

# Urgent Medical Decision Making Regarding a Jehovah's Witness Minor: A Case Report and Discussion

Paul R. Brezina, MD, MBA; John C. Moskop, PhD

## Abstract

**Background:** Physicians strive to respect the autonomy of patients. The emergent care of Jehovah's Witnesses, however, leaves health care providers struggling with ethical and legal questions. These are further compounded when the patient in question is a minor.

**Case:** A girl aged 15 years presented with anemia, a large ovarian mass, massive hemoperitoneum, and parents who were devout Jehovah's Witnesses who refused administration of blood products. Following discussion of the patient's condition and treatment options with the patient, her family, members of the treatment team, and consultants, the patient was transferred to a hospital that offered a blood conservation program for surgical patients. The patient received surgical management without the need for blood transfusion. Her surgeons, however, reserved the legal right to give blood if an emergent need arose despite the lack of parental consent.

**Conclusion:** Society grants considerable legal latitude in dealing with Jehovah's Witness minors, and physicians must be aware of the legal and ethical parameters surrounding the care of such patients.

The right of competent adults to make decisions regarding their medical care is well established in US law and ethics and widely recognized throughout the medical community.<sup>1</sup> Jehovah's Witnesses' refusal of blood products is a commonly referenced example of this right.<sup>2</sup> Whether minors also have a right to make such decisions regarding care, however, is much less clear.<sup>3</sup> Legal and ethical standards regarding the autonomy and rights of minors have evolved over time. Due to this evolution, confusion exists within the medical community regarding the appropriate response to a minor whose parents refuse medically necessary treatment.

We present a patient who is a female minor with anemia, an urgent surgical need, and parents who are devout Jehovah's Witnesses who refuse administration of blood products. The following article describes this case, reviews the beliefs of Jehovah's Witnesses regarding blood products, discusses legal standards for medical treatment of minors, and offers practical guidelines for physicians in these situations.

## Case Description

A girl aged 15 years presented to the emergency department of a tertiary care hospital with the chief complaint of 2 weeks of increased abdominal girth and constipation. These symptoms had previously been evaluated by primary care doctors who instructed the patient to come to the emergency department after failed outpatient treatments for constipation. On exam, the abdomen was tensely distended with no guarding or rebound, and the remainder of the physical exam was normal. There was mild tachycardia of approximately 105 beats per minute but otherwise normal vital signs. The rest of the review of systems was negative.

The patient stated she had no prior medical, obstetric, or surgical history, had never used any alcohol, tobacco, or drugs, had no significant family history, no history of sexual activity, and no known drug allergies. She noted normal monthly menses since age 11. Her last menstrual period began 1 week prior to presentation. The patient's family was present at all times in her care and stated they were devout Jehovah's Witnesses. The parents, upon meeting the medical team, expressed their intention to remain at the patient's bedside at all

**Paul R. Brezina, MD, MBA**, is a resident physician in the Department of Obstetrics/Gynecology and Internal Medicine at the Brody School of Medicine, East Carolina University. He can be reached at BREZINAP (at) ecu.edu or 600 Moye Blvd., Greenville, NC 27834.

**John C. Moskop, PhD**, is a professor of Medical Humanities at the Brody School of Medicine, East Carolina University, and director of the Bioethics Center of University Health Systems of Eastern Carolina.

times during her hospitalization. This was not challenged by the medical staff. The parents stated that under no circumstance would they accept a transfusion as a part of their daughter's treatment even if it meant the death of their daughter. When questioned directly, the patient also refused blood products even if this could save her life. The hospital ethics team was consulted and risk management was notified.

Laboratory results showed a negative urine pregnancy test and hematocrit of 32.5%. A computed tomography scan showed a right adnexal mass, likely ovarian in origin, with mixed solid and cystic components, measuring 10 x 10.6 cm and with massive ascites. There was no evidence of peritoneal seeding. The liver, spleen, adrenals, appendix, pancreas, and kidneys were normal. No adenopathy or osseous lesions were seen. Ultrasound-guided paracentesis was performed, removing 3 liters of fluid. Analysis showed a large amount of blood and an albumin level consistent with an exudative process.

