

# Jehovah's WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RITE/RIGHT

*David Ziebart\**

## INTRODUCTION

Responsible and caring parents seek the best possible medical care for their children. In the case of parents who are Jehovah's Witnesses their religious beliefs prohibit medical intervention which uses blood. This prohibition specifically includes the refusal of blood transfusions even where such a refusal may result in the death of the person concerned. Jehovah's Witnesses as a result are often viewed with animosity or contempt, considered foolhardy and recklessly disregarding life, martyring themselves and their children. This article seeks to examine the religious origins of the blood prohibition and attempts to set the rationale for refusal in its religious context. It also explores the approach of the courts in the UK, the US and Canada to Jehovah's Witnesses children (supported by their parents) including those who have expressed a wish to refuse such treatment or else have been too young to do so. It concludes with presenting such refusal as a religious right which it is argued engages article 9 of the European Convention on Human Rights (ECHR).

## THE BIBLICAL DOCTRINE ON BLOOD

Jehovah's Witnesses' belief system is derived from the Bible. This is the means by which Jehovah<sup>1</sup> transmitted his standard to mankind and established the principles governing the way one should worship and live one's life.<sup>2</sup> Biblical principles are applied to all aspects of life, ranging from parenting<sup>3</sup> to

---

\* This article is based on an undergraduate dissertation submitted to the Faculty of Law, University of Reading LLB programme 2005. David Ziebart LLB gave permission to the Denning Law Journal's Editor to adapt the dissertation for publication. David Ziebart is a consultant at Michael Page International and a practising Jehovah's Witness.

<sup>1</sup> The personal name of God in the Bible, translated from Hebrew, meaning 'He Causes to Become.'

<sup>2</sup> 'All Scripture Is Inspired of God and Beneficial,' (Watchtower Bible and Tract Society, Inc 1990) p 7.

<sup>3</sup> Eg 'How to be a Successful Parent,' *Watchtower 1st May 1988*, (Watchtower Bible and Tract Society, Inc 1988) p 3-6.

## JEHOVAH’S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

moral behaviour<sup>4</sup> and to political neutrality. Throughout the Bible, life is viewed as a gift from Jehovah and many Christians today recognise Jehovah as the ultimate Source of life.<sup>5</sup> In the Bible, blood is often used as a symbol of the soul or life of a human or animal, and this is seen as belonging to God. The first Biblical injunction prohibiting the eating of blood was given to Noah and his sons: “Every moving animal that is alive may serve as food for you. As in the case of green vegetation, I do give it all to you. Only flesh with its soul - its blood - you must not eat.”<sup>6</sup>

This was repeated much later in Mosaic Law, where, to prevent the consumption of blood, it was not to be stored but instead “poured out” on the ground like water and covered with dust effectively giving it back to Jehovah, not using it for one’s own purpose.<sup>7</sup> Mosaic Law called for a number of offerings to be made to God, such as grain, oil and wine.<sup>8</sup> It permitted the Israelites to use blood ONLY in the offering of animal sacrifices to Jehovah so that they could be granted forgiveness for their inherited sinful state. The redemptive power of blood is found in Leviticus 17: 11,12 (emphasis added):

“The soul of the flesh is in the blood, and I myself have put it upon the altar for you to make atonement for your souls, because *it is the blood that makes atonement by the soul in it.* That is why I have said to the sons of Israel: “No soul of you must eat blood.”

Christians also understood blood as having a unique role associated with providing relief from sin and death inherited from Adam. The Apostle Paul writing in the 1<sup>st</sup> Century CE, in Hebrews 9:22 commented, “nearly all things are cleansed with blood according to the Law, and unless blood is poured out no forgiveness takes place.” Under Mosaic Law, animal’s blood was poured at the base of the altar to illustrate that atonement depended on blood.<sup>9</sup> However in Hebrews 10:3,4 it is written, “By these sacrifices there is a reminding of sins from year to year, for it is not possible for the blood of bulls and goats to take sins away.” Hence the animal sacrifices only prefigured the sacrificial death of Jesus Christ, who would give his life or pour out his blood to redeem mankind. Jehovah’s Witnesses believe that the Bible is categorical

---

<sup>4</sup> Eg ‘Learn and Teach Christian Morality,’ *Watchtower* 15<sup>th</sup> June 2002, (Watchtower Bible and Tract Society, Inc 2002) p 17-22.

<sup>5</sup> Acts 17:28 ; Revelation 4:11.

<sup>6</sup> Genesis 9:3,4; Ibid.

<sup>7</sup> Deuteronomy 12:16.

<sup>8</sup> Leviticus 2:1-4; 23:13; Numbers 15:1-5.

<sup>9</sup> Leviticus 9:9; Hebrews 9:22; 1 Corinthians 1:18; See also *Insight on the Scriptures Volume 2* (Watchtower Bible and Tract Society, Inc 1988) p 345.

about forgiveness resting on the presence of Christ's blood. "This means *my blood* of the covenant, which is to be poured out on behalf of many for forgiveness of sins."<sup>10</sup> Similarly, Paul's letter to the congregation in Ephesus provides further evidence on this point:

"By means of him we have the release by ransom *through the blood of that one*, yes, the forgiveness of our trespasses, according to the riches of his undeserved kindness."<sup>11</sup>

The only way for Christians to be forgiven for their sins and gain benefits from the ransom is "*through the blood he (Jesus) shed*."<sup>12</sup> Revelation speaks of those who "*wash their robes in the blood of the Lamb (Jesus)*,"<sup>13</sup> thought to symbolize followers of Jesus cleansing their consciences before God.

Hence mankind was not allowed to use blood in any unauthorised way. It had legal significance before Jehovah as it enabled permanent forgiveness and eternal salvation. Such sanctity was to be respected.

Whether the restrictions in the Mosaic Law were to be binding on 1st century Christians was debated by a Council in Jerusalem in 49 C.E. After careful consideration, James, the Chairman of the Council, stated that Christians were only bound to observe certain divine requirements, as outlined in Acts 15:28,29:

"The holy spirit and we ourselves have favoured adding no burden to you, except these necessary things, to keep abstaining from things sacrificed to idols *and from blood and from things strangled* and from fornication. If you carefully keep yourselves from these things you will prosper."

Although not all the specific provisions within the Mosaic Law were to be binding on Christians after the death of Christ, the need to "abstain from blood" and recognise its elevated position was clearly ratified within this text. The early Christian congregations took the ruling of the Jerusalem Council as definitive, with the "decision that they should keep themselves from what is sacrificed to idols as well as from blood and what is strangled and from fornication."<sup>14</sup>

---

<sup>10</sup> Matthew 26:28.

<sup>11</sup> Ephesians 1:7.

<sup>12</sup> Colossians 1:20.

<sup>13</sup> Revelation 7:9,14.

<sup>14</sup> Acts 21:25. See also The historical record of theologian Priestley J *The Theological and Miscellaneous Works*, (Volume IX, 1818) p 366also recognizes the importance of the Biblical injunction on the Christians in the 1<sup>st</sup> Century CE: "The prohibition to eat

## BLOOD PROHIBITION IN MEDICAL TREATMENT

The medical use of blood is also incorporated within the scope of this prohibition. The scriptural passages in Acts refer separately to “blood” and “what is strangled” in order to clarify that blood is to be avoided both as part of one’s diet, as in the case of un-bled meat, and also as “blood” itself.<sup>15</sup> This latter context includes the use of blood for therapeutic purposes, a popular therapy for certain ailments at the time. The second-century physician Aretaeus of Cappadocia, reported on the drinking of human blood as a treatment for epilepsy.<sup>16</sup> By the 16<sup>th</sup> century experiments involving transfused blood began. Thomas Bartholin, the professor of anatomy at the University of Copenhagen, noted with concern the dilemma medical treatment posed for religious observance.

