal debate concerning the tension between patient autonomy and the moral integrity of healthcare professionals. In this field, one can identify positions that are clearly critical of conscientious objection, arguing that professionals who refuse to provide a legally recognized service on moral grounds fail in their fundamental duty to act in the patient's best interests. From this perspective, allowing conscientious objection could jeopardize equity, efficiency, and the quality of the healthcare system, particularly where the professional acts as a public servant. It has also been argued that objection unfairly shifts onto the patient the burden of locating a willing professional, generating inequalities in access and inefficient use of public resources⁷.

These positions, however, have themselves been criticized, insofar as an absolute denial of conscientious objection entails a severe restriction of the professional's freedom of conscience and a reductionist conception of medical ethics. Where respect for the professional's conscience can be accommodated without detriment to quality of care or to the patient's effective access to the service, sacrificing it is difficult to justify in a pluralist democratic society ([Savulescu 2006](#), p. 296).

Beyond its positive regulation, conscientious objection in healthcare should not be interpreted as a residual or exceptional phenomenon. The scientific literature has highlighted that, in contexts where morally highly controversial practices are regulated—such as abortion, euthanasia, or assisted reproduction—conscientious objection emerges recurrently and stably as an expression of deep ethical convictions, often linked to coherent religious or philosophical worldviews. In this regard, various studies maintain that conscientious objection is part of the professional identity of a significant number of healthcare workers

and does not simply reflect contingent resistance to regulatory change (Cantor and Baum 2004, p. 2009; Fiala and Arthur 2017, p. 255).

This structural character is intensified when conscientious objection is grounded in firmly articulated religious convictions (Ferrari 2012, p. 368). As analyzed in the preceding sections of this paper, the main religious denominations present in Spain maintain—albeit with nuances—critical or clearly adverse positions toward active euthanasia. These positions are not limited to abstract moral prescriptions; they shape comprehensive ethical frameworks that directly influence the professional practice of believers. In contexts of religious diversity, socio-legal scholarship has emphasized that conscientious objection cannot be treated as an individual anomaly, but rather as a foreseeable collective phenomenon, derived from society's moral pluralism and from the healthcare workforce itself (Bader 2007, p. 45).

From this perspective, conscientious objection not only protects the individual against a normative imposition incompatible with their deepest convictions, but also fulfills a relevant systemic function in the public sphere. The possibility of objecting introduces an internal limit on State power and serves as a reminder that the law, even when pursuing legitimate aims, cannot demand full moral endorsement from those who are called upon to apply it. In healthcare, this function is especially significant, given that clinical decisions affect legal interests of the highest value—life, integrity, dignity—and are made in contexts of extreme vulnerability (Fernández-Coronado 2014, pp. 123–48; Herranz Rodríguez 2002, pp. 179–80).

In this sense, conscientious objection is configured as a balancing mechanism between two opposing risks: on the one hand, the risk of disorderly ethical subjectivism that compromises equality in access to healthcare services; on the other hand, the risk of normative formalism that turns professionals into mere executors of legally prescribed decisions, regardless of their moral judgment. Regulating conscientious objection helps avoid both extremes by recognizing the legitimacy of individual moral dissent without turning it into a factor that blocks the system.

Thus, religious freedom—and its practical projection through conscientious objection—cannot be reduced to an intimate preference tolerated exclusively within the private sphere. On the contrary, it is a constitutive dimension of the person that deserves protection also when it is projected into social and professional life. In a plural democracy, the risk does not lie in the coexistence of diverse convictions, but in turning secularism into an exclusionary orthodoxy that imposes a single legitimate mode of public reasoning. For this reason, rather than rigid uniformity models, it is more coherent to craft regulations that allow for reasonable accommodations, with clear limits and procedural guarantees. Regulating conscientious objection does not entail granting privileges; it means legally ordering pluralism and providing predictable channels to prevent moral coercion, preserve professional integrity, and sustain the legitimacy of the State (Trigg 2018, p. 57).

