The Case of an Underage Jehovah’s Witness

It was a typical Friday night, and I was going to dinner with a girlfriend. We were waiting to cross the street downtown when we noticed a young girl and her boyfriend holding hands and running across the street towards us. I realized what was about to happen as I looked to my left to see a line of cars approaching. As if in slow motion, I heard the boy call “hurry up!” to the girl, and then a split second later, the crash occurred. We heard a distinctive crunching sound and saw the girl fly backwards through the air as the Explorer came to an abrupt halt. The image is seared in my mind. We ran to the girl assess how bad things were. Thankfully, another doctor was there and had his stethoscope with him. As a third and fourth year medical student, we weren’t sure we wanted to be the only ones taking care of this girl until the paramedics arrived. She regained consciousness quickly and started screaming. It was obvious that she had a right femur fracture. Then we saw blood streaming from the back of her head and pooling on the pavement. Tons of curious spectators were gathered around, watching us go through as much of a primary survey as we could. EMS arrived and quickly got her on a backboard to whisk her away to The Medical Center.

It just so happened that I was on surgery during this time, so she later became my patient on service. As I checked in on her the next day, I got more of the story. I had talked to her boyfriend on the scene, mostly just to calm him down and assure him that she would be alright. As it turns out, she is a Jehovah’s Witness. She is also only sixteen years old. They had lied to her parents and gone downtown on a date. Another student updated me on what happened when
she came in as a trauma code. She was conscious but had lost a good amount of blood. Luckily, her blood pressure was stable. Her hemoglobin and hematocrit were also high enough that they were able to adequately resuscitate her with fluids alone. There was a question, though, about the urgent surgery she needed to repair her fractured right femur. It was possible that she would lose a lot of blood during the surgery, so the issue of possibly needing a blood transfusion or using a “Cell Saver” came up. Apparently there was a heated argument between the patient and her mother. The young girl stated that she wanted a transfusion if it was needed, and this made the mom furious. She did not appear to share the same values as her mother regarding her religious beliefs. It is unclear what decision the mom and daughter came to, but they went ahead with the surgery in the hopes that she would not need any blood products. In the end, she ended up not requiring a transfusion during the operation to repair her femur. Thankfully, the courts and/or ethics committee did not have to be involved in this case. However, there were numerous ethical issues brought up. They include ideas such as competency, consent to treatment, mature minors, and advanced directives.

Jehovah’s Witnesses (hereafter referred to as JWs) are members of the Watchtower Bible and Tract Society (WTS) and are considered a fundamentalist Christian Sect. JWs seek and accept the benefits of medical care with one notable exception: the WTS believes that blood transfusions violate God’s will. JWs do not even accept autologous transfusion of their own predeposited blood, though intraoperative salvage (or cell saver) is accepted as long as extracorporeal circulation is uninterrupted via a tube. However, the WTS does allow the use of components such as albumin, immune globulins, and hemophiliac preparations. Since the blood ban in 1945, JW parents have fought for the right to refuse blood on behalf of their children based on religious freedom and their right to raise children as they see fit. Adolescent JWs have
also sought to refuse blood products regardless of the views of their parents. Despite this, courts worldwide have overwhelmingly established that parents cannot refuse blood on their children’s behalf.

Accepting a blood transfusion willingly and without regret is seen as a sin. The punishment for accepting blood products is loss of eternal life and excommunication from the church. The person concerned is no longer viewed as a Jehovah’s Witness because they no longer accept and follow a core tenet of the faith. However, the WTS does not require JWs to shun members who have received a transfusion under court order. By taking the apparent choice out of the patient’s hands, the law can remove a minor from an impossible social position and enhance patient freedom by doing so. Therefore, if a JW is transfused against their will, this is not regarded as a sin on the part of the individual. Children who are transfused against their parents’ wishes are thus not rejected or stigmatized in any way. In addition, a patient may want to accept blood but refuse because of fear of social and religious effects of such a choice. The upside is that if a JW changes their mind and repents of their action they can return to the Church.

The refusal of blood products by JWs raises many ethical and legal dilemmas that are not easily answered. Do an individual’s rights (namely bodily control, right to privacy, right to decide about life/death issues, right to religious freedom) outweigh society’s rights (namely the preservation of life, the prevention of suicide, the protection of minors, and maintenance of the ethical integrity of the medical profession)? JW patients who refuse life-saving blood transfusions may be misinformed, misguided and, to some degree, coerced. The WTS imposes a strict code of moral standards among its members, and it is unlikely that any JW is making a truly autonomous decision about blood transfusions. Knowing the basis for the blood doctrine
and how it is enforced, physicians face the question of whether we should ignore this information and respect the patient’s decision no matter how irrational and misguided we think they might be. It may be beneficial to at least pursue in-depth discussion to encourage a rational and truly autonomous decision.

