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Ethical perspectives on Jehovah's Witnesses' refusal of blood

ABSTRACT

When Jehovah's Witnesses refuse blood, they regularly ask their physicians to explore and provide all other medically and scientifically based alternatives, even when these alternatives may not be as effective and may carry risk of failure that could lead to physical disabilities or death. An awareness of the values at stake and of other cases from personal experience and the literature can help physicians, patients, and their families to move toward ethically responsible decisions and actions.

KEY POINTS

Jehovah's Witnesses do *not* subscribe to "faith healing"; they do seek the assistance of modern, scientific medicine when they need it.

For Jehovah's Witnesses, the prohibition against blood transfusions applies to whole blood, packed red blood cells, white blood cells, plasma, and platelets, including autologous transfusions. However, this teaching does not absolutely forbid minor blood fractions such as immune globulins, albumin, erythropoietin, and clotting factors for hemophilia.

Except in emergency situations, a physician can decline to enter into a fiduciary relationship with a patient who places unacceptable conditions on a treatment plan, as long as the physician assures that the patient is not abandoned.

LIKE MOST PERSONS IN AMERICAN SOCIETY, Jehovah's Witnesses seek modern medical care when they are sick. But unlike most Americans, committed Jehovah's Witnesses consistently refuse blood transfusions and blood products. And this refusal sometimes puts physicians in a moral dilemma.

Two profound principles apply here: the right of patients to autonomy, and the obligation of physicians to promote health and preserve life. What happens when these principles collide? And what if the patient is a child, or unable to make an informed decision?

In reviewing this issue, I hope to provide some guidelines to physicians confronted with this dilemma. As in much of medicine, open, honest communication between all parties is key.

WHAT DO JEHOVAH'S WITNESSES BELIEVE ABOUT BLOOD?

Jehovah's Witnesses, a Christian denomination, believe that the Bible is the word of God, which expresses the divine will on important matters of life and must be obeyed.[1] They do *not* subscribe to "faith healing," and thus seek the assistance of modern, scientific medicine when they need it, except for blood transfusions. To Jehovah's Witnesses, three passages from the Bible that prohibit the eating of blood also constitute a divine prohibition against all blood use—human or animal, oral or intravenous (see "What the Bible says

What the Bible says about blood

"Every creature that is alive shall be yours to eat; I give them all to you as I did the green plants. Only flesh with its lifeblood still in it you shall not eat. For your own lifeblood too, I will demand an accounting: from every animal I will demand it, and from man in regard to his fellow man I will demand an accounting for human life." *Genesis 9:3–5*

"Anyone hunting, whether the Israelites or of the aliens residing among them, who catches an animal or a bird that may be eaten, shall pour out its blood and cover it with earth. Since the life of every living body is its blood, I have told the Israelites: You shall not partake of blood of any meat. Since the life of every living body is its blood, anyone who partakes of it shall be cut off." *Leviticus 17:13–14*

"It is my judgement, therefore, that we ought not cause God's Gentile converts any difficulties. We should merely write to them to abstain from anything contaminated by idols, from their illicit sexual union, from the meat of strangled animals, and from eating blood." *Acts of the Apostles 15:19–20*

SOURCE: *The New American Bible*

Jehovah's Witnesses are not antimedicine

about blood" on this page). According to these biblical texts and Jehovah's Witnesses' beliefs, once blood has been removed from the body, it should be disposed of and not returned to the body; violating this proscription can lead to loss of eternal life.

The prohibition applies to whole blood, packed red blood cells, white blood cells, plasma, and platelets.[2] The source of the blood is irrelevant; autologous blood transfusions are also prohibited. However, this teaching does not absolutely prohibit minor blood fractions such as immune globulins,[3] albumin, erythropoietin,[4] and clotting factors for hemophilia; individual Jehovah's Witnesses, with appropriate knowledge and counsel, are free to make their own decisions about these agents. Also left up to the individual are use of vaccines from nonblood sources; blood tests; transplantation of organs, tissue, or bone; dialysis and heart-lung machines that are not primed with blood; and reinfusion of one's own blood if the blood is not stored and if the equipment is arranged in a circuit that is constantly linked to the patient's circulatory system (eg, some intraoperative blood-salvaging techniques).[5]

Jehovah's Witnesses are not antimedicine. Rather, when routine medical practice would call for a transfusion of blood or blood products, they would like physicians to use alternatives.[6–8]

When treating Jehovah's Witnesses, physicians should remember that, as in all religious communities, not every believer accepts fully every official teaching. Patients who say they are Jehovah's Witnesses during a medical interview can have varying commitments to official religious teaching. Timely communication with each patient can ascertain levels and limits of adherence to official teaching regarding blood products.