The patient was given intravenous hydration, and a repeat complete blood count showed a drastic drop in her hematocrit to 20.9% with worsening tachycardia. Intravenous iron and *Procrit*<sup>®</sup> were begun, and interval monitoring of the patient's blood levels was changed to every 6 hours. An urgent consultation meeting with the patient and her family, the medical team, and the ethics team was conducted. Also present were several elders from her church. The parents stated their refusal to permit the use of blood products. In response to an option suggested by the ethics consultants, they requested transfer to a facility "more comfortable with bloodless surgery."

Following this meeting with the ethics consultants and family, the treatment team began aggressive efforts to accommodate the request for transfer. Hospital attorneys made preliminary contact with a local judge in case a court hearing was deemed necessary. Six hours later the hematocrit remained stable at 22%. Another tertiary care center in the state that offered a "blood conservation program" accepted the patient, and within 24 hours the patient was transferred in stable condition.

The patient was taken to surgery at that institution 2 days later with a hematocrit of 25%. The parents were told that blood would be given if needed, and the parents signed an "acknowledgement statement" detailing their understanding that emergency transfusion would not be withheld from a minor regardless of parental refusal. In surgery, a right salpingo-oophorectomy was performed as was removal of a 10 cm right ovarian mass and 5 liters of bloody ascites. Blood loss during the procedure was reported to be 25 cc. Pathology of the mass revealed a granulosa cell tumor, juvenile type. No blood was given and the patient was discharged in stable condition.

## The Religious Context: Jehovah's Witnesses

Jehovah's Witnesses are members of an international religious community who adopt a literal interpretation of the Bible and assert that their faith is a restoration of early Christianity.<sup>4</sup> Jehovah's Witnesses comprise a small proportion of the population in both North Carolina and the nation. In 2001 approximately 0.6% of the US population and less than 0.5% of North

Carolina residents identified themselves as Jehovah's Witnesses.<sup>5</sup> Jehovah's Witnesses cite the following biblical passages from the King James Bible to support their belief that accepting blood products is a serious sin:<sup>6,7</sup>

- Genesis 9:4 "Blood ye shall not eat."
- Leviticus 17:12-14 "No soul of you shall eat blood... whosoever eateth it shall be cut off."
- Acts 15:29 "That ye abstain...from blood."
- Acts 21:25 "Gentiles...[should] keep themselves from things offered to idols and from blood."

This sin is considered so grave by the faith that any direct partaking of blood results in the "loss of eternal life."<sup>3</sup> Therefore, it is common for Jehovah's Witnesses in critical need of blood transfusions to choose death over acceptance of blood products. The right of adults to make this decision is well accepted in the medical and bioethics literature and widely respected in medical practice.<sup>3</sup> The ability of minors, however, to comprehend the gravity of such a decision or to make an autonomous decision independent of the wishes of their parents is much less clear.

## The Legal Context: Treatment of Minors

The legal limits of Jehovah's Witness parents to dictate the activity of their children were first addressed in the 1944 US Supreme Court case *Prince v. Commonwealth of Massachusetts*.<sup>8</sup> This case involved a girl aged 9 years named Sarah Prince who was instructed by her Jehovah's Witness guardian to sell religious literature on public streets in Brockton, Massachusetts. This prompted discontent in the community, and the child and her guardian were convicted of violating a child labor law that read, "No boy under twelve and no girl under eighteen shall sell, expose, or offer for sale any newspapers, magazines, periodicals or any other articles of merchandise of any description."

The case was appealed to the US Supreme Court which upheld the conviction. The Court concluded that there exists an "interest of society to protect the welfare of children" and supported the "State's assertion of authority to that end." Furthermore, the Court established that "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."<sup>8</sup>

This decision established the right of the state to supersede parental authority, and it has shaped current legal opinion regarding the administration of emergency blood transfusions and other medical care to minors. Indeed, legal protection of minors from abuse and neglect is now well established in both federal and state law. The federal Child Abuse Prevention and Treatment Act defines child abuse or neglect as any act or failure to act by a parent or caretaker of a child, usually under the age of 18 years, "resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation."<sup>9</sup>

Although federal law provides a general framework for and funding support of child protection activities, each state establishes its own specific child abuse and neglect policies and enforcement programs. The case described above took place in North Carolina which has a clearly defined policy regarding the state's authority to supersede the wishes of parents or guardians. The North Carolina "Treatment of Minors Act" of 2005 includes the following passage:

It shall be lawful for any physician licensed to practice medicine in North Carolina to render treatment to any minor without first obtaining the consent and approval of either the father or mother of said child . . . where the parents refuse to consent to a procedure, and the necessity for immediate treatment is so apparent that the delay required to obtain a court order would endanger the life or seriously worsen the physical condition of the child. No treatment shall be administered to a child over the parent's objection as herein authorized unless the physician shall first obtain the opinion of another physician licensed to practice medicine in the state of North Carolina that such a procedure is necessary to prevent immediate harm to a child.<sup>10</sup>

This statute gives physicians the authority to provide emergency medical care to minors including blood transfusions without parental consent or a court order, provided that they obtain a second physician's opinion that there is an immediate need for treatment. The statute also provides an account of when treatment constitutes an emergency, namely, "when the delay required to obtain a court order would endanger the life or seriously worsen the physical condition of the child."

Hospitals have an ethical obligation to delineate expressly to the guardians of minors the parameters of the law and how medical care will be administered. The institution operating the "blood conservation program" in the above case routinely utilizes acknowledgement statements in circumstances involving the medical care of minors whose parents seek to refuse blood transfusions.<sup>11</sup> These statements serve as a tool ensuring and documenting that clear and complete disclosure of the hospital's intentions are conveyed to the patient's guardians. Similar statements may be viewed at <http://www.noblood.com>. Failure of the parents to sign such a document would not alter the care administered to the minor under North Carolina law in the event a life saving transfusion is required. From a legal and ethical standpoint, the statement serves to document formally that a clear dialogue was conducted between the hospital and the parents regarding the emergent administration of blood products.

It is important to note that North Carolina's minor treatment statute also provides legal protection to physicians who choose not to override parental refusal of treatment for a minor child. The minor treatment statute cited above goes on to state:

"Provided, however, that the refusal of a physician to use, perform or render treatment to a minor without the consent of the minor's parent, guardian, or person standing in the position of loco parentis, in accordance with this Article, shall not constitute grounds for a civil action or criminal proceedings against such physician."<sup>10</sup>

North Carolina law thus gives legal protection and discretion to physicians to make a considered decision, based on the moral arguments and the specific circumstances of the case at hand, either to honor or to override parents' refusal of treatment for their minor child. To make this decision, physicians must identify and weigh a constellation of values including family integrity, religious freedom, the wishes of the parents and of the minor patient, and the life and health of the minor patient.

It is also worth noting that North Carolina is one of a small minority of states that does not grant to parents an exemption from charges of child neglect if they withhold medical treatment from their child as a result of their religious beliefs.<sup>12</sup> At least 41 states provide such a religious exemption from child abuse and neglect laws, although many of these states permit courts to order necessary treatment for children even when parents are protected by religious exemption laws from conviction for criminal abuse or neglect.<sup>13</sup>

In addition to the emergency treatment exception noted above, North Carolina law allows treatment of minors without parental or guardian consent in several other particular circumstances. By statute, minors can consent to treatment for the following specific medical conditions: sexually transmitted and other reportable diseases; pregnancy (but not abortion); abuse of controlled substances or alcohol; and emotional disturbance.<sup>14</sup> Emancipated minors can consent to their own medical treatment.<sup>15</sup> In North Carolina, minors aged 16 and 17 years may petition the court for a judicial decree of emancipation. Minors who are married or members of the armed forces of the United States are also emancipated under North Carolina law. In nonemergency situations, the Department of Social Services may, after investigation, assume custody for a minor when it determines that the minor needs treatment that parents are unwilling to provide.<sup>16</sup> Finally, although some states permit older or "mature" minors to make at least some of their own medical treatment decisions, North Carolina law does not recognize this "mature minor rule."<sup>16</sup>

## The Case Revisited: Practical Guidelines

In the United States, adult patients with decision-making capacity have wide-ranging authority to accept or refuse medical treatment recommendations. Parents also have significant responsibility and authority to choose the medical care of their children, but that authority is circumscribed by certain legal and moral limits. Conflicts between the medical treatment choices of parents for their minor children and the treatment recommendations of physicians often resist easy resolution because they pit deeply held principles of professional ethics, such as respect for the wishes of parents and minor patients and the duty to protect the life and health of patients, against one another. The case described above offers a widely recognized example of this type of conflict. When such conflicts occur, physicians should be able to recognize their causes and pursue options for conflict resolution. In the concluding section of this article, we offer several practical guidelines for addressing these situations.

