ETHICS

Children of Jehovah’s Witnesses and adolescent Jehovah’s Witnesses: what are their rights?

S Woolley

The Jehovah’s Witnesses Society (JW), a fundamentalist Christian sect, is best known to laypersons and healthcare professionals for its refusal of blood products, even when such a refusal may result in death. Since the introduction of the blood ban in 1945, JW parents have fought for their rights to refuse blood on behalf of their children, based on religious beliefs and their right to raise children as they see fit. Adolescent JWs have also sought to refuse blood products based on their beliefs, regardless of the views of their parents.

Traditionally, except in the emergency situation, parental consent is required in order to perform medical procedures on children, including adolescents. Courts throughout the western world recognise that parents have rights but additionally recognise that these rights are not absolute and exist only to promote the welfare of children. Worldwide, JWs have challenged this view. In addition to parental challenges adolescent JWs have been fighting their own battle to be recognised as mature enough to make their own decisions regarding blood products. Unfortunately, where the courts have been consistent regarding young children, they have been equally inconsistent where adolescent JWs are concerned.

The legal inconsistencies mean that confusion still exists amongst the medical profession about their legal liability if they transfuse children of JW parents or adolescents of the JW faith. This article examines cases from the United States, Canada, the United Kingdom, and Australia, and clarifies any confusion that may exist regarding the necessary transfusion of the children of JWs and the refusal of blood products by adolescent JWs.

The Jehovah’s Witness Society is a fundamentalist Christian Sect, based in New York, whose followers believe the Bible is the true word of God. The most rapidly growing religious organisation in the western world, there are approximately 5 500 000 committed, baptised members, 125 000 of whom reside in the United Kingdom. To many people, JWs are best known for their absolute refusal of blood products, even when death may result. This refusal is based on the belief that transfused blood is a nutrient, with three Biblical passages allegedly forbidding transfusion: Genesis 9:4, Leviticus 17:11–14, and Acts 15:20,29. The punishment for accepting blood products is loss of eternal life and on earth, a type of ex-communication.

YOUNG CHILDREN OF JEHOVAH’S WITNESSES

Traditionally, where young children are concerned, the power to give or withhold consent to medical treatment on their behalf lies with those with parental responsibility. Legally, except in an emergency, parental consent is necessary to perform any medical procedure on a child. Two commonly used arguments when parents refuse treatment are parental rights to raise children as they see fit and religious freedom. JW parents have expressed both these arguments when defending their right to refuse blood on behalf of their children.

Courts throughout the western world recognise parental rights, but these rights are not absolute. Parental rights to raise children are qualified by a duty to ensure their health, safety, and wellbeing. Parents cannot make decisions that may permanently harm or otherwise impair their healthy development.

If treatment refusal results in a child suffering, parents may be criminally liable. However, prosecution rarely occurs. Instead, the courts are asked to exercise their power under the doctrine of parens patriae which allows state interference to protect a child’s welfare. Used frequently when parental religious beliefs preclude specific treatments, Prince v Massachusetts set out the reigning legal principle:

“Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children…”

This principle applies whether or not the child is in imminent danger, as parents are always required to make decisions in the child’s best interests. When parental refusal is based on religious beliefs, the court can justify compulsory medical treatment based on the avoidance of physical harm.

United States

In the USA, the Free Exercise Clause of the First Amendment is relied on by parents when defending their right to refuse blood on their children’s behalf. This defence is rarely successful: the freedom to believe is absolute; the right to act on that belief is not. In American courts there is no doubt: the child’s welfare is paramount.

The Watchtower Society issued the blood product ban in 1945 and the first case concerning a JW child appeared before the US court in
that when parents refuse treatment, any procedure is an
imminent, the court contended that the New York State
courts. Some cases reiterated old decisions; others brought
new decisions, increasing the state’s ability to protect
children by extending the right of protection to the unborn
child and introducing the concept of neglect into JW cases. Declaring
a child neglected under state law allowed
transfusion despite parental objection.

The next important case extended court authorised
transfusion to the possible, rather than the definite, need for blood. Although the child did not require blood
imminently, the court contended that the New York State
Children’s Bill of Rights made it clear that parents no longer
had the right to deny children required medical care and that
“under no circumstances, with or without due process, with
or without religious sanction, may they deprive him of his
life”. Unusually, the judge commented on JW’s beliefs and
clarified that when a child’s right to live and parental
religious beliefs collide, the child’s welfare is paramount.