ETHICAL NORMS THAT APPLY IN DECISION-MAKING

By and large, physicians subscribe to certain ethical norms or principles, several of which apply when patients refuse blood or blood products.

Patients have the right to autonomy

Physicians often differ from their patients in their interests, goals, expertise, values, lifestyle, beliefs, and "way of being," and when they do, tensions can develop. In determining what is in the best interests of patients, physicians tend to focus more narrowly on the physiological aspects of treatment, while patients may have more holistic concerns that encompass their emotional, psychological, social, spiritual, *and* physical well-being.

Consequently, what the physician believes is best for the patient may not be what the patient believes is best. Respect for the patient compels the physician to approach such differences with sensitivity and to avoid deceit, manipulation, arrogance, and hardline "authoritarianism."

Ethicists and physicians generally accept the concept of patient autonomy as a legitimate moral claim that in most situations ought to be respected. Therefore, patients who are mentally capable of making decisions should be viewed and treated as autonomous and self-determining persons, generally allowed to act in accord with freely chosen and informed goals.

Physicians have moral obligations

Physicians have a moral obligation to always act in their patients' best interests, and on their behalf when necessary. This obligation goes beyond the principle of "above all, do no harm": it is a positive responsibility to promote the patient's good,[9] especially physical life and health. The medical needs of patients call the physician's obligation into existence; the partnership between patients and physicians makes the obligation a moral consideration.

Usually the physician's recommendations and values are in harmony with the patient's goals and wishes, but sometimes conflicts arise. For example, to not give a blood transfusion in a life-threatening situation might violate a physician's personal, ethical, cultural, or religious convictions.

Sometimes, physicians can simply bow out of such a situation, declining to participate in professional activities that they think are morally wrong. Except in emergency situations, a physician can decline to enter into a fiduciary relationship with a patient who places unacceptable conditions on a treatment plan. As long as he or she assures that the patient is not abandoned, a physician could be ethically justified in transferring the patient's care. Local Jehovah's Witness hospital liaison committees usually keep lists of physicians (including surgeons) willing to treat patients without using blood transfusions.

Parents have rights—up to a point

In some situations in which blood transfusions are refused, the patient is a child or adolescent. These cases raise questions about the responsibilities of the parents or guardians, and the role that children and adolescents can and should have in decisions about their health care.

Refusal of blood should not be interpreted as a desire to die

With parenthood comes responsibilities: ensuring the survival of one's children's, protecting them from injury, comforting them when they need it, and respecting their developing autonomy.[10] Society recognizes that parents have the authority to rear their children in a manner they consider appropriate for achieving physical and personal development.[11]

But whose children are they? Some parents, believing that they alone have authority over and responsibility for their children, ask "Aren't my children mine?" Others, acknowledging that they share their rights and responsibilities with a wider family, community, and society, ask "Aren't my children ours?" Both perspectives are valid, but each, by itself, is inadequate. A pragmatic answer is that this authority and responsibility belong primarily to the parents, but society has an interest as well. The rights of the parents can be overridden in some circumstances, especially when there is evidence of neglect or abuse or if a serious illness, injury, or other medical condition endangers a child's life or threatens substantial harm or suffering.[12]

Children and adolescents also have some autonomy, although it is difficult to estimate to what degree they are free and capable of making decisions about their care. Not only do their intellectual and volitional capabilities need to be considered, but also the nature

and gravity of the choice.[13,14] Further, because they lack experience, reflect less on choices, and are more interested in the present, their values are more likely to change with time than those of older persons.[15] Nevertheless, physicians should respect the autonomy of their pediatric patients and include them in the decision-making process as much as possible. Weithorn and Campbell[16] found that children approximately 7 years old were usually capable of assenting (ie, agreeing or at least not objecting) to treatment, and adolescents approximately 14 years old could often give voluntary consent.