“Those who drag in the use of human blood for internal remedies of diseases appear to misuse it and to sin gravely. Cannibals are condemned. Why do we not abhor those who stain their gullet with human blood? Similar is the receiving of human blood from a cut vein, either through the mouth or by instruments of transfusion. The authors of this operation are held in terror by the divine law, by which the eating of blood is prohibited.”<sup>17</sup>

Jehovah’s Witnesses will not accept transfusions of whole blood, or any of the primary components namely red and white blood cells, plasma and platelets. There is no biblical command that forbids the use of other human tissue or bone. None of the scriptures state that such body parts have special significance in God’s eyes. It is therefore left to the conscience of an

---

blood, given to Noah, seems to be obligatory on all his posterity...If we interpret [the] prohibition of the apostles by the practice of the primitive Christians, who can hardly be supposed not to have rightly understood the nature and extent of it, we cannot but conclude, that it was intended to be absolute and perpetual; for blood was not eaten by any Christians for many centuries.’ See also Benson J, *The Holy Bible, Containing the Old and New Testaments*, (New York, Volume I, 1839) p 43, see also Newton I, *The Chronology of Ancient Kingdoms Amended*, (Dublin, 1728) p 184.

<sup>15</sup> Stevenson P *A Manual for Blood Conservation*, (tfm Publishing Ltd, 2005) p 191.

<sup>16</sup> Adams F *The Extant Works of Arateaus, the Cappodocian*, (The Sydenham Society, London, 1855) p 471. See also Tertullian (c 160-230 CE), *Apology* (Loeb Classical Library, Cambridge and London, 1977) Chapter 30, p 409; Pliny, *Natural History*, By Pliny XXVIII.ii.4, (Loeb Classical Library, Vol VIII, Harvard University Press, Cambridge, MA) p 5.

<sup>17</sup> Bartholin T ‘*A Medical Disquisition Concerning the Prohibition of Blood*,’ (Frankfurt, 1673) p 11.

individual as to whether they view organ transplants as an acceptable form of treatment. With regard to the use of secondary blood components such as albumin and haemophiliac preparation, it is again for the individual concerned to decide whether they fell these fall within the scope of the scriptural prohibitions.<sup>18</sup>

## **JEHOVAH’S WITNESSES - MEDICAL TREATMENT AND SELF DETERMINATION**

How does the law regard Jehovah’s Witnesses who wish to be treated without the use of blood products? The starting point requires consideration of how far the principle of self-determination is granted legal recognition in relation to medical care, and how that principle is affected by the age of a patient.

### *Self-Determination – An Established Legal Principle*

The concept of self-determination was summarized by Lord Donaldson as “the patient’s interest...to live his own life how he wishes, even if it will damage his health or lead to a premature death.”<sup>19</sup> The general legal rule that is a well established cornerstone of medical law within the UK is that in order for a doctor to proceed, the consent of the patient is required:

“...every human being of adult years and sound mind has a right to determine what should be done with his own body; and the surgeon who performs an operation without consent commits an assault for which he is liable in damages.”<sup>20</sup>

Justice Cardoza’s legal rule is clear and unambiguous, and has received recognition not only in common law and legislation but also within numerous ethical codes<sup>21</sup> and international agreements.<sup>22</sup> The penalties imposed on

---

<sup>18</sup> *Family Care and Medical Management of Jehovah’s Witnesses*, (Watchtower Bible and Tract Society, Inc 2000) Beliefs p 4.

<sup>19</sup> *Re T (Adult: Refusal of Medical Treatment)* (1992) 9 BMLR 46 at 59.

<sup>20</sup> *Schloendorff v Society of New York Hospital* (1914) 211 NY 125 at 126 *per Cardoza* J Approved, for example, in *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545; *Airedale NHS Trust v Bland* [1993] 1 All ER 821; Hughes J in *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129; Butler-Sloss P in *Ms B and an NHS Hospital Trust* [2002] EWHC 429 (Fam).

<sup>21</sup> Eg *Information and Consent for Anaesthesia*, The Association of Anaesthetists of Great Britain and Ireland, July 1999; *Seeking Patients’ Consent: The Ethical Considerations*, General Medical Council, August 1999.

## JEHOVAH’S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

physicians who disregard such a principle can be criminal as well as civil. In 1992, the House of Lords said:

“Any treatment given by a doctor to a patient which is invasive (ie involves any interference with the physical integrity of the patient) is unlawful unless done with the consent of the patient: it constitutes the crime of battery and the tort of trespass to the person.”<sup>23</sup>

The potential charge of battery is designed to act as a deterrent to make doctors think twice about treating patients in a way that they personally view as correct but that has little regard for the autonomy of the patient. Although unlikely to be liable for the crime of battery if they have acted in good faith, the fact that there can be civil repercussions for physicians either in the tort of battery or negligence illustrates that the judiciary will not simply ignore a patient’s autonomy by deferring to the doctor’s assessment of what is medically appropriate. If the situation is an emergency and the patient is unable to communicate their medical wishes, the common law grants a doctor the right to proceed without patient consent under the doctrine of necessity.<sup>24</sup> Such permission would apply to unconscious/comatose adults in an emergency situation where their personal wishes cannot be ascertained.<sup>25</sup> However, when the wishes of the patient are clear, the right of self-determination is unaffected if a patient decides to reject a form of medical intervention that is regarded as the only chance for the life of the patient. The actions of a doctor who proceeds without patient approval will be unlawful.

The extent to which the UK courts will protect an adult’s right to choose or refuse is evident by the force of the language in the judgements in *Airedale NHS Trust v Bland*:

“A (competent) person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be

---

<sup>22</sup> Eg The Universal Declaration of Human Rights, 1948; The European Convention for the Protection of Human Rights and Fundamental Freedoms, 1950.

<sup>23</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821 at 882 *per* Lord Browne-Wilkinson.

<sup>24</sup> *Re F (A Mental Patient: Sterilisation)* [1990] 2 AC 1, *per* Lord Goff at 73.

<sup>25</sup> Under such circumstance the Advanced Medical Directive. Provides a means of anticipating a patients wishes see. *HE v A Hospital NHS Trust* [2003] EWHC 1017; *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129.

that he will die.”<sup>26</sup>...”The principle of sanctity of human life must yield to the principle of self-determination.”<sup>27</sup>

Doctors can face civil liability in negligence or criminal culpability in manslaughter<sup>28</sup> or even murder<sup>29</sup> where inappropriate treatment, or no treatment at all, is administered. However, even in this critical context, the individual’s right to self-determination where competent should be the prevailing interest.

When applying these legal principles to the medical care of an adult Jehovah’s Witness, the case law establishes that the principle of self-determination allows a competent individual to refuse a blood transfusion on religious grounds. The key issue is whether the patient has the necessary capacity, or competence to decide, whether to consent to or refuse a particular form of treatment.<sup>30</sup> *Re T*<sup>31</sup> established that an adult will be presumed to have such decision-making capacity, but such a presumption can be rebutted, at which point such an individual is classed as incompetent.<sup>32</sup> Capacity within the UK legal system is not determined on the basis of what society in general views as a reasonable or rational decision, but instead on the three-stage test of competence identified by Thorpe J in *Re C*.<sup>33</sup> The adult patient must be able to:

1. comprehend and retain the necessary information
2. believe it; and
3. weigh the information, balancing the risks and needs, so as to come to a choice.

Lord Donaldson MR made it abundantly clear in *Re T* that an adult who refused a potentially lifesaving blood transfusion on religious grounds would not be regarded as incompetent simply because the majority of society would view such a stance as wholly irrational. The adult patient still had the right to decide: “[a patient’s ] right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making a choice are rational, irrational, unknown or even non-existent.”<sup>34</sup> The Court

---

<sup>26</sup> *Airedale Trust* at 860 per Lord Keith.

<sup>27</sup> *Airedale Trust* at 866 per Lord Goff of Chieveley.

<sup>28</sup> *R v Adamako* [1995] 1 AC 171.

<sup>29</sup> *R v Adams (Bodkin)* [1957] Crim LR 365; *R v Cox* (1992) 12 BMLR 38.

<sup>30</sup> This discussion will use the terms ‘capacity, and ‘competence’ interchangeably.