The WTS has a long history of changing doctrines regarding medical issues. The WTS has in fact changed its views of transfusions over time, specifically the practice of distinguishing between different blood products. They also note that the WTS used to ban vaccinations and organ transplantations but has reversed these positions. Critics of the JW doctrines claim it is illogical to permit some blood products but not others when the Bible itself does not distinguish among blood components. With the precedent of other policy reversals and these piecemeal changes in the blood ban, it is possible this will eventually lead to acceptance of all blood products in medical emergencies. Other ethically questionable practices condoned by the WTS include: the completion of advance directives during group Bible study sessions while discouraging use of independent legal advice, the official church suggestion that it is ethically appropriate for hospital personnel to breach patient confidentiality and to report the unauthorized medical treatment of a JW to religious leaders, and the requirement that orthodox JWs disassociate themselves from and actively shun members who have accepted religiously unauthorized medical treatment. The practice of excommunication has been known to cause severe emotional distress to estranged JWs, occasionally even leading to their suicides.

When a Witness is a minor, the ethical issues become even more confusing. Courts recognize parental rights, but they cannot make decisions which may permanently harm their child or impair their development. If treatment refusal results in child suffering, the parents may be criminally liable. Usually, though, the courts are asked to exercise their power under the
The doctrine of *parens patriae*, which allows state interference to protect a child’s welfare. In the case of *Prince v Massachusetts*, the Supreme Court held that the government has the broad authority to regulate the treatment of children, and that parental authority can be restricted if doing so is in the interests of a child’s welfare. In the majority opinion, Justice Rutledge wrote, “Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.” Thus, when parental refusal is based on religious beliefs, the court can justify compulsory medical treatment based on the avoidance of physical harm. Further cases have reiterated this decision while also increasing the right of protection to unborn children and introducing the concept of child neglect. The points made by all of the cases regarding this matter emphasize that a child’s interests and those of the state outweigh parental rights to refuse medical treatment, that parental rights do not give parents life and death authority over their children, and that parents do not have an absolute right to refuse medical treatment for their children based on their religious beliefs.

Courts in other countries have also agreed with the judicial opinion of the U.S. in the matter of JW’s and transfusions, most citing the child’s welfare as paramount. Only a few cases in the UK have challenged parental treatment refusal, but permission for transfusion was granted in all three. The court stressed, however, that consideration would be given to parental beliefs particularly when the situation was not imminently life threatening. In Australia, the NSW Child Care and Protection Act requires that the decisions regarding treatment of minors must be in the child’s best interest, decisions about the urgency of treatment reside with the medical doctors caring for the child, and that *parens patriae* authority may override a parental decision.
The rights of adolescents to refuse medical treatment vary among different countries, and this judicial inconsistency creates some confusion among healthcare workers. In the U.S., the situation is state dependent. Usually, parental consent must be obtained in order to perform procedures on adolescents up to age eighteen (in most states) except in emergent situations. All states allow parental consent for treatment of a minor to be waived in the event of a medical emergency. The emergency exception is a well established legal doctrine to prevent harm to the health of a child that may result from the delay in securing consent. Beyond age, courts can declare a minor emancipated from their parents. Although not recognized by the Supreme Court, some states including Illinois and Pennsylvania have a “mature minor” doctrine which allows some minors to consent to treatment without parental consent. Other states recognize the “mature minor” doctrine but will not act on it. The standards for allowing a minor to be considered a “mature minor” and able to make medical decisions include marriage, pregnancy, being a parent, or on active duty with the armed forces. Under this doctrine, minors who are not emancipated from their parents and show the ability to comprehend the risks and benefits of treatment may provide consent to that treatment. In contrast to the policies in the U.S., mature minors in England may consent to, but not refuse, treatment. In Scotland, however, the Age of Legal Capacity Act implies that a competent child can accept or refuse treatment. Thus, the ability of mature minors to refuse treatment is not straightforward and varies according to location.

There are a few issues regarding minors and consent, including the child’s capacity to consent to treatment, parental authority and its limitations, whose view prevails if the parents and child disagree, and the extent of the court’s power over the adolescent. Before someone can legally consent to medical treatment, three conditions must be met: competence, accurate information, and lack of coercion. Cases involving adolescents in JW families can be confusing.
because they may focus solely on the first condition, yet competence alone is not a sufficient condition for valid consent. Even if conscious with adequate cognitive function and maturity to comprehend information, a patient may still be unable legally to give or refuse consent. If a patient does not understand and appreciate the risks and benefits of a proposed procedure or treatment, the patient is not in a position to accept or reject the plan. Coercion by actual or threatened shunning and excommunication also occurs, and these factors may affect adolescent decision-making. It would be very difficult to accept a treatment option if that particular choice will lead to the loss of important relationships. In addition, religious advice is often made to seem as accurate as medical advice, and this may provide a skewed or biased view of a treatment to a patient. One can hardly make an informed decision when using inaccurate information to do so.