Resources must be allocated fairly

Undecided patients are vulnerable to manipulation and coercion

Justice requires that the burdens and benefits of health care be distributed and allocated fairly. Although dilemmas of justice can arise over questions of compensation and due process, more often they arise over how to distribute scarce and insufficient resources to meet the needs of everyone.

We Americans are comfortable with the principle of justice, but it is often complex and problematic to put into practice. For example, should patients who cannot pay for their own health care be given equal access to it? If two patients with similar medical acuity both need a bed in an intensive care unit but only one bed is available, which patient should get it? Is it an appropriate use of scarce medical resources when a patient's refusal of a standard treatment (eg, blood transfusions) leads to more extensive and extraordinary use of other resources (eg, ventilatory support, intensive care)? The complexity of these questions demonstrates the challenges of applying the ethical norm of justice to specific situations and issues.

Concerns about resource utilization and cost-containment are increasing in all areas of medicine, and patients whose refusals of standard life-saving treatment lead to greater resource utilization may soon be required to assume greater financial responsibility for their care. Managed care contracts and insurance and institutional policies may begin to forewarn patients of these responsibilities if they refuse standard treatments against medical advice.

HOW TO DECIDE: LEARNING FROM PAST CASES

To resolve ethical dilemmas like these satisfactorily, physicians not only need to be aware of the principles involved, but also need a process or model for decision-making. Most suggested decision-making models include the following[17] or similar steps:

- Collect data, including medical and psychosocial information about the situation, and identify persons involved in the decision.
- Identify the options, and the consequences of each.
- Evaluate the options by applying relevant ethical norms.
- Resolve and decide, by selecting an ethically justified option.
- Act to carry out the decision.
- Reflect after the fact, to learn and prepare for future dilemmas.

In identifying and evaluating options, persons experienced with clinical ethical dilemmas often rely not only on abstract ethical norms but also on concrete past cases that may be analogous to the new case. This process, similar to the process that experienced physicians use in diagnosing an illness in a new patient, is sometimes called *casuistry*.[18]

Basically, casuistry is a method of moral reasoning based on practical judgments about the similarities and differences between cases. In this method, we first establish the details and specific circumstances of the case at hand and then attempt to find previous cases analogous to the new case. A previous case can serve as a model (paradigm), shedding light on the ethical and unethical options for the new case, provided that a strong consensus already exists as to right or wrong conduct in the original case. In the process of identifying similarities and differences between cases, the moral maxims or rules of thumb functioning in the paradigm case are determined (eg, a patient's refusal of treatment should not be accepted without discussion with the patient). For the new case, a determination must be made as to which maxim or maxims should rule and to what extent.

Adult patients can refuse treatment

In general, a patient's refusal of life-saving treatment should be honored when the patient:[19]

- Is an adult;
- Has reached the decision freely and without coercion;
- Clearly and currently has decisional capacity; and
- Is well informed about the nature, purpose, benefits, risks, and alternatives of the proposed treatment.

The ethical consensus about honoring the refusal grows even stronger if:

- All persons involved are comfortable with the communication that has taken place.
- The patient clearly understands the consequences of the treatment refusal.
- The refusal is consistent with the person's longstanding values and beliefs.
- The refusal is not based on a private or idiosyncratic motive, but is consistent with the tenets of a socially recognized or accepted group.
- No "innocent third party" will suffer harm or burden if the patient's choice is respected.
- Refusing the treatment will not lead to greater use of medical resources.

Refusal of one treatment should not be interpreted as a desire to die or a refusal of other or alternative treatments within accepted standards of care. In fact, when they refuse blood, Jehovah's Witnesses regularly ask their physicians to explore and provide all other medically and scientifically based alternatives, even though these alternatives may not be as effective and can carry the risk of failure that could lead to physical disabilities[20] or death.

Same rules apply to adolescents as to adults

As noted above, many adolescents (approximately age 14 and older) are mature enough to give their informed consent to treatment, or to refuse it. For such patients, the same conditions and criteria apply as for adults, and if those conditions and criteria are met, an adolescent's refusal of life-saving treatment should be honored.

Surrogates can refuse treatment for once-competent-patients—if they have evidence

Patients who once had decisional capacity can temporarily or permanently lose this capacity (eg, due to coma, persistent vegetative state, severe dementia, or bilateral stroke). In life-threatening emergencies or when patients have irreversible conditions that make them unable to decide for themselves, other persons can make "substituted judgments" on their behalf.[21]

Evidence of the wishes, values, and beliefs of a now-incompetent patient can consist of previous conversations, letters, and documents such as living wills and the "no-blood cards" that many Jehovah's Witnesses carry and that are signed, witnessed, and updated regularly.