The first JW case, concerning parental treatment refusal,
commonly used to declare children wards of court in order
to administer blood, and sought a court order to prevent
Washington physicians administering blood to JW patients.
The Supreme Court was clear in its upholding of the decision in Prince explaining, “the right to practice religion freely
does not include liberty to expose…the child…to ill health or
death.”

The majority (with the exception of one) of subsequent
cases have maintained the trend, reiterating the views of
earlier cases and emphasising three main points:

- The child’s interests and those of the state outweigh
parental rights to refuse medical treatment
- Parental rights do not give parents life and death authority
over their children
- Parents do not have an absolute right to refuse medical
treatment for their children based on their religious
beliefs.

United Kingdom

Well established in British law, is the fundamental principle
that every person’s body is inviolate. Traditionally, under
British law, while regarding the child’s welfare as
paramount, courts respect parental wishes concerning children’s
medical treatment. Parents have the right and the duty to
give proxy consent, where required, for a minor. Some argue
that when parents refuse treatment, any procedure is an
assault on the child. However, as parental rights and duties
are not absolute, existing only for the child’s best interests, the
court, ultimately, has overriding control.

Established in 1875, the prevailing law in British jurisprudence regarding parental treatment refusal on religious
grounds remains unchallenged: parents who fail to obtain medical treatment for their children, are subject to
criminal liability even if their refusal is religiously based. In contrast to the USA, there are only three JW cases in the UK
contesting the well established legal opinion on parental
treatment refusal. In all three cases (Re O, Re S, Re R),
permission for transfusion was granted, confirming the
judicial opinion of the US courts: the child’s interests are paramount. The court did stress, however, that although the
child’s welfare is paramount, consideration would be given to
parental beliefs, particularly when the situation was not
imminently life threatening.

Australia

Australian courts adopt a similar view: the child’s welfare is paramount. Every Australian jurisdiction has legislation permitting certain medical treatments, including blood
transfusions, without parental consent. Unfortunately, inconsistencies in the wording of the legislation makes
interpretation difficult. All four cases appearing before the
New South Wales Supreme Court arose because of the
inconsistent wording. The first case clarified the requirements of the NSW Child (Care and Protection) Act, that
decisions regarding medical treatment of minors must be in
the child’s best interests, that decisions about treatment
urgency rest with the medical profession, and that parens patriae authority may override a parental decision.

The second case sought to clarify whether a transfusion necessary to alleviate “an appreciable risk of serious damage
to the child’s health” equated to “necessary to prevent serious damage to the child’s health” under the NSW Child
(Care and Protection) Act. Unfortunately, the court failed to
consider in any depth the Act’s provisions, leaving it open
to further challenges. In the third case, brought before the courts by a doctor concerned about the detrimental
effect his decision would have on the doctor-patient relationship, the doctor was criticised for wasting the court’s time.
The court, however, recognised that parental awareness of the
Act’s provisions was important, particularly when despite religious objections, the parents are happy to obey
the law.

Most recently, the court reiterated the necessity for courts
to override parental objections if the child is at risk. While respecting parental wishes regarding blood products as much
as possible, the judge concluded that because the child’s
welfare is paramount, doctors can administer blood when necessary.

ADOLESCENT JEHOVAH’S WITNESSES

The rights of adolescents to refuse medical treatment vary
throughout the world and this judicial inconsistency creates
confusion among healthcare workers. In England and Wales, mature minors may consent to, but not refuse, treatment,
with the courts using the “best interests” test to override the
opinions of adolescents. In Scotland, although the Age of
Legal Capacity (Scotland) Act does not specifically refer to
treatment refusal, the inference is that a child deemed
competent could refuse, as well as consent to, treatment.
In North America, the situation for mature minors is state/
province dependent.

United Kingdom

The legal position with regard to mature minors remains ambiguous. In 1969, the Family Law Reform Act set the age
of consent for medical treatment at 16 but did not specifically
deal with parental-child conflict. The implication, however, is
that a child’s consent to a procedure overrides parental opinion. If refusing treatment, however, parents (and indeed the Court) in England and Wales may override the child. In Scotland, this is less likely to happen.