5. Religious Convictions and Conscientious Objection in Euthanasia: Limits of Empirical Analysis and Interpretive Keys in the Spanish Context

The question of whether religious convictions are determinative in healthcare professionals' exercise of conscientious objection in the implementation of euthanasia in Spain raises significant methodological difficulties that should be made explicit from the outset. Unlike other areas of legal debate, in this case there are no systematic empirical data that would allow direct correlations to be established between religious affiliation and the exercise of conscientious objection, particularly with regard to healthcare professionals. The regional registers of objectors envisaged by Organic Law 3/2021 do not record information

about the personal motivations for objection, nor about professionals' religious beliefs, which considerably limits any attempt at causal analysis. Added to this is the fact that religious convictions form part of the most intimate core of freedom of conscience, constitutionally protected, which makes understandable—and legally desirable—the absence of mechanisms for publicly identifying such motivations.

This empirical limitation helps explain why, in a substantial part of the theoretical literature, conscientious objection is analyzed through broad categories in which “religion” and “conscience” tend to be used almost interchangeably. Within these approaches, religion functions as a paradigm of deep, identity-constituting convictions resistant to normative coercion, operating as a kind of conceptual shorthand for intense moral conflicts. However, when analysis shifts from the theoretical plane to the empirical one, the available findings depict a more complex and nuanced scenario, requiring heightened interpretive caution.

Indeed, the scientific literature that has examined the reasons invoked by healthcare professionals to exercise conscientious objection shows that explicitly religious motives are, in general terms, a minority. Most empirical studies locate such reasons within what are often termed “secular reasons”: personal moral convictions, deontological principles, professional conceptions of care, or considerations derived from training in bioethics. To such an extent is this the case that some authors have questioned the analytic usefulness of distinguishing between religious and non-religious conscientious objections, arguing that both respond to moral structures that are equally deep and equally relevant to personal identity (Triviño Caballero et al. 2023, p. 110).

In the same vein, it has been noted that the fact that a moral conviction has a religious origin does not make it deeper, more central, or more costly to betray than convictions held without reference to the divine. From this perspective, analytically privileging religious objections over secular ones is not only conceptually problematic, but may introduce unjustified normative biases by suggesting that certain motivations deserve enhanced protection because of their religious character, when in reality a conflict of conscience can be equally intense in the absence of religious belief (Sumner 2020, p. 31).

The empirical data available in the Spanish context reinforce this need for prudence. The study by Fortes Ponce et al. provides a meaningful approximation by analyzing nursing staff attitudes toward euthanasia. According to its results, 76.67% of respondents report a positive attitude toward euthanasia, while 23.3% adopt a neutral position, without identifying a clearly defined group of active rejection or consolidated objection. The predominant profile in the sample corresponds to primary care nurses, mostly women, over 45 years of age, married, and—crucially for this analysis—not practising any religion. These data suggest that, at least within this group, religious affiliation does not constitute a significant predictor of negative attitudes toward euthanasia (Fortes Ponce 2022, pp. 3–4).

However, other studies introduce relevant nuances that prevent the influence of religious convictions from being entirely dismissed. Drawing on data from the hospital-based study by Muñoz Camargo et al.⁸, religious convictions—operationalized as religious practice—appear associated with greater resistance to euthanasia and, by extension, allow one to infer a higher potential for conscientious objection when such practices are implemented as a healthcare service. In particular, practising Catholics are the subgroup showing significantly higher opposition both to the legalization of euthanasia and to its application in a clinical scenario (in both cases, $p = 0.0001$), and they are also more opposed to withdrawing extraordinary measures if the patient were a close family member ($p = 0.001$), suggesting that religiosity may function as a factor of moral reserve with respect to interventions perceived as “active” at the end of life (Muñoz Camargo et al. 2012, p. 111).