<sup>31</sup> *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649.

<sup>32</sup> *Ibid*, per Lord Donaldson at 796D.

<sup>33</sup> *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 FLR 31 at 33D. Reaffirmed, for example, in *St George’s Healthcare NHS Trust v S* [1998] 3 All ER 673.

<sup>34</sup> Concurring with *Sidaway v Bethlem Royal Hospital* [1985] AC 871, per Lord Templeman at 904.

## JEHOVAH'S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

of Appeal in *Re MB*<sup>35</sup> endorsed the *Re C* test and recognised that in principle a patient's veto of medical treatment on religious grounds could be valid even if the consequences could be death for, in this instance, the pregnant mother or her unborn child. The present state of the law did not support the conclusion that an unborn child should be granted any legal interests, as had been suggested in previous cases.<sup>36</sup> The court in *Re MB* also concurred with the earlier remarks of Lord Donaldson MR in *Re T*, that the competence of a patient must be "commensurate with the gravity of the decision... The more serious the decision, the greater the capacity required."<sup>37</sup> Such a statement is not thought to promote the view that a greater level of reasoning ability is required for a decision with more serious consequences, but rather, that the patient should be able to understand more detail about the procedure involved before making such a decision. As such, judicial scrutiny of a patient's decision-making capacity and reasoning will be at its highest in a life-threatening situation.<sup>38</sup> However, once capacity is established on the basis of *Re C*, the State has no power to interfere or obstruct competent adult refusal.

The recent approach of the judiciary has been to defer to the wishes of competent adults, even when the personal view of the judge in question may well have been that refusal of treatment based on religious beliefs was an irrational stance.<sup>39</sup> Although there may be an understandable reluctance on the part of a doctor to discontinue treatment when they perceive that they can intervene to remedy a medical condition, it was recently emphasised that such a desire to preserve life should not take precedence over an adult's competent request for cessation of treatment.<sup>40</sup>

### *Competent Minors and medical treatment*

The UK law has demonstrated an unwillingness to apply these clearly embedded legal principles to minors in the regulation of their own healthcare even where they are ostensibly competent. Historically, the common law was unclear as to whether a minor could make medical decisions for themselves, leaving some to suggest that a child could never validly consent to

---

<sup>35</sup> *Re MB (Adult: Medical Treatment)* (1997) 38 BMLR 175 at pp 48 *per* Butler-Sloss LJ.

<sup>36</sup> *Eg Re S (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 671; Thorpe J *obiter* in *Secretary of State for the Home Department v Robb* [1995] 1 All ER 677.

<sup>37</sup> *Re T per* Lord Donaldson at 796F.

<sup>38</sup> Kennedy I and Grubb A, *Medical Law*, (Butterworths 3<sup>rd</sup> Edition 2000) p 627.

<sup>39</sup> See *Re T* approving the Canadian case of *Malette v Shulman* (1990) 72 OR (2d) (Ontario CA).

<sup>40</sup> *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All E.R. 449.

treatment.<sup>41</sup> However, the right of competent minors to consent under certain conditions is codified within government legislation. For example, a 16 or 17-year-old can consent to medical treatment under the provisions within Section 8 of the Family Law Reform Act 1969. Nolan LJ, commenting on the effect of this statute in *Re W*,<sup>42</sup> made it clear that 16 and 17-year-olds have “the same capacity as an adult to surgical, medical or dental treatment.”<sup>43</sup> This is rebuttable, however, if the child suffers from a mental disability which will affect their understanding. In general though, the minor who is 16 or older is placed in the same legal position as an adult in this context.

Lord Scarman in *Gillick v West Norfolk and Wisbech Area Health Authority*<sup>44</sup> established that a minor who is under 16 and who demonstrates a “sufficient understanding and intelligence,” can have the legal right to make their own medical decisions.<sup>45</sup> The court would have to be satisfied that the minor understood the nature, purpose and likely consequences of undergoing or not undergoing the procedure, although such issues would be a question of fact, and would often depend on the maturity and developmental capacity of the young person.<sup>46</sup> Once a minor has demonstrated the necessary level of capacity required of them, any consent to medical treatment will be legally effective despite any parental objections to such medical intervention. In the context of minors whose parents are Jehovah’s Witnesses but who themselves do not believe or adhere to such religious views, the law allows “*Gillick*” competent minors to consent to a blood transfusion even if their parents do not consider such treatment to be correct or proper. The doctor would be able to proceed without the risk of litigation from any disapproving parents or relatives.<sup>47</sup>

When a minor wishes to refuse medical treatment, all minors including 16 and 17-year-olds must fulfil the test of legal competence expected of children under 16; namely, they must have or achieve “*Gillick*” competence. However, many of the cases dealing with the issue of “*Gillick*” competence within this category have required a very high level of understanding and appreciation of the consequences of the decision made when life is at risk.

---

<sup>41</sup> Eg See the discussion by Staughton LJ in *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592 at 604.

<sup>42</sup> *Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1992] 3 WLR 758.

<sup>43</sup> *Ibid* at 776.

<sup>44</sup> *Gillick v West Norfolk and Wisbech AHA* [1985] 3 All ER 402.

<sup>45</sup> *Ibid* at 423.

<sup>46</sup> *Ibid* at 411 *per* Lord Fraser.

<sup>47</sup> *Ibid* at 423.

## JEHOVAH'S WITNESSES MINORS – SELF DETERMINATION

This has been particularly evident when the courts have had to confront cases involving young people who are conscientious Jehovah's Witnesses. In *Re E*,<sup>48</sup> which concerned a boy of 15  $\frac{3}{4}$  who suffered from leukaemia, the medical treatment advised by the hospital authority involved administering blood products offering a predicted full remission rate of 80-90 per cent. E, a Jehovah's Witness, refused such treatment. In these circumstances, Ward J addressed what he felt to be the necessary level of understanding in order for "Gillick" competence to be established. He was impressed by the obvious intelligence of E and recognised that E was of sufficient intelligence to make decisions about his own well-being, nonetheless, the judge still found that he could not be classed as a "Gillick" competent minor and as such his veto of treatment could not be legally binding.<sup>49</sup> Ward J considered E possessed:

"no realisation [by E] of the full implications which lie before him as to the process of dying. He may have some concept of the fact that he will die, but as to the manner of his death and to the extent of his and his family's suffering I find he has not the ability to turn his mind to it nor the will to do so."<sup>50</sup>

Ward J suggested that in later years, E could be likely to "suffer some diminution in his convictions."<sup>51</sup> Ward J was to be proved wrong. E maintained his religious convictions throughout his life and on reaching the age of majority, refused all blood-based treatment and subsequently died.<sup>52</sup>

In *Re S*,<sup>53</sup> the minor in question was 15½-years-old and had a potentially life-threatening form of thalassaemia that had been treated from birth using blood products, something that the minor wished to stop. Johnson J was full of praise for S, but he concluded that:

"...whilst as she gave evidence I was so very strongly impressed by her integrity and her commitment, I believe they were the integrity and commitment of a child and not of

---

<sup>48</sup> *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.

<sup>49</sup> *Ibid* at 224.

<sup>50</sup> *Ibid* at 224.

<sup>51</sup> *Ibid* at 226.

<sup>52</sup> Revealed by Johnson J in *Re S (A Minor) (Consent to Medical Treatment)* [1994] 2 FLR 1065 at 1075.