In a child under 16, four main issues arise: (1) the child’s capacity to consent to treatment; (2) parental authority and its limitations; (3) whose view prevails when parents and children clash; and (4) the extent of the courts’ powers over adolescents. Gillick v West Norfolk & King’s Lynn CC considered the first three issues, with the majority of the House of Lords holding that, if a child under 16 could demonstrate sufficient understanding and intelligence to understand fully the treatment proposed they could give their consent to treatment.70 If they failed this competence test, parental consent is required. Unfortunately, treatment refusal was not considered. However, this case did specify the limitations of parental rights: “parental rights are derived from parental duty...exist only so long as they are needed for the protection of...the child”.71

The logical inference from Gillick is that competent children are competent to both accept and refuse treatment; yet subsequent decisions suggest a child’s refusal may be overridden by a proxy’s consent to that treatment and that the child’s refusal, while important, may not be conclusive.72

Re R73 sought to clarify a minor’s right to refuse treatment. However, by emphasising that, unlike adults who are presumed competent, minors must prove their competence;74 and by suggesting that as both parents and children were keyholders to the door of consent, parental consent would be sufficient in circumstances of disagreement, the court undermined the Children Act 1989, which sought to enable mature minors to make medical decisions.75 Additionally, Lord Donaldson made it clear that the court, in addition to parents, could override a minor’s decision.76 Essentially this case disempowered minors with regards treatment refusal. Re W77 confirmed the courts ability to override parents, children, and doctors when performing its protective functions, but imposed limits on the power to overrule, with the judge stating that this power should only be exercised if “the child’s welfare is threatened by a serious and imminent risk that the child will suffer grave and irreversible mental or physical harm”.78 All three cases concerning adolescent JWs refusing blood73–75 reinforce the decisions made in Re R73 and Re W.77

The initial test of the “Gillick competence” concept came in Re E.74 With parental support, a JW aged 15¾ refused the blood transfusions associated with conventional leukaemia treatment. Court approval was sought to treat him. His parents argued that his wishes should be respected, as he was nearly 16, at which point his consent would be required.79 In a carefully reasoned judgment, the judge overrode both the child and his parents, deeming the child not “Gillick competent”.77

Ward J recognised not only the distinction between knowing the fact of death and fully appreciating the death process, but also the absence of freedom in a teenager “conditioned by the very powerful expressions of faith to which all members of the creed adhere”.79 Confirming wardship and authorising treatment for the welfare of the child,79 he concluded that although parents may martyr themselves, the “court should be very slow to allow an infant to martyr himself”.79

Re S70 presented the court with a further opportunity to clarify the question of minors and treatment refusal. Influenced by her mother, S had been attending regular JW meetings and decided that she no longer wanted the blood transfusions necessary to treat her thalassemia major. Court intervention was requested and after careful consideration the judge declared S not “Gillick competent”.77 Despite an outward portrayal of confidence, S lacked the maturity of many girls of her age, had led a sheltered life, and showed a lack of understanding about her disease, the mode of death,70 and the seriousness of her decision (believing in miracles and not understanding that transfusion refusal would certainly result in death).71 The court should therefore authorise treatment in her best interests.

In Re L72 the decision was much easier. The young JW had serious burns and it was impossible to explain to her the severity of her injuries or the unpleasant nature of her death73 which would occur without vital blood products. The court deemed her Gillick incompetent because, despite the sincerity of her religious beliefs, she was only 14 and had limited life experience.

Logically, the Gillick competence concept should ability to both consent to and refusal of treatment. Nevertheless, under English and Welsh law, minors have no absolute right to refuse medical treatment.72 In the cases described above, the courts concluded that although the minors showed some evidence of maturity and understanding, they lacked sufficient understanding and experience to refuse treatment offering a high probability of success at a relatively low risk. Where treatment refusal was religion based, there was concern about the child’s freedom of choice in the context of a religious upbringing in addition to concerns about whether the child fully grasped the implications of treatment refusal. Thus, while a child’s refusal should be considered, it is likely that the court will override the refusal in the child’s best interests.79

Canada

Canadian cases involving adolescent JWs fall into two categories: those supporting the rights of adolescents to refuse medical treatment, and those refusing the suggestion that adolescents are mature enough to make life or death decisions.