There are several examples of cases in the UK involving adolescent JW’s where the courts concluded that although the minors showed some evidence of maturity, they lacked sufficient experience and understanding to refuse treatment that offered a high probability of success with low risk. Many early Canadian cases supported the notion of adolescent autonomy, but cases since the mid-1990’s support the English view that adolescents lack the maturity to refuse life saving treatment. The Ontario Court recognized that forcing a child to accept blood products against their religious belief was an infringement of their freedom of religion but that legislation protecting minors was reasonably justified in doing so. All these cases agree that the child’s opinion should be considered, but they reiterate the point that the court can override the decisions of both parents and their children.

Since the 1970s, JW’s have carried blood refusal cards distributed annually by the WTS. These cards specify that the owner will not accept blood products under any circumstances. The
card recognizes risks associated with blood transfusions to make sure that treating physicians are satisfied that JWs have enough information to make a decision to refuse it. In an emergency, the doctor must be satisfied that a card carrying JW has been provided with the information necessary to make an informed decision. This is unlikely, given the WTS provides information about the risks but not the benefits of blood. Physicians should, of course, provide the necessary information for an individual to make an informed choice when they are able to. In addition to the possible lack of information, there is also concern about whether an individual’s decision to carry a card is without external influence since disfellowshipping is the penalty for accepting blood. This is crucial when considering the principle of autonomy.

In an emergency, the situation is more complex. Unconscious JWs, with signed blood refusal cards, a form of advance directive, create medical, ethical, and legal dilemmas for healthcare professionals. Patients have the right to refuse medical treatment “even in circumstances where they are certain to die in the absence of treatment.” Emergency conditions do not allow physicians to verify blood card status or discuss the patient’s convictions. In this instance, treatment that is in the patient’s best interests may be given under the doctrine of necessity. This doctrine assumes that “under the circumstances, a reasonable person would consent, and thus the probabilities are that the patient would consent.” This idea is unlikely to apply to JWs, since most would object to treatment if conscious. However, in an emergency, if doubt exists about the validity of a blood refusal card, physicians should aim to preserve life and administer the necessary blood products.

JWs presenting to the Emergency Department continue to cause concern. Health care professionals caring for acute patients of JW families should actively look for evidence that the patient has accurate medical information and is acting without coercion. The physician should
verify with the patient alone and with their family, on an ongoing basis, that they understand the medical condition, the risks of blood transfusion, and the risks of foregoing blood transfusion when it is urgently recommended. We, as doctors, have an ethical responsibility towards our JW patients to be fully reassured of their autonomous decision making without coercion in regard to blood-based treatment. We also cannot ignore the possibility of contradictory medical information and the reality of sanctions for those who do not follow official JW rules.

On the other hand, the law regarding young children, adolescents, and adults (in the non-emergency situation) is clear: parents may not refuse blood on their children’s behalf if such a refusal is deemed unreasonable, adolescents cannot necessarily refuse blood, and competent adults can refuse unwanted treatment. With regard to religious based refusal of blood products by parents, courts are of the opinion that the child’s welfare is paramount and blood can be given. Consideration should be given to parental views and treatment moderated where possible, but if conflict occurs, the child’s interests always come first. Regarding adolescents, there is no worldwide consensus on the legal position of adolescents refusing blood transfusions. An adolescent’s ability to consent must be assessed by looking for all its constituent parts: competence, information, and freedom from coercion. Such assessment may reveal that patients in JW families, even though competent, can be in the unusual position of not having all three legal elements necessary for refusal.

There is not an easy solution to the problem of the state discharging its duty to protect children when the family’s religious community advises them (often based on misinformation) to refuse life-saving treatment, and the children know that serious social consequences are almost certain to follow if they disobey. With such an unusual social situation combined with the duty of the state to protect minors, distress by all parties seems inevitable. Physicians do have a legal
obligation to report a case if a minor is in need of intervention or protection when the child’s life is in danger. It is not a question of physicians forcing a transfusion but the state ensuring that minors receive essential medical treatment. In the case of the girl mentioned above, intervention was fortunately not needed. However, if it was, the court almost definitely would have intervened and given an order to transfuse her. This case proved to be a great example of how we should treat minor JWs, and it also provided a number of ethical issues to consider. Thankfully, there was a happy ending for this patient.
References