In general, there is strong ethical support for honoring treatment refusals made by surrogates on behalf of incompetent patients, especially when there is clear and convincing evidence about the patient's wishes.

Physicians are not violating patient freedo when they giv their medical advice

PROBLEMATIC SITUATIONS

In ethics as in medicine, every case is different, and the more that a case differs from a paradigm case, the more difficult the solution. The following cases illustrate situations in which ethical consensus is more difficult to achieve and hard choices are unavoidable.

When can children decide? When should they be overruled?

As noted earlier, some children (approximately ages 7 through 14) may be capable of assenting and disagreeing to treatment. Their capacity for freely choosing and understanding is limited but nonetheless present and real.

Sometimes the parents and child together refuse a recommended treatment such as a blood transfusion.[22] In this situation, we must consider society's obligations to protect the child, but also balance this consideration against the psychological and spiritual burdens and harms that imposing treatment on the patient and family would cause. Even if the physician decides not to honor the parent's and child's refusal, he or she should obey the ethical norm of respect for patients as per-

sons by discussing the situation with them.

Sometimes, however, the parents agree to the transfusion, but the child dissents. In this situation, we should probably give greater weight to the obligation of parents, physicians, and society to promote the child's best interests than to the child's growing but not sufficiently developed autonomy. In seeking the cooperation of the child in this situation, the caregivers should use persuasion, explanation, and trust rather than force.

In never-competent patients, society's interests deserve consideration

Patients included in a category of "never-competent" include infants and younger children (approximately age 7 and younger), and patients with severe mental retardation regardless of chronological age. For these patients it is impossible to discern their subjective wishes, real or hypothetical; therefore, patient autonomy plays no role. In such situations, physicians and parents must make decisions on the basis of weighing the burdens and benefits of treatment.

Often, ethically justified actions are the result of compromise

When parents disagree with a physician's recommendation for a standard treatment such as a blood transfusion,[23] society's interests and physicians' obligations to protect the welfare of never-competent patients must be given serious consideration. An additional and related justification for possibly overriding a parental refusal of treatment is the role of society and the state to ensure that children ultimately become adults, able then to decide, independently, what is in their own best interests.[24] As noted earlier, the conflict-resolution process used in such cases should include communication and consideration of scientifically based alternatives that are acceptable to the parents.

Will "innocent third parties" suffer?

Sometimes, a patient's free and informed decision may harm other "innocent third parties." For example, if a single parent refuses a life-saving treatment and dies, the child would be orphaned.[25] Both the child's welfare and any additional burdens to society in assuming care for the child are appropriate considerations in the ethical decision process, and could place limits on and even negate the patient's exercise of autonomy.

Some patients need help in deciding

An additional issue is how to approach patients who are unclear, undecided, or wavering about their decisions concerning treatment options. In situations that are somewhere on a continuum between emergencies and elective procedures, there is usually some time for discussion and an informed consent process, yet with some urgency for a decision if a life-threatening situation is developing. The goal in these situations is still to help the undecided patient, to the extent possible, to make a free and informed decision. Physicians are not violating patient freedom when they clearly communicate their medical recommendations based on risks and benefits, nor are ecclesiastic representatives when they provide spiritual or pastoral counseling. All persons assisting the patient should be mindful that the wavering or undecided patient is vulnerable to manipulation and coercion.

ETHICS IS NOT LAW

This discussion illustrates some differences between law and ethics. Laws and precedent-setting court cases do not regulate all human activity and behavior. Further, there is a tendency for legal cases to be adversarial, with winners and losers, guilty and not-guilty verdicts, and clear authoritative decisions. Ethics, on the other hand, depends on systematic analysis of situations, and tends to focus on the values and moral norms at stake. Resolution of ethical conflict is based less on external authority and more on the circumstances and values internal to the case. Often, ethically justified decisions and actions are the result of compromise. Ambiguity, ambivalence, and regret may remain even after a thorough ethical analysis because the circumstances of the case were too different from known paradigm cases, and because all the values at stake in the case could not be upheld.

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