Pre-1996, the majority of cases supported the concept of adolescent JWs making medical treatment decisions. In 1985,74 the judge, believing that the emotional trauma of receiving unwanted blood products would have a negative effect on the child’s treatment and having determined that her parents had arranged suitable treatment elsewhere, refused to declare the child neglected75 or sanction an unwanted transfusion. In 1993, the Newfoundland Family Court reached a similar decision,76 declaring that blood was not essential,77 that the child was a minor with a sincerely held belief78 and that a holistic approach to treatment was important.

Although the New Brunswick Court of Appeal’s79 decision supported adolescents in their decision making capacity, based on several important facts—(1) Canadian common law allows mature minors to consent to their own treatment; (2) Section 3 of the Medical Consent of Minors Act is determinative if two medical practitioners declare the child mature; and (3) unlike the UK, the Medical Consent of Minors Act allows mature minors to refuse treatment—no other decisions since have supported this view.

While earlier Canadian cases supported the notion of adolescent autonomy, cases since 199679–82 support the English view that adolescents lack the maturity to refuse life saving treatment. The Ontario Court79 recognised that forcing a child to accept blood products against her religious belief was indeed an infringement of her freedom of religion. However, in the court’s opinion, legislation that existed to protect minors reasonably justified limiting a child’s freedom of religion. All three cases, as in the UK, accept that the child’s opinion should be considered, but reiterate the point that the court can override the decisions of both children and their parents.
United States

Traditionally, US minors have no legal rights and remain under parental jurisdiction until they reach the age of majority. Over the past century, however, legislation has altered this, allowing minors to obtain treatment for specific conditions without parental consent and in some states, make medical treatment decisions. Unfortunately, the inconsistency of legal decisions regarding adolescent JWs is clearly evident in the USA.

Although not recognised by the US Supreme Court, some states have a “mature minor” doctrine, which allows some minors to consent to medical treatment without parental consent. In Pennsylvania and Illinois, minors have legally recognised this doctrine, with the Illinois Supreme Court recognising that minors have a common law right to refuse medical treatment and determining that, although Supreme Court judgements were lacking, individual judges could determine “whether a minor is mature enough to make health care choices.” Unfortunately for adolescent JWs, the court qualified this right, noting that it was not absolute and had to be balanced against state interests. Additionally, in circumstances of parental-child conflict, parental wishes might override the child’s decision.

Other states recognise the existence of a “mature minors” doctrine but will not act on it. Instead, they adopt the English court’s approach declaring adolescent JW’s immature and allowing the court to determine of reasonable sanctions and consequences of refusing treatment. The most recent case Confuses the issue further as the Massachusetts Appeals court granted minors the right to determine their own medical treatment. Placing emphasis on the evaluation of a minor’s maturity, the court directed judges to consider a minor’s wishes and religious convictions and to receive the testimony of minors. Unfortunately, only three states use the mature minor exception to consent to or refuse specific medical treatment, and the majority of adolescents rely on parental decision-making.

CONCLUSION

With regard to religious based refusal of blood products by parents, courts in the western world are of the opinion that the child’s welfare is paramount and blood can be given. Consideration should be given to parental views and treatment moderated where possible but if conflict occurs, the child’s interests always come first. Regarding adolescents, there is no worldwide consensus on the legal position of adolescents refusing blood transfusions, but recent cases suggest that the UK’s approach is probably the most acceptable. While many children raised in JW communities may never experience the “outside world”, the judiciary would be wrong not to give them that opportunity. Religion is a powerful persuading voice, but it is also an individual belief. A limited life experience cannot truly give one the opportunity to rationalise a belief that may eventually lead to death.

Competing interests: none declared

REFERENCES AND NOTES

5 Anon. The Watchtower, 1 July 1951, page 415: “A patient in hospital may be fed through the mouth, through the nose or through the veins. When sugar solutions are given intravenously, it is called intravenous feeding. So the hospital’s own terminology recognizes as feeding the process of putting nutrition into one’s system via the veins. Hence the attendant administering the transfusion is feeding the patient blood through the veins, and the patient receiving it is eating through his veins.”
9 CYPA 1933, s(1) and (2)(a) but liability here is not as a parent but as a person over 16 having the “custody, charge, or care” of a child under 16.
12 Prince v Massachusetts (1944) 321 US 158.
13 Ibid at 170.
14 In re Eric B. 235 Cal. Rptr. 22, 24–27 (Cal. Ct. App. 1987) ruling that despite absence of actual harm, threat