The conscience-based reasons invoked by healthcare professionals are frequently articulated around professional ethical considerations rather than religious ones. These

include reluctance to become the direct causal agent of death, the perception that “doing the right thing” morally prevails over professional participation in a practice deemed ethically problematic, or fear of social or professional judgment (Martins-Vale et al. 2023, p. 9)⁹. Likewise, concerns are identified regarding potential abuses of assisted suicide among vulnerable groups—such as older persons who are alone, or those with cognitive or psychological deterioration—which reinforces the idea that conscientious objection draws on a plurality of ethical motivations not reducible to religion.

With regard to physicians, the lack of specific data on religious beliefs constitutes a particularly relevant limitation. To date, there are no published studies that directly analyze Spanish physicians’ religious affiliation and its possible relationship to exercising conscientious objection in the area of euthanasia and assisted suicide. In the absence of such evidence, one can only resort indirectly to general data on the population resident in Spain, provided by the Observatory of Religious Pluralism and the Spanish Centre for Sociological Research (Observatorio del Pluralismo Religioso en España 2025)¹⁰. These data show a sustained trend toward secularization between 2008 and 2018 (Observatorio del Pluralismo Religioso en España n.d.), particularly marked among the middle and upper-middle classes, which are precisely the strata with the highest rates of access to university studies and, in particular, to medical education. While this extrapolation must be handled with caution, it suggests that physicians are not insulated from the broader secularization processes affecting Spanish society.

Overall, the information available supports a necessarily nuanced conclusion. It is not methodologically appropriate to claim that religious convictions are the decisive factor in the exercise of conscientious objection in the implementation of euthanasia in Spain. Empirical studies indicate that religious motivations are rarely invoked explicitly and that, in many cases, objection is grounded in secular reasons of a deontological, professional, or ethical nature. However, nor can it be ruled out that religious convictions play a relevant role in certain cases or subgroups, especially when those convictions are integrated into coherent moral frameworks that guide professional practice.

In this context, it is useful to recall that, in some strands of legal-theoretical work focusing on protecting professionals’ religious freedom, conscientious objection is framed as a particularly intense conflict when participation in euthanasia or assisted suicide is interpreted—on the basis of deep religious convictions—as cooperation in the “intentional taking of an innocent human life,” that is, as an act incompatible with the principle of the sanctity/inviolability of life and therefore morally unavailable. On that view, the refusal does not necessarily stop at the direct clinical act, but may extend to indirect forms of involvement (for example, referral), when the professional perceives that referring the patient makes them complicit in the final outcome, with the moral burden of the act remaining intact (Knoetze 2018, pp. 151, 159).

This logic is also formulated in expressly religious terms to underscore the density of the conflict: the conduct is described as “murder” and, consequently, as grave sin or transgression of the divine command (“you shall not kill”), with a component of responsibility “before God” that intensifies the experience of normative coercion and the subjective cost of “betraying” one’s beliefs (Knoetze 2018, pp. 79, 130).

Finally, these approaches often add an interpretive key that is relevant to the Spanish debate: the structure of this type of objection does not depend exclusively on reference to the divine, since it can equally rest on non-religious “foundational beliefs” that perform an equivalent identity function. Hence, even while acknowledging the semantic specificity of religion, the juridical core of the conflict lies in protecting ultimate convictions (religious or secular) whose violation is experienced as a form of moral self-betrayal.

This conclusion ultimately reinforces the need to address conscientious objection from a perspective that recognizes the real moral pluralism of society and of the healthcare system, without reducing it to an exclusively religious phenomenon or trivializing the depth of conscience conflicts that may arise around euthanasia. Precisely because the ultimate motivations for objection are diverse and, in many cases, inaccessible to empirical verification, the law cannot demand proofs of moral authenticity or rank reasons of conscience; rather, it must confine itself to establishing normative frameworks that allow for reasonable coexistence between respect for professional conscience and the guarantee of patients' rights.