When a patient or the patient's representative refuses a recommended treatment, it is important to elicit and acknowledge the reasons for that refusal. In the case we describe here, both the parents and the adolescent patient clearly expressed their refusal of blood products and cited their religious beliefs as Jehovah's Witnesses as the reason for that refusal. In open and respectful discussion with members of the treatment team, the patient and her parents demonstrated that they had an adequate understanding of the patient's medical condition, the potential need for blood products to treat that condition, and the potential consequences of forgoing this treatment. The team could thus establish that the refusal of blood products was not based on a misunderstanding about the nature or seriousness of the patient's condition or about the rationale for this treatment.

In most situations, we suggest that health care professionals discuss treatment options with adolescent patients both with and apart from their parents or others to ensure that the patient is able to express wishes or concerns that he or she is unable or unwilling to express to family members. In the case discussed, the family chose to remain with the patient, presumably to prevent administration of unwanted treatment without their knowledge or consent. The patient appeared to understand the situation and clearly expressed a refusal of blood products. There was no indication that she disagreed in any way with her parent's views or wished to speak privately with her physicians, so the treatment team decided not to insist on a private discussion with the patient.

By acknowledging a family's religious beliefs and values as the reason for their refusal of treatment, members of the health care team can demonstrate that they have listened to and understood that reason and that they respect the importance of those beliefs and values. We hold that it is important to do this as a sign of respect for the patient and parents as moral agents. For similar reasons, it is important for the health care professionals to articulate the reasons for their treatment recommendation. In this way, the health care professionals make clear the values that underlie that recommendation and commend those values to the patient and family. By offering reasons for their recommendation, the health care professionals also make clear that they too are moral agents responsible for their actions.

When professionals, patients, and parents express their opinions, beliefs, and guiding values, they can begin to seek common ground. Recognizing the value of respecting family wishes and religious freedom, for example, physicians might pledge to the patient and family that they will not pursue blood transfusions or will not do so unless the patient's life is in imminent danger. Recognizing the value of life, the patient and parents might express a willingness to accept blood products if absolutely necessary to save the patient's life, although they did not do so in this situation. This search for common ground can

**Table 1.**  
**Practical Guidelines for Addressing Refusal of Treatment for Minor Patients**

- (1) Elicit the reasons for the refusal.
- (2) Clarify any misunderstandings about the patient's condition, prognosis, or treatment options.
- (3) Seek a private discussion with adolescent patients.
- (4) Acknowledge beliefs and values informing the refusal.
- (5) Articulate the reasons for the treatment recommendation.
- (6) Seek common ground.
- (7) Enlist assistance in identifying and evaluating options.
- (8) If conflict is intractable, make a considered moral judgment.

identify shared beliefs and values and can sometimes lead to a resolution of conflict.

We recommend that health care professionals seek assistance from others when they encounter conflicts with patients and families regarding treatment choices. In the case we describe, the treatment team sought advice from both the hospital's ethics consultation and risk management services. Risk managers offered advice on the legal options available to the team. Ethics consultants suggested an option unavailable in the hospital, namely, a surgery program better prepared to accommodate the family's wishes. As described above, the family expressed interest in this option and a transfer to a hospital with such a program was accomplished with a successful outcome for the patient.

When conflict about treatment for a minor patient is rooted in incompatible and deeply held values, it may prove intractable. In this case, the parents and the patient might have refused transfer, but also persisted in their refusal of blood products. The patient's condition might have deteriorated, and the need for a blood transfusion might have become more urgent or emergent. As described above, North Carolina law permits 2 physicians to administer emergency medical treatment over the patient's and parent's objections, but it also protects physicians from liability if they choose to honor the parent's refusal of treatment. Thus, law does not dictate the physician's action, and the physician's decision is ultimately a moral one. Physicians should exercise this important moral responsibility with careful reflection on the relevant moral principles and values and on the particular circumstances of the case at hand. **NCMJ**