<sup>53</sup> *Ibid*.

somebody who was competent to make a decision that she tells me she has made.”<sup>54</sup>

The minor was held to not be “Gillick” competent on the basis of her emotional immaturity and the fact that she was “very much ...a child.” Johnson J placed reliance on Ward J’s judgement in *Re E*, concurring with his views that a sufficient level of understanding about death is necessary, concluding that:

“an understanding that she will die is not enough. For her decision to carry weight she should have a greater understanding of the manner of the death and pain and the distress.”<sup>55</sup>

In *Re L*<sup>56</sup> a 14-year-old refused a blood transfusion. Bloodless surgery was not viewed as possible and the minor was likely to undergo a “horrible” death without the necessary surgery being performed. The refusal of such medical treatment manifested itself both in the anticipatory form of an ‘Advanced Medical Directive’ prohibiting the use of blood for medical treatment in all circumstances, signed by the minor, as well as a clear refusal of consent given to the surgeon by the minor after the accident. Throughout the judgement, Sir Stephen Brown, P, acknowledged that such religious beliefs were strongly and sincerely held and also accepted that L was “mature for her age.” However, L was held not to have the necessary competence under the “Gillick” test. The basis for such a conclusion was the fact that L’s view “did not in fact lend itself in her mind to a discussion.”<sup>57</sup> Sir Stephen Brown commented that she had not been told or made aware of all the grave consequences relating to the manner of her death that would occur. As such, her lack of understanding of the way that she would die effectively vitiated her ability to be competently able to give such a refusal.<sup>58</sup>

The reasoning used by the judges in these cases to rebut a finding of “Gillick” competence has been criticized. In *Re E*, Ward J concluded that the minor was unable to give sufficient thought to the concept and process of dying, although such an exceptionally comprehensive understanding of the dying process and death is unlikely to be found in a sick patient who has achieved majority status. Similarly, the level of understanding in both *Re S* and *Re L* would not be legally required by an adult looking to exercise their

---

<sup>54</sup> Ibid.

<sup>55</sup> Ibid at 1073.

<sup>56</sup> *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810.

<sup>57</sup> Ibid at 812A.

<sup>58</sup> Ibid at 812G.

## JEHOVAH'S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

autonomy in this situation. Such an individual would merely have to satisfy the three-stage test in *Re C*, something it can be strongly argued that all three conscientious minors would have done. An understanding of the nature of the pain that may follow refusal, or the manner of death, or the reaction of family members would not be required. This is highly significant in the context of minors that are Jehovah's Witnesses as the practical effect of such a stance is that it will be almost impossible to hold that such minors are "*Gillick*" competent. One commentator noted that "case law establishes far less stringent requirements when assessing an adult patient's competence to refuse treatment [than a child]. These requirements are difficult to justify on logical grounds to the teenagers themselves."<sup>59</sup>

In *Re S*, Johnson J also used in his reasoning the fact that S was hopeful of some kind of miracle as a reason to conclude that she lacked the necessary level of legal competence. It was suggested that the hope that S had that she might not actually die limited her understanding of the severity of the situation. However, there was never any suggestion that S had a mental condition causing a misperception of reality, which, if that had been the case, would have rebutted any adult's presumption of competence. Her reasoning was not distorted; she simply hoped for a miracle that would relieve her of death. Kennedy and Grubb notes that many terminally ill patients hope for a miracle cure even when their doctors make clear that they are going to die.<sup>60</sup> The fact that the patient perceives their chances of survival differently from the doctor should not be used against a patient to conclude that they are incompetent. Surely the preferable view is that such a hope is the product of an individual's belief system, in S's case motivated by the strong religious background with which she was associated.

In *Re L*, Sir Stephen Brown seemed to hold against the minor the fact that she did not consider her religious views to be negotiable. Instead of viewing this as a positive indication of L's strength of feeling on the matter, he attributed this view to the fact that she was a child with a largely sheltered upbringing which limited her understanding. Her lack of experience of life was said to make the minor unable to formulate a competent opinion. However, the judge acknowledged how deeply held and sincere L's religious convictions were, and the minor's anticipatory refusal was clear evidence reflecting her most recent views that she did not want blood in relation to medical care in any circumstances. Is it likely then that if L had been an 18-year-old her additional life experience would have resulted in anything but the same conscientious refusal?

---

<sup>59</sup> Fortin J *Children's Rights and the Developing Law* (1998), pp 108-109.

<sup>60</sup> Kennedy I and Grubb *A Medical Law*, (Butterworths 3<sup>rd</sup> Edition 2000) p 650.

Even if this latter point cannot be definitively concluded either way, Sir Stephen Brown’s reasoning, that L could not be sufficiently competent on the basis that she had not been made aware of the actual manner of her death, does not adequately protect the patient’s interests. The minor was unaware of such information because the doctor felt that such disclosure was inappropriate. Although the intentions of the doctor may have been honourable in this regard, such a fact should hardly be used against the minor to deprive her of the opportunity of establishing legal competency. It is the responsibility of the practicing physician to provide the patient with all the vital information that will impact on the decision-making process.<sup>61</sup> The consent or refusal of the patient will then be suitably informed. The patient’s lack of information could have been remedied before the case came to Court. The cynical though persuasive view of some commentators is that doctors might deliberately vitiate refusal of consent by withholding information.<sup>62</sup> How can negligence on the part of the doctor in withholding vital information from L be used by the judiciary as justification for disregarding the minor’s autonomy?

The decisions of Jehovah’s Witness teenagers have wrongly been classed as incompetent to provide justification for disregarding beliefs that are sincere and heartfelt, and wholly defensible. To manipulate the legal concept of competence so that more is expected of minors than adults in such a serious context is totally inappropriate, notes Kennedy and Grubb.<sup>63</sup> Other critics go as far as suggesting that such an approach amounts to positive discrimination, and cannot be reconciled with Article 14 of the Human Rights Act 1998, due to the way that it endorses age based discrimination.<sup>64</sup>

## **JEHOVAH’S WITNESSES MINORS – THEIR “BEST INTERESTS”**

Whilst all these judgements have concluded that the youths have been incompetent when assessing their decision-making capacity, the case law can be seen to endorse the view that the issue of competence is not the most important consideration to the judiciary. Ward J in *Re E* stated that whether the minor was “*Gillick*” competent or not was not in his opinion the key issue. “Whether or not he is of sufficient understanding to have given consent or to

---

<sup>61</sup> The need for proper consultation with the patient was emphasized in *St. George’s Healthcare NHS Trust v S; R v Louise Collins et al, ex parte S* [1998] 2 FLR 728.

<sup>62</sup> Mason G K & McCall Smith A, *Law and Medical Ethics*, (Butterworths 4<sup>th</sup> Edition 1994); *supra* note 19 p 616.

<sup>63</sup> Kennedy I and Grubb A, *Medical Law*, (Butterworths 3<sup>rd</sup> Edition 2000) p 650.

<sup>64</sup> Wicks E The Right to Refuse Medical Treatment under the European Convention on Human Rights, [\*Medical Law Review\*, \(2001; 9\) p 17-40.](#)

## JEHOVAH'S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

withhold consent is not the issue for me.”<sup>65</sup> The primary concern in Ward J’s eyes, endorsing the observations of Lord Hailsham in *Re B*,<sup>66</sup> was the welfare of the child from an objective viewpoint. The Court would do all it could to stop the child from damaging himself. Ward J had strong views about what the obligations of the Court were in this regard: “There is compelling and overwhelming force in the submission of the Official Solicitor that this court, exercising its prerogative of protection, should be very slow to allow a child to martyr himself.”<sup>67</sup> The jurisdiction of the High Court was comprehensively discussed in two Court of Appeal cases considering the right of a minor to veto recommended medical treatment.<sup>68</sup> Instead of focusing on the concept of self-determination, these cases instead viewed the “child’s own best interests, objectively considered”<sup>69</sup> as the key consideration. This approach was exemplified by Nolan LJ’s comments that: “An individual who has attained the age of 18 is free to do with his life what he wishes, but it is the duty of the court to ensure so far as it can that children survive to attain that age.”<sup>70</sup>

Such a viewpoint was echoed in *Re R*, where Lord Donaldson quoted the words of Lord Upjohn that the duty of the court was to “act as the judicial reasonable parent.”<sup>71</sup> However, he then clarified that the Court’s powers extend beyond those of a parent, or a competent minor, when evaluating when to give consent to medical treatment. The Court had a duty to exercise its powers in the interests of the children, reflecting the reasonable standards in society at the time about how children should be brought up. In *Re R* such reasoning was used to justify the Court exercising its jurisdiction to override the wishes of a minor who had refused anti-psychotic medication. It was reinforced that even if a decision regarding medical treatment was made by a “*Gillick*” competent minor, the jurisdiction of the court could still be exercised to override such a decision. The “best interests” approach that the judiciary have taken to such cases was evident again in *Re W*, which concerned the refusal of treatment by a troubled minor suffering from anorexia nervosa. Balcombe LJ said that the question of when the courts should override the wishes of a minor refusing medical treatment should be looked at on an incremental basis as a matter of fact. He concluded: “What I do stress is that the judge should approach the exercise of discretion with a

---

<sup>65</sup> *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386 at 226.