6. Conclusions

In light of the analysis carried out, the regulation of euthanasia in Spain through Organic Law 3/2021 constitutes a normative milestone that, far from closing the debate, reconfigures it around a new axis: the need to give legal form to the tension between life, dignity, and autonomy, while simultaneously incorporating institutional safeguards capable of preserving freedom of conscience within a public healthcare system. The Spanish Constitution provides the indispensable frame of reference: Article 15 places life and physical and moral integrity among the essential constitutional interests, while Article 16 recognizes ideological and religious freedom—including freedom of conscience—as a prerequisite for democratic pluralism. In the clinical sphere, this architecture is projected through informed consent as a concrete expression of patient autonomy and as a limit on any medical intervention lacking constitutional justification. The LORE fits squarely within this evolution of contemporary constitutionalism: it does not deny the value of life, but recognizes that, under certain strictly typified circumstances, respect for dignity and personal freedom requires legally enabling the decision to bring an intolerably experienced suffering to an end.

One of the LORE's main contributions lies in its design of cross-cutting safeguards. On the one hand, it frames euthanasia as an enforceable individual right under strengthened substantive and procedural requirements: a delimited euthanasia context, reiteration of the request, clinical deliberation, a consulting physician's report, and external institutional oversight by the Guarantee and Evaluation Commissions. On the other hand, it incorporates the protection of professional freedom of conscience through the express recognition of the right to conscientious objection (Art. 16), conceived as individual, prior, and formalized in writing, and embedded in a system of confidential registers aimed at enabling healthcare planning without frustrating patients' effective access to the service. This balance reflects a deliberate normative choice: the legislator affirms the operative primacy of the applicant's autonomy in accessing assistance in dying, while at the same time recognizing that a democratic State cannot demand full moral obedience from those who materially carry out the service, especially where ultimate convictions—religious or secular—are incompatible with participation in the act.

That said, this paper has also shown that the practical articulation of this balance is not free from tension. The statute contains relevant ambiguities, particularly regarding the delimitation of those "directly involved" who may object and the breadth that certain guidelines or manuals have suggested for the exercise of objection beyond the core of direct clinical intervention. These gray areas increase the risk of legal uncertainty and may give rise to expansive or restrictive interpretations with uneven effects on real access to the service. From a structural standpoint, conscientious objection should not be treated as an anomaly: in healthcare fields with a high moral load, it emerges recurrently as an expression of ethical pluralism and as an internal limit on the State's normative power. Its recognition fulfills a systemic democratic function: it preserves the professional's moral integrity,

prevents coercion over deep convictions, and maintains a space for ethical deliberation within public institutions—provided that the system is organized so that objection does not translate into unjustified inequalities for patients.

The socio-religious analysis developed in the article reinforces this reading. The main denominations present in Spain show, with nuances, critical or adverse positions toward active euthanasia and assisted suicide, although many of them ethically accept limiting therapeutic effort and value palliative care positively when its purpose is to alleviate suffering without deliberately causing death. This doctrinal plurality helps explain why, in a society characterized by religious diversity, conscientious objection can be a collectively foreseeable phenomenon rather than a purely individual one. However, studying the specific relationship between religion and objection in the Spanish context requires caution: the available empirical evidence suggests that explicitly religious motives are rarely invoked directly and that, in many cases, objection is grounded in secular reasons—deontological, professional, or ethical—without excluding the possibility that, within certain subgroups, religiosity may operate as a factor of moral resistance. The absence of systematic data on religious beliefs among physicians, together with the intimate and protected character of convictions, prevents causal conclusions; but it does not warrant denying the relevance of religion as a significant moral framework in some cases, just as it does not allow the phenomenon to be reduced to religious motivations.

Conscientious objection also helps maintain a space for ethical deliberation within public institutions. Its recognition prevents certain normative options from being presented as morally neutral or beyond dispute and fosters a more complex understanding of democratic pluralism. Rather than conceiving State neutrality as the exclusion of moral convictions from the public sphere, conscientious objection makes it possible to articulate an inclusive neutrality, capable of accommodating different conceptions of the good without imposing a single moral hierarchy.