## REFERENCES

- 1 Berg JW, Appelbaum PS, Lidz CW, Parker LS. *Informed Consent: Legal Theory and Clinical Practice*. 2nd ed. New York: Oxford University Press; 2001.
- 2 Dixon JL, Smalley MG. Jehovah's Witnesses: the surgical/ethical challenge. *JAMA*. 1981;246(21):2471-2472.
- 3 Sheldon M. Ethical issues in the forced transfusion of Jehovah's Witness children. *J Emerg Med*. 1996;14(2):251-257.
- 4 "Jehovah's Witnesses," *Wikipedia*. [http://en.wikipedia.org/wiki/Jehovah%27s\\_Witnesses](http://en.wikipedia.org/wiki/Jehovah%27s_Witnesses). Accessed June 12, 2007.
- 5 Kosmin BA, Mayer E, Keysar A. American religious identification survey 2001. The Graduate Center, City University of New York. [http://www.gc.cuny.edu/faculty/research\\_briefs/aris.pdf](http://www.gc.cuny.edu/faculty/research_briefs/aris.pdf). Accessed June 12, 2007.
- 6 Vercillo AP, Duprey SV. Jehovah's Witnesses and the transfusion of blood products. *NY State Med J*. 1988;88:493-494.
- 7 *How Can Blood Save Your Life?* Brooklyn, NY: Watch Tower Bible and Tract Society of New York; 1990.
- 8 *Prince v. Commonwealth of Massachusetts*, 321 US 158 (1944).
- 9 Child Abuse Prevention and Treatment Act (CAPTA) (2003 version), 42 U.S.C. 5101, *et seq*.
- 10 NC Gen. Stat. § 90-21.1.
- 11 Personal communication, Dr. Stephen Hill, director, Duke University blood conservation program, June 2007.
- 12 Janofsky M. Colorado's children's deaths rekindle debate on religion. *New York Times*. 2001 (February 21):A10.
- 13 Stanfield J. Faith healing and religious treatment exemptions to child-endangerment laws: Should parents be allowed to refuse necessary medical treatment for their children based on their religious beliefs? *Hamline J Pub Law Policy*. 2000(1);22:45-86.
- 14 NC Gen. Stat. § 90-21.5.
- 15 Crill J. Consent to medical treatment. In Feezor L, ed. *North Carolina Patient & Provider Rights Guide*. Cary, NC: North Carolina Hospital Association, 2003: 3.1-3.7.
- 16 Dellinger A, Davis AM. *Health Care for Pregnant Adolescents: A Legal Guide for Healthcare Providers*. Chapel Hill, NC: Institute of Government, University of North Carolina at Chapel Hill, 2001:1-2.

# Call for Papers

John W. Williams Jr, MD, MHS  
Scientific Editor, *North Carolina Medical Journal*

North Carolina is blessed with some of the finest medical research institutions in the world. The work of the medical scientists that labor in our research facilities becomes complete (in many ways) and public when it is published in peer-reviewed journals.

While medical researchers in North Carolina have many journals to which they can submit their manuscripts, we want them to consider keeping their work here at home. To be more specific, we invite the authors of our state to submit their papers to the *North Carolina Medical Journal*.

The Journal seeks papers that convey the results of original research. We are especially interested in publishing research papers that have relevance to the health of the people of our state.

An editor reviews all papers received and those of sufficient quality are peer-reviewed. As with any journal of merit, only papers of high quality will be published. Papers printed in the Journal are indexed in the National Library of Medicine's MEDLINE public database.

We generally accept two types of manuscripts for review: (1) original clinical or health services research contributions and (2) systematic reviews (both regardless of specific topic).

The *North Carolina Medical Journal* is published six times a year. It is distributed free of charge to the members of the North Carolina Medical Society, the North Carolina Hospital Association, the North Carolina College of Internal Medicine, the North Carolina Board of Pharmacy, the North Carolina Association of Pharmacists, the North Carolina Division of Public Health, the North Carolina Dental Society, the North Carolina Health Care Facilities Association, and The Carolinas Center for Medical Excellence. The Journal is available by subscription to others.

For guidance on manuscript preparation, authors should consult the "Author Guidelines," which can be found at [www.ncmedicaljournal.com](http://www.ncmedicaljournal.com).

North Carolina  
**MEDICAL JOURNAL**