<sup>66</sup> *Re B (A Minor) (Wardship: Sterilisation)* (1987) 2 BMLR 126 at 133.

<sup>67</sup> *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386

<sup>68</sup> *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592; *Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1992] 3 WLR 758.

<sup>69</sup> *Ibid* at 776 per Balcombe LJ.

<sup>70</sup> *Ibid* at 781.

<sup>71</sup> *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592 at 601-2.

predilection to give effect to the child's wishes on the basis that prima facie that will be in his or her best interests."<sup>72</sup>

Such a position illustrates the way that the judiciary is willing to respect the decision-making capacity of a minor up to the point where it is felt that the minor is in danger of causing harm to themselves. At this point, although the wishes of the minor are not totally disregarded, they are overridden as the welfare of the child is deemed to be paramount. The practical impact of the common law position for conscientious minors who are Jehovah's Witnesses was summarised by Sir Stephen Brown in *Re L*:

"It is also my view... that it would be the appropriate order to make even if I were not justified in coming to the conclusion that she was not so called 'Gillick competent.' This is an extreme case and her position is grave indeed. It is vital that she should receive this treatment."<sup>73</sup>

Although such judgements suggest that an assessment of the minor's capacity is a key consideration in deciding whether the refusal of treatment can be binding, satisfying the test of competency will make no difference to whether the autonomy of the minor is to be respected. Refusal of treatment will be overridden if it is felt that this is in the best interests of the minor when objectively considered. Whether the minor sufficiently understands the decision they are making ultimately has no practical value whatsoever.

Such an approach is unsatisfactory because it displays a total unwillingness on the part of the courts to treat the competent minor in the same way as the competent adult, on the basis that age should be considered above all else for decision-making purposes. Lowe and Juss comment that "in the final analysis, a child is still only a child."<sup>74</sup>

The possibility that an autonomous minor could make decisions that risk their health or, possibly, even their life needs to be placed in a societal context. A 16-year-old is legally entitled to drive a moped or a car at 17.<sup>75</sup> Similarly, the law allows a 16-year-old to buy cigarettes or fireworks.<sup>76</sup> Government legislation expressly allows minors to exercise self-determination even if the consequences of such actions may be serious harm. Parents are not afforded a right to veto such activities and the judiciary is given no opportunity to objectively consider the child's best interests.

---

<sup>72</sup> *Ibid* at 776.

<sup>73</sup> *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810 at 813.

<sup>74</sup> Lowe N and Juss S 'Medical Treatment – Pragmatism and the Search for Principle,' *Medical Law Review*, (1993) p 865-871.

<sup>75</sup> Motor Vehicle (Driving Licences) Regulations 1999.

<sup>76</sup> Children and Young Persons Act 1933; Explosives Act 1875 s 31.

## JEHOVAH’S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

Similarly, children from 14 or even younger can be made criminally culpable for their actions, illustrating that their decisions can carry with them legal responsibility.<sup>77</sup> Against such a background, can it really be justifiable to overrule a competent child who wants to exercise autonomy in relation to his healthcare?

The criticism of adopting such an approach is that minors who are Jehovah’s Witnesses who fully understand the implications of vetoing blood based medical treatment and the possible consequences of such a refusal, will never have such conscientious views respected. Their religious stance will always be undermined, due to such a belief system not being the recognised norm within society. Can such paternalistic intervention really be argued to represent the best interests of the minor? It is suggested that, although no one doubts the good intentions of the judiciary in giving primacy to the preservation of life in such cases, such an outcome-based approach is ill-advised when applied to cases involving Jehovah’s Witnesses.

After all, although in the case of *Re E* the decision of the court to prescribe blood- based treatment gave the minor two more years of life, the fact that he immediately refused blood when attaining the age of majority suggests that the minor still had ultimate regard for his religious beliefs rather than his life being preserved at all costs. It is arguable that prolonging his life in such circumstances when his views were clear and unambiguous simply added to his level of emotional distress and deprived him of his dignity. This point has not gone unnoticed within the medical community, with the Association of Anaesthetists commenting:

“Administration of blood to a competent patient against their will and in conflict with their genuinely held beliefs has been likened by the witnesses to rape. It may have as deep a psychological effect as forceful sexual interference.”<sup>78</sup>

Against the backdrop of such psychological anguish for the minor, can it really be said that the outcome-based approach used to justify judicial paternalism is truly in their best interests. E, S and L all made their refusals clear either using an ‘Advance Medical Directive’ or by notifying the doctors of their stance prior to an emergency situation. Refusal of blood was not merely based on a whim or the emotion of the situation, but was due to deeply rooted religious objections.

Surely the lack of respect for a minor’s autonomy in such circumstances is likely to be deeply traumatic for the youth and leave them with a profound

---

<sup>77</sup> Crime and Disorder Act 1998.

<sup>78</sup> *Management of Anaesthesia for Jehovah’s Witnesses*, Association of Anaesthetists of Great Britain and Ireland, (March 1999) p 3 pp 2,4.

sense that they have been violated. Can it really be in the minor's best interests to pay no respect to their religious views in such an instance? Even Johnson J acknowledged in *Re P*<sup>79</sup> that "treatment which is imposed against the wishes of the patient is surely to be avoided wherever possible." This is all the more true when dealing with Jehovah's Witnesses who satisfy the legal test of capacity.

The *Gillick* decision was thought to herald a new legal dawn granting competent minors a right to self-determination with respect to all medical decisions. However, subsequent case law has demonstrated that the aim is to protect a doctor from possible litigious claims.<sup>80</sup> The representation by Lord Donaldson of consent either as a "legal flak jacket"<sup>81</sup> or as "merely a key which unlocks a door"<sup>82</sup> can be criticized for not protecting the principle of self-determination by focusing too heavily on the avoidance of punishment. The British Medical Association has taken a position that clearly supports and respects minors who have the capacity to make medical decisions for themselves:

"The tendency to regard mature young people as autonomous in their own right is a very welcome trend which should not be undermined... Respect for autonomy must be commensurate with the ability of the individual to decide... Minors who are clearly competent to agree to treatment must be acknowledged as also having an option to refuse treatment if they understand the implications of doing so."<sup>83</sup>

The medical profession in the UK clearly recognizes that a competent minor has the right to self-determination. There can be no justification for the courts to paternalistically disregard such a right.

---

<sup>79</sup> *Re P(A Minor)* [2003] EWHC 2327 (Fam) at 10.

<sup>80</sup> Douglas G The Retreat from *Gillick*, *Medical Law Review*, (1992) 55 MLR 569.

<sup>81</sup> *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] 3 WLR 758. at 767.

<sup>82</sup> *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592 at 599.

<sup>83</sup> *Medical Ethics Today: Its Practice and Philosophy*, (British Medical Association, 1993) pp 1:3.2; 3:2.1.