Finally, it must be emphasized that recognizing conscientious objection does not relieve the State of its duty to guarantee patients' rights. On the contrary, it shifts the focus of responsibility from the individual objector to the organization of the healthcare system. In this regard, conscientious objection requires rethinking workforce planning, the distribution of roles, and the structuring of care teams, so that the legitimate exercise of freedom of conscience does not translate into unjustified inequalities in access to the service. This organizational logic, rather than a restrictive one, strengthens the coherence of the model and prevents conflicts between rights from being resolved improperly at the expense of professionals or patients.

In sum, the effective implementation of euthanasia in Spain will depend less on the formal proclamation of the right than on the healthcare system's capacity to sustain—under conditions of equity—an ordered coexistence between patient autonomy and professional conscience. The legal and social significance of this debate lies in the fact that it compels a rethinking of how moral pluralism is managed within public institutions that operate upon the highest legal interests, and it underscores that end-of-life regulation cannot be understood merely as a matter of legislative technique, but as an architecture of safeguards designed to protect, simultaneously, the patient's dignity and the professional's moral integrity. From this perspective, the remaining challenge is not to choose between life and autonomy as mutually exclusive values, but to consolidate an organizational and legal framework capable of preventing the exercise of a right from becoming, for others, the imposition of a moral orthodoxy—whether religious or secular—at the very heart of clinical practice.

From an empirical perspective, the available evidence does not support the conclusion that religious affiliation alone constitutes a determinative factor in healthcare professionals'

conscientious objection to euthanasia. The studies examined suggest a more complex reality in which religious beliefs may interact with professional ethics, personal moral convictions, cultural contexts, and institutional factors. While greater religious commitment may be associated with more restrictive attitudes towards euthanasia, the current empirical literature remains limited and does not justify reducing conscience-based conflicts to exclusively religious motivations.

From a normative perspective, however, the existence of such conflicts remains legally significant regardless of their precise empirical prevalence. In a pluralistic democratic society, the constitutional protection of freedom of conscience requires legal frameworks capable of accommodating deeply held convictions while simultaneously guaranteeing effective access to legally recognized healthcare services. The challenge posed by Organic Law 3/2021 is therefore not merely the regulation of euthanasia itself, but also the development of institutional mechanisms capable of reconciling moral pluralism, professional integrity, and patients' rights within the Spanish healthcare system.

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Notes

- ¹ Within legal scholarship, the right to freedom of conscience has been regarded as the primary foundation of patients' rights (Gracia Guillén 1994, p. 116; McConnell 2000, p. 45; Tarodo Soria 2005; Pugh 2020, p. 131).
- ² Spanish Constitutional Court Judgment 137/1990 of 19 July (RTC 1990/137), concerning members of the terrorist group GRAPO who were on hunger strike and to whom assisted feeding was administered by the authorities.
- ³ Article 143.4 CP. "El que causare o cooperare activamente con actos necesarios y directos a la muerte de otro, por la petición expresa, seria e inequívoca de éste, en el caso de que la víctima sufriera una enfermedad grave que conduciría necesariamente a su muerte, o que produjera graves padecimientos permanentes y difíciles de soportar, será castigado con la pena inferior en uno o dos grados a las señaladas en los números 2 y 3 de este artículo".
- ⁴ Article 5.1 LORE establishes the requirements that must be met in order to receive medical aid in dying.
 "1. Para poder recibir la prestación de ayuda para morir será necesario que la persona cumpla todos los siguientes requisitos:
 - (a) Tener la nacionalidad española o residencia legal en España o certificado de empadronamiento que acredite un tiempo de permanencia en territorio español superior a doce meses, tener mayoría de edad y ser capaz y consciente en el momento de la solicitud.
 - (b) Disponer por escrito de la información que exista sobre su proceso médico, las diferentes alternativas y posibilidades de actuación, incluida la de acceder a cuidados paliativos integrales comprendidos en la cartera común de servicios y a las prestaciones que tuviera derecho de conformidad a la normativa de atención a la dependencia.
 - (c) Haber formulado dos solicitudes de manera voluntaria y por escrito, o por otro medio que permita dejar constancia, y que no sea el resultado de ninguna presión externa, dejando una separación de al menos quince días naturales entre ambas.
 Si el médico responsable considera que la pérdida de la capacidad de la persona solicitante para otorgar el consentimiento informado es inminente, podrá aceptar cualquier periodo menor que considere apropiado en función de las circunstancias clínicas concurrentes, de las que deberá dejar constancia en la historia clínica.
 - (d) Sufrir una enfermedad grave e incurable o un padecimiento grave, crónico e imposibilitante en los términos establecidos en esta Ley, certificada por el médico responsable.
 - (e) Prestar consentimiento informado previamente a recibir la prestación de ayuda para morir. Dicho consentimiento se incorporará a la historia clínica del paciente."

