1. For an opposing view on this case, see A. Brummett and N. Jones, "The Case for Baptizing a Dying, Unconscious Atheist," *Hastings Center Report* 55, no. 1 (2025): 5-6.
2. J. Moström and P. Granqvist, "There Are Plenty of Atheists in Foxholes—in Sweden," *Archive for the Psychology of Religion* 36, no. 2 (2014): 199-213.
3. S. Latcha et al., "'Please Keep Mom Alive One More Day'—Clashing Directives of a Dying Patient and Her Surrogate," *Journal of Pain and Symptom Management* 59, no. 5 (2020): 1147-52.
4. J. Thomas and G. Moore, "Medical-Legal Issues in the Agitated Patient: Cases and Caveats," *Western Journal of Emergency Medicine* 14, no. 5 (2013): 559-65.
5. D. Shaw et al., "Family Overrule of Registered Refusal to Donate Organs," *Journal of the Intensive Care Society* 21, no. 2 (2020): 179-82.

CASE STUDY

The Case for Baptizing a Dying, Unconscious Atheist

by ABRAM BRUMMETT and NELSON JONES

In another essay in this issue of the *Hastings Center Report*, Tate Shepherd and Michael Redinger discuss a clinical ethics case that involves a conflict between emotional benefits to the patient's mother from seeing her son baptized at the end of his life and a concern about inflicting dignitary harm to the patient by violating a preference related to a deeply held belief.[1] In considering the case, Shepherd and Redinger argue that the ethicist should oppose baptism on the basis that the patient has refused the sacrament throughout his life.

This recommendation might be expected to follow from the standard decisional hierarchy—known patient wishes, then substituted judgment, and then (failing the first options) the patient's best interests—and reasoning that, because we know the patient's preferences, we should follow them, especially when it comes to preferences related to core beliefs. However, as Jeffrey Berger, Evan DeRenzo, and Jack Schwartz have argued, sometimes surrogates can make ethically supportable decisions that depart from the standard hierarchy, especially when a patients' primary concern in a decision may be "nonmedical or non-patient-centric, such as concerns for minimizing emotional or other burdens on family members."[2] Berger and colleagues offer the following example in which a surrogate uses substituted judgment to trump known wishes: "I know that my wife wrote in her living will that under no circumstances would she want to be on a ventilator, but our son is returning from Iraq next week, and I believe that she would want to be kept alive so they can say goodbye."[3] In their example, the surrogate reasons that the patient's circumstances contain unique psychosocial features that were not considered when the patient signed her living will refusing ventilation.

Applying this reasoning to the case presented by Shepherd and Redinger, the key question for the ethicist to address with the mother (and any additional family) is whether the patient would have wanted baptism for family benefit in these circumstances. Here, the ethicist can collaborate with a hospital chaplain to aid the family in reflecting on some key considerations. One key consideration is the patient's reasons for past refusals of baptism. The patient may have been motivated to reject baptism primarily by a desire to avoid unwanted life changes that would be associated with conversion to a religious tradition, such as attending church on Sundays, praying before eating, or having to accept the tradition's values. However, accepting baptism in the current circumstances is very different in this respect because it does not involve accepting any life changes, given that the patient is imminently dying. Another key consideration is that, unlike when baptism was proposed to the patient in the past, the purpose of this baptism would be to provide the family some measure of emotional relief in the context of the patient's imminent and unexpected demise. While the moral dilemma here involves dignitary harm to the patient versus emotional benefit to the family, not all dying atheist patients would consider baptism to constitute a dignitary harm, and even if they did, they may reasonably hold that the degree of dignitary harm does not outweigh the significant emotional benefits that would be provided to their family in tragic circumstances.

However, it is also possible that the patient would have maintained an overriding objection to baptism, even in the face of emotional benefits to family. To determine whether

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Not all dying atheist patients would consider baptism to constitute a dignitary harm.

this patient would have maintained such an objection, the ethicist can direct the family to reflect on the nature of the patient's belief in atheism by asking questions such as, "Was he a member of any atheist organizations?," "How frequently did he talk about his atheism?," or, "Did he ever make strong statements about his beliefs?" After giving the family time to reflect on these key considerations, the ethicist can ask, "Given what you know about his beliefs, do you think it would be respectful of your son's beliefs to baptize him in these circumstances to bring you some comfort during this difficult time?"

If the surrogate remains unsure whether the patient would agree to baptism, it is best for the ethicist to recommend against baptism. Default positions in clinical ethics, such as following the standard decisional hierarchy, should guide decision-making unless there are compelling reasons to deviate from them.[4] They are default positions for good reasons, so epistemic uncertainty is insufficient to override them.

Our analysis for baptizing some dying, unconscious atheist patients cannot easily be generalized to dying, unconscious patients who are committed to religious traditions in which belief and ritual aim at securing important spiritual objectives, such as salvation. These patients might be concerned not only about a dignitary harm but also, and perhaps even more so, about significant spiritual harm, such as a threat to their salvation. This difference introduces an additional consideration for the substituted-judgment analysis of some patients that is not present for atheist patients who reject the very concept of spiritual harm.

1. T. Shepherd and M. Redinger, "'Please baptize my son': The Case against Baptizing a Dying, Unconscious Atheist," *Hastings Center Report* 55, no. 1 (2025): 3-5.
2. J. T. Berger, E. G. DeRenzo, and J. Schwartz, "Surrogate Decision Making: Reconciling Ethical Theory and Clinical Practice," *Annals of Internal Medicine* 149, no. 1 (2008): 48-53, at 49.
3. Ibid.
4. P. Crutchfield, T. S. Gibb, and M. J. Redinger, "Default Positions in Clinical Ethics," *Journal of Clinical Ethics* 34, no. 3 (2023): 258-69.

The Need for Bioethics Departments in HBCU Medical Schools

by DONALD E. CARTER III

The 1910 Flexner Report,[1] initially supported by the American Medical Association (AMA) and Carnegie Foundation, played a pivotal role in the history of medical education and training in the United States. Despite the fact that its creator, Abraham Flexner, held neither a medical nor science degree, he generated a report on medical education that led to curricular and financial reforms and the closure of 75 percent of the nation's medical and psychiatric facilities.[2] Five of the seven medical schools devoted primarily to the education of Black students were closed, reducing the production of Black doctors by an estimated 10,000 to 30,000 over the following century.[3] Today, although approximately 12 percent of the U.S. population

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