## THE INCOMPETENT JEHOVAH'S WITNESS MINOR AND PARENTAL CONSENT

### *Parental Autonomy*

When a child is clearly incapable of looking after themselves because of tender age Jehovah's Witnesses believe that the appropriate decision-makers should be the child's parents.<sup>84</sup> The family unit has always been regarded within society as the appropriate place to protect the interests of the child, a point highlighted in the United Nations *Convention on the Rights of the Child*:

“[the family is] the natural environment for the growth and well-being of all its members and particularly children, and should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.”<sup>85</sup>

Lord Fraser acknowledged such a principle in *Gillick*,<sup>86</sup> when he commented that “Nobody doubts, certainly I do not doubt, that in the overwhelming majority of cases the best judges of a child's welfare are his or her parents.” When exercising such a choice, the fact that a parent takes a medical decision on the basis of religiously held views with which the medics disagree should not legitimate transferring the power to make that decision away from parents to an officer of the State. Such a principle was upheld in the United States Supreme Court.<sup>87</sup> Julius Landworth, MD, noted:

“Parents have a right to select among medically appropriate options based on their individualised assessment of the relative burdens and benefits of the proposed intervention from the perspective of personal and family values.”<sup>88</sup>

---

<sup>84</sup> *Family Care and Medical Management for Jehovah's Witnesses*, (Watchtower Bible and Tract Society, Inc. 2002) Family p 3.

<sup>85</sup> *Convention on the Rights of the Child*, Adopted by the General Assembly of the United Nations on 20<sup>th</sup> November 1989, Preamble.

<sup>86</sup> *Gillick v West Norfolk and Wisbech Area Health Authority*, [1985] 3 All ER 402 at 412.

<sup>87</sup> *Parham v J R* 442 US 584, 99 S Ct 2493,2504 (1979).

<sup>88</sup> Landwirth J ‘Ethical Issues in Paediatric and Neonatal Resuscitation,’ *Annals of Emergency Medicine*, Vol 22, No 2 (Part 2), February 1993, pp 236-41 at 238.

## II. *The Question of Medical Necessity*

When the doctor considers the minor's health to be in serious danger unless they receive an immediate blood transfusion the situation is not so straight forward and whether the situation is one of medical necessity, or not, may still be a matter of opinion. The notes editors writing in the *Minnesota Law Review* commented:

“The issue of compulsory treatment should only be reached after the diagnosis is sound. In determining whether the judgement is sound, the opinion of the doctors seeking authorisation should be carefully scrutinized in view of their involvement.”<sup>89</sup>

The Honourable Madame Justice Beverley McLachlin of the Supreme Court of Canada, called for caution when “weighing whether the facts show a likelihood of severe physical or emotional harm to the child unless state intervention is permitted.”<sup>90</sup> Dr. Richard Spence speaking for physicians unwilling to treat Jehovah's Witnesses in accordance with their wishes has said: “If you can't transfuse, transfer. [This] helps the patient to live and the transferring physicians to live with themselves.”<sup>91</sup> Once all reasonable steps have been taken to explore medical alternatives to blood and the situation is truly life-threatening, parents that are Jehovah's Witnesses will respect the decisions of the courts if the judge in question feels compelled by the circumstances to issue an order permitting the use of blood. To support and assist patients who are Jehovah's Witnesses, the Hospital Liaison Committee Network has been designed to act as a liaison between the doctor and the adult patient, or the parents and the minor, at the patient's request.<sup>92</sup> Jehovah's

---

<sup>89</sup> Notes editors Edwin C Carpenter, Lawrence A Lokken and Thomas D Tews ‘Compulsory Medical Treatment: The State's Interest Re-evaluated’ 51 *Minnesota Law Review* 293 at 304 (1966).

<sup>90</sup> Honourable Madame Justice B McLachlin, ‘Who Owns Our Kids? Education, Health and Religion in a Multicultural Society,’ Address to the Canadian Institute for Advanced Legal Studies, Cambridge Lectures, July 1991.

<sup>91</sup> Spence R K ‘The Status of Bloodless Surgery,’ *Transfusion Medicine Reviews*, Vol V, No 4, October 1991, pp 274-286 at 285.

<sup>92</sup> Such Committees are made up of qualified professionals who are able to help hospitals to locate doctors who are willing to treat patients using non-blood medical management. In the UK, the Hospital Liaison Committees have a database of around 5000 doctors who have submitted that they would be willing to be available for consultation or a transfer, in order to treat Jehovah's Witnesses using non-blood medical management. I am grateful for an interview with Paul Wade, Head of Hospital Information Services (Britain) for Jehovah's Witnesses, March 2005.

## JEHOVAH’S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

Witness families with the help of the Hospital Liaison Committees seek a solution that can give the best medical care to their children whilst accommodating the sincere religious beliefs of the parents.

*In Re S*<sup>93</sup> a 4 ½ year old child suffered from T-cell leukaemia with a high risk of death. The parents of S were dedicated Jehovah’s Witnesses who conscientiously refused to the intensive chemotherapy that was able to treat the disease since it included the transfusion of blood as an integral part of the treatment. The local authority sought an order from the court permitting the use of blood transfusions. Thorpe J commented that the parenting of S had always been above criticism, and that a close accord had been established between the hospital and parents on diagnosis.<sup>94</sup> The judge also remarked on how impressed he was with the emotional control and sincerity with which the father of S stated his convictions, concluding that “there was no impression of the bigot, of the closed mind, or of unreasonable obstinacy.”<sup>95</sup>

Thorpe J considered the appropriate legal test to be the “best interests” of the child. Under these circumstances, the duty of the court was felt to be to do all that could be done to offer S a chance of a medical remedy and provide the appropriate consent for such medical treatment endorsing the use of blood. The judge also made clear that the judicial act of taking responsibility for consent away from the parents of S would allow the parents to absolve their conscience of responsibility for the child being treated using blood.<sup>96</sup> The Family Division was again asked to consider the question of whether the court should override beliefs of two of Jehovah’s Witnesses, in order to treat their incompetent child using blood in *Re O*.<sup>97</sup> This case concerned a baby that had been born 12 weeks prematurely and consequently suffered from respiratory distress syndrome. The local authority made an application for an emergency protection order that would allow a blood transfusion to be given without the consent of the parents in an emergency situation. Furthermore, they applied for a care order on the basis that there was a further and continuing need for medical treatment involving blood transfusions. Johnson J recognised that the dilemma for the parents was “awesome”, due to the fact that they were “deeply committed and loving parents” who did not want their child to die.<sup>98</sup> However, the judge also felt that, whilst endeavouring to pay every respect to the religious principles underlying the family’s decision, intervention was necessary in this instance to protect the welfare of the child, quoting from

---

<sup>93</sup> *Re S (A Minor)(Medical Treatment)* [1993] 11 BMLR 105.

<sup>94</sup> *Ibid* at 106.

<sup>95</sup> *Ibid* at 108.

<sup>96</sup> *Ibid* at 109.

<sup>97</sup> *Re O (A Minor)(Medical Treatment)* [1993] 2 FLR 149 (Fam).

<sup>98</sup> *Ibid* at 151.

Lord Upjohn that he must act “as the judicial reasonable parent.”<sup>99</sup> On this basis, he would give directions to administer blood when the medical need arose.

In *Re R*<sup>100</sup> a 10-month-old baby suffering from lymphoblastic leukaemia, needed a blood transfusion, R’s parents, as Jehovah’s Witnesses, withheld consent. A specific issue order was applied for. Booth J considered such an order, ordering the treatment of the child with blood, to be appropriate on the basis that “the welfare of the little girl is the court’s paramount consideration.”<sup>101</sup> It was agreed amongst all parties that the specific issue order, although allowing blood to be administered in an imminently life-threatening situation without the consent of the parents, should require the doctors to consult with the parents in any situation less than imminently life-threatening. Such consultation would allow all alternative forms of non-blood medical management to be considered. If the conclusion of the doctor after such consultation was that there was no reasonable alternative to the administration of blood, then they could act in this way without the parents consent.

Such cases illustrate the fact that the welfare of the child will always be viewed as the key consideration, and this is to be assessed on the basis of what the courts consider to be the outcome of parental refusal to treatment. This approach is perhaps not surprising in relation to incompetent minors when one bears in mind that the judiciary have decided cases involving “*Gillick*” competent minors in the same way. The approach of the courts has given a high level of respect to parental autonomy, whilst recognizing that in certain circumstances there are criteria that the proxy cannot have regard to when coming to a decision for the incompetent patient. These decisions do not endorse a blanket-like overruling of parental autonomy when the court does not agree with a decision based on religious beliefs. The courts were not seeking to disregard the right of the parents to make a choice in all cases. Rather, the protective powers of the court would only be exercised in very particular circumstances. It was felt that an order to give blood should be issued only when there was no reasonable alternative to using blood to treat the serious condition of the child.

The UK courts have not had to provide a judgement on whether they would override the wishes of Jehovah’s Witnesses who wished their children to be treated using a blood-free form of treatment that had a lower chance of success to a blood-based alternative. However, it is likely from the obiter dicta of the judges that deference would be given by the courts to parental autonomy as long as there was a reasonable alternative to using blood. This

---

<sup>99</sup> *Ibid* at 152.

<sup>100</sup> *Re R (A Minor) (Blood Transfusion)* [1993] 2 FLR 757 (Fam).

<sup>101</sup> *Ibid* at 759.

## JEHOVAH’S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

conclusion can be made on the basis that Booth J. phrased the specific issue order in such a way to make sure that other options were considered before blood products were administered.<sup>102</sup> The order was only to have legal force if such an alternative did not exist. Blood transfusions were not to be administered simply as a matter of routine when they were not medically necessary, a point clarified in *Re O*.<sup>103</sup> Thorpe J also intimated that the legal position may well be different if there was a choice of procedures, one of which was medically more risky but not objected to by the parents. He did not make a definitive statement on such a point, but the fact that there was only one available form of treatment seemed to be the determining factor in reaching the conclusion that judicial intervention was justified. Although it would be dependant on the facts of the particular case, it is likely that a decision by one of Jehovah’s Witnesses to opt for treatment for their child that was medically riskier, but blood free, would be within the zone of decision-making afforded to parents as long as the treatment has not been totally rejected by all responsible medical authority. Such a conclusion would echo the approach that has been adopted in foreign jurisdictions and is felt to be justified because, as noted by Kennedy and Grubb, there is no real basis for the court to claim that they are a better parent than those who are prima facie entitled to form such a judgement.<sup>104</sup>

The need for the parents to be heard and remain part of the decision-making process in cases where doctors seek an order to administer blood, guided the reasoning in both *Re O* and *Re S*. The basic procedural right of giving parents formal notice of such an order and a suitable hearing was overlooked in *Re O*, where an emergency protection order was made without necessary notice to the parents. Johnson J commented:

“Whatever the circumstances, efforts should in my view be made to achieve an inter partes hearing however unusual the particular arrangements may need to be.”<sup>105</sup>

Booth J concurred with such a view, noting that “the most strenuous efforts should always be made to achieve an inter partes hearing. Such issues should be determined by a High Court judge.”<sup>106</sup> Similarly, in the New Zealand case of *Re CL* the court recognised that there should be a proper opportunity for everyone with a legitimate interest to be heard. Justice Robertson stated:

---

<sup>102</sup> Ibid at 760.

<sup>103</sup> Ibid at 761.

<sup>104</sup> Kennedy I and Grubb A, *Medical Law*, (Butterworths 3<sup>rd</sup> Edition, 2000) p 795.

<sup>105</sup> *Re O (A Minor)(Medical Treatment)* [1993] 2 FLR 149 (Fam) at 151.

<sup>106</sup> *Re S (A Minor)(Medical Treatment)* (1993) 11 BMLR 105.

“Whenever there is the potential for an interference with parental rights, then to the extent that it is in all the circumstances reasonable, the parents’ views should be heard and weighed in the decision making process.”<sup>107</sup>

The case law in both the High Court of Australia<sup>108</sup> and the Divisional Court of Ontario, Canada confirms this as the correct process, with the order of a blood transfusion without a fair hearing in Canada deemed to be a “clear violation of the fundamental principles of natural justice.”<sup>109</sup>

Once legal steps have been taken seeking an order to administer blood, reasonable notification should be given to the parents. This will allow the court to come to an informed decision about what actions are necessary to protect the welfare of the child and demonstrate that parental autonomy will not be disregarded without proper consideration. When such actions are followed a fair balance is struck between the competing interests of Jehovah’s Witnesses faced with an impossible moral dilemma and the judiciary who must ensure that the welfare of incompetent patients is not compromised. The role of the law in this regard is perhaps best summed up by the words of Johnson J. in *Re O*:

“When the State, in the form here of the legal system, is asked to override the views of parents. . . then the system should ensure that so far as judicial ingenuity can ensure, justice is seen, and felt, to be done.”<sup>110</sup>

## THE WAY FORWARD

### *I. Lessons From Abroad: The American Approach*

The approach of the courts in the United States to this issue has endeavoured to pay more than mere lip service to the decision-making capacity of conscientious minors. The law in the United States includes the firmly established doctrine of the “mature minor,” the American equivalent to a “*Gillick*” competent minor. Since the late 1980’s such a doctrine has been applied to minors who are Jehovah’s Witnesses. *Re E.G.*<sup>111</sup> is a good example,

---

<sup>107</sup> *Re CL* [1994] NZFLR 352 at 355 (HC New Zealand).

<sup>108</sup> *J v Lieschke* (1987) 11 Fam LR.

<sup>109</sup> *Children’s Aid Society of Metropolitan Toronto v F(M)* (1993), 99 DLR (4<sup>th</sup>) 378 at 379 (Ont Div Ct).

<sup>110</sup> *Re O (A Minor)(Medical Treatment)* [1993] 2 FLR 149 (Fam) at 151.

<sup>111</sup> *Re EG* 549 NE 2d 322 (Ill 1989).

## JEHOVAH’S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

where the Supreme Court of Illinois decided that a 17 year old minor had a sufficient level of maturity and understanding to refuse blood based treatment. The judgement commented:

“Age is not an impenetrable barrier that magically precludes a minor from possessing or exercising certain rights normally associated with adulthood.”<sup>112</sup>

The basic prerequisite in America for the State exercising the inherent jurisdiction of the High Court, also known as *parens patriae* authority, on behalf of any individual, is that:

“The individual himself must be incapable of making a competent decision concerning treatment on his own. Otherwise, the very justification for the State’s purported exercise of its *parens patriae* power - its citizen’s inability to care for himself - would be missing.”<sup>113</sup>

The approach in the United States endorses the view that competent persons with decision-making capacity, even if they are minors, do not need the State to tell them what is the “best” or “right” thing for them, according to the value judgement of a doctor or a judge or a social institution. The “best interests” approach commonly adopted within the UK has been heavily criticized due the lack of real guidance that it gives a judge. The consequence of applying such a vague standard is thought to be that “Judges...may find it difficult to avoid decisions resting on subjective values.”<sup>114</sup> The US approach has consistently opposed the position evident in *Re Estates of Brooks*:

“What has happened here involves a judicial attempt to decide what course of action is best for a particular individual, notwithstanding that individual’s contrary views based upon religious convictions.”<sup>115</sup>

It is submitted that the American legal model to competence not only recognizes that a competent minor should have the right to self-determination but also actively seeks to give the law some practical significance for the

---

<sup>112</sup> Ibid at 327-328. See also, *In Re Rena* 705 NE 2d 1155 (Mass Ct App 1999); *In Re Swan*, 569 A 2d 1202 (Me 1990).

<sup>113</sup> *Rogers v Okin*, 634 F 2d 650, 657 (1<sup>st</sup> Cir 1980).

<sup>114</sup> *Smith v Organization of Foster Families for Equality and Reform*, 431 US 816, 835 n 36 (1977).

<sup>115</sup> *Re Estates of Brooks*, 205 NE 2d 435, 442 (Ill 1965).

conscientious Jehovah's Witness. The outcome based approach within the UK that undermines adolescent autonomy when life is at risk in the perceived "best interests" of the minor, is no justification for positive state intrusion within this model. The state has no lawful interest in protecting competent individuals capable of independently protecting their own interests.

## *II. Lessons From Abroad: The Canadian Approach*

The case of *Re LDK*<sup>116</sup> concerned a 12-year-old with life-threatening leukaemia who refused blood transfusions as a form of treatment. When such treatment was forcibly administered without her consent, this was found to violate her rights under the Canadian Charter. An application for further blood-based treatment was dismissed by the judge on the basis that this offended her religious beliefs and the fact that she had "wisdom and maturity well beyond her years."<sup>117</sup> This approach was followed in *Re AY*<sup>118</sup> and *Walker*,<sup>119</sup> both cases conferring the right of self-determination on youths who refused blood transfusions. They were deemed to be mature young adults "capable of understanding the nature and consequences of medical treatment."<sup>120</sup>

The position in relation to self-determination and competent minors is still evolving<sup>121</sup> but such cases illustrate that certain judges have found no reason to justify paternalism when faced with refusal by mature minors who are Jehovah's Witnesses.

## *III. An Alternative UK Legal Model*

If a minor has the sufficient understanding and maturity to make an informed, competent decision, the only difference between the minor and an adult in the same situation is that the minor has not yet attained the chronological age of majority. A distinction based on nothing more than the fortune of majority status should not negate a competent minor's right to determine what happens to his or her body within a principled legal system.

---

<sup>116</sup> *Re LDK*; 1<sup>st</sup> November 1985 48 RFL (2d) 164 (Ontario Provincial Court).

<sup>117</sup> *Ibid* at 168, 169, 171 *per* Main Prov J.

<sup>118</sup> *Re AY* (6<sup>th</sup> February 1994) 111 Nfld & PEIR 348 APR 91 (Supreme Court of Newfoundland)

<sup>119</sup> *Walker (Litigation Guardian of) v Region 2 Hospital Corp.* (June 23<sup>rd</sup> 1994) 4 RFL (4<sup>th</sup>) 321 (New Brunswick Court of Appeal).

<sup>120</sup> *Ibid* at 29,30.

<sup>121</sup> Compare *BH (Next Friend of) v Alberta*, (Court of Queen's Bench of Alberta), 2002 ABQB 371.

## JEHOVAH'S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

A more appropriate model could be for the medical profession to start out from the position that all patients are presumed to be competent, irrespective of age, but that presumption can be rebutted if the patient is unable to satisfy a codified test of competency based on the three stages outlined in *Re C*. This test has been carried over into the proposals in the Draft Mental Incapacity Bill (2003), with the added provision that a patient should be “able to communicate the decision (whether by talking, using sign language or any other means).”<sup>122</sup>

By treating all patients in this way, it would create a legal standard of competency that was impartial and was based on the patient’s decision-making capacity as opposed to any arbitrary age limit imposed by the State. Such a model would bring to an end the unsatisfactory situation in the UK where a minor may have to establish a significantly higher level of understanding regarding the consequences of a particular decision than an adult patient with the same medical predicament.

Some critics have suggested that a determination of every patient’s individual ability for competence would be time consuming and impractical, Elliston notes that such an objection is not sustainable. He commented that:

“While setting an arbitrary age for such reasons as ability to vote is acceptable, since the administrative difficulties involved in questioning every citizen in order to establish their competence for enfranchisement would be practically insurmountable, the same is not true where decisions about the management of the health of an individual are concerned. Here the individual’s ability to make a decision can be scrutinized...”<sup>123</sup>

Such a model would reflect the UK law’s current attitude evident in *NHS Trust Airedale v Bland* that “the principle of sanctity of human life must yield to the principle of self-determination.”<sup>124</sup> The difference would be that this legal position would apply to all competent patients, not just those over 18.

As such, it is likely that under this new approach, the conscientious refusal of blood by E, S and L would have been respected if regarded as the decision of a competent patient.

---

<sup>122</sup> Clause 2 (1)(d).

<sup>123</sup> Elliston S ‘If You Know What’s Good For You...’: A Consideration of Refusal of Consent to Medical Treatment by Children, *Contemporary Issues in Law, Medicine and Ethics*, (Dartmouth Publishing Co, 1996) p 29-55.

<sup>124</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER at 866 per Lord Goff of Chieveley.

It is important to note that all decisions relating to medical care would have to be scrutinised to make sure that the patient was free from any undue influence and not compromised by pressure from family or friends. The common law already establishes that where a competent patient's decision is based on the undue influence of a third party, however well intentioned, such a decision will not be based on the independent understanding of that person and will be disregarded.<sup>125</sup>

Critics may suggest that such an approach effectively signs a death warrant for unstable minors like those in the cases of *Re R* and *Re W*. However, when analysing the position of such minors, it is important to recognise what the legal position would have been for these ones had they been judged against the *Re C* criteria. There is the definite possibility that R would have been held not to satisfy the second requirement of the test in *Re C*, that she believed the treatment information given to her. R was diagnosed with a psychotic disorder but nevertheless sought to refuse the anti-psychotic medication prescribed as necessary to help such a condition. A veto of medication in the light of such circumstances makes it highly debatable whether R truly believed that she actually had a mental condition that required treatment.

Similarly, in *Re W*, although W was not directly suffering from a mental illness, medical evidence makes it clear that one of the characteristics of anorexia nervosa is that it is capable of destroying the sufferer's ability to make an informed choice. Also, Lord Donaldson noted that one of its clinical manifestations was "a firm wish not to be cured, or at least not to be cured until the sufferer wishes to kill herself."<sup>126</sup> Against such a background, it is easy to conclude that W's ability to satisfy the third limb of *Re C*, weighing the information in the balance so as to arrive at a clear choice, could be compromised. Although neither case demonstrates a complete misperception of reality which would automatically rebut the presumption of competence in an adult, it is suggested that the underlying mental instability of both W and R could result in them not being able to demonstrate that they had arrived at a clear choice, being denied competency on these grounds even if they were adults.

With respect to the patient who is unconscious but has made their wishes clear through the use of an anticipatory form of refusal such an 'Advance Medical Directive,' the law should respect the wishes of the patient when it can be established that the patient was competent at the time that such wishes were made, and all the other criteria to make such a directive valid are present. The problem that arises is where the unconscious patient has no

<sup>125</sup> *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649.

<sup>126</sup> *Re W (A Minor)(Medical Treatment: Court's Jurisdiction)* [1992] 3 WLR 758 at 761E.

## JEHOVAH'S WITNESSES – MEDICAL CARE, MINORS AND THE RELIGIOUS RIGHTS

opportunity to satisfy the *Re C* test, and the evidence is ambiguous as to whether an advance directive reflects the independent wishes of a competent person who understands the significance of the form. For example, a scenario could arise where a 14-year-old unconscious Jehovah's Witness was admitted to hospital in a serious condition. Although she had an advanced "no blood" directive signed and up to date, how could the doctor be sure that such a stance represented the view of a competent patient free from undue influence? In such a situation, as the decision-making capacity of the patient is in doubt, it is suggested that the most appropriate response would be for the medical practitioner to initially try and do all that they can to preserve life, until it can be ascertained what the minor's true wishes are. The patient should surely be the one that bears the responsibility of making their wishes clear to the medical profession if they have special circumstances like religious beliefs that they want to impact on their healthcare. One practical suggestion for dealing with this type of situation would be for a patient that wished to make use of an anticipatory form of refusal to have such a directive placed on the medical record that they have with their General Practitioner. Such a person would be in a position to assess whether their patient satisfied the three stage test in *Re C* and such a refusal was the product of independent thought. If the patient had performed such steps and they were deemed competent, in the case of an emergency situation where they were unconscious, such actions should be given sufficient recognition to entitle the patient's anticipatory refusal to be respected.

Many today may consider that a loving God would not object to a worshipper undertaking a form of healthcare involving blood products if it was likely to have a positive effect, possibly even a lifesaving effect, on his or another's physical health. However, far from martyring themselves, Jehovah's Witnesses are exercising their right to determine how they are medically treated, choosing to act in a way that will not contravene what they regard as perpetual commands and expressing their right to hold and manifest their religious belief through the refusal of blood products. Article 9(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (as set out in Schedule 1 to the Human Rights Act 1998). Article 9 asserts:

"1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance. 2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are

necessary in a democratic society . . . for the protection of the rights and freedoms of others.”