Ley Orgánica 3/2021, de 24 de marzo, de regulación de la eutanasia. En: «BOE» núm. 72, de 25 de marzo de 2021, disponible en: <https://www.boe.es/buscar/doc.php?id=BOE-A-2021-4628> (accessed on 11 November 2022). With this Act, Spain joins the small group of countries that have decriminalized euthanasia and assisted suicide, framing them as a new individual right (“medical aid in dying”). Since its adoption, the Act has been subject to criticism, particularly for its lack of precision in defining the euthanasia context that would give rise to the granting of this entitlement.

- 5 Spanish criminal law does not punish the act of suicide itself, but it does criminalize conduct ancillary to suicide, such as inducement and assistance, as well as homicide at the victim’s request.
- 6 The constitutional interpretation of Article 15 of the Spanish Constitution has been inconsistent over time in the case law of the Constitutional Court. By way of representative examples, this can be seen in Judgments STC 120/1990 of 27 June (RTC 1990/443) and STC 121/1990 of 28 September (RTC 1987/361), concerning the forced feeding of members of the terrorist group GRAPO, and, on the other hand, in Judgment STC 154/2002 of 18 July (RTC 2002/154), which upheld the parents’ right to freedom of conscience in a case involving Jehovah’s Witnesses who initially opposed a blood transfusion for their child, who ultimately died. The debate centers on whether the individual, in the legitimate exercise of personal freedom, enjoys a right to dispose of his or her own life under certain circumstances. Indeed, the answer depends on the scope attributed to the protection of the right to life and to physical and moral integrity under Article 15 of the Constitution.
- 7 According to Savulescu, “to be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of the healthcare system. If we do not allow moral values or self-interest to corrupt the delivery of the just and legal delivery of health services, we should not let other values, such as religious values, corrupt them either”. He points out that, against accepting conscientious objection, “the service that patients receive depends on the values of the treating doctor. Not only does this imply that patients must shop among doctors to receive the service to which they are entitled, introducing inefficiency and wasting resources, it also means some patients, less informed of their entitlements, will fail to receive a service they should have received. This inequity is unjustifiable”. (Savulescu 2006, p. 295; Triviño Caballero 2014, p. 170).
- 8 However, the interpretative scope must remain within the limits of the study’s own design: the questionnaire does not measure conscientious objection in the legal sense (neither its formal declaration nor its explicit motivations), but rather attitudes and hypothetical decisions. Accordingly, the methodologically prudent approach is to frame the conclusion in terms of association and probability of conscience-based conflict; that is, greater religious practice correlates with more negative attitudes toward euthanasia (and, predictably, toward assisted suicide as a closely related practice), thereby increasing the likelihood that, once clinically available, certain professionals will seek exemption on grounds of conscience.
- 9 Secular or moral reasons are linked to the idea that requests for medical aid in dying run counter to professional principles, which many healthcare professionals frequently internalize as their own personal moral principles.
- 10 Although 54% of the Spanish population identifies with a religion (with only 8% of these individuals identifying with religious denominations other than Catholicism), only 17% of the population declares itself to be religiously practicing. Moreover, among Catholics, only 28% are practicing, whereas among the 8% affiliated with other religious traditions, 45% report being practicing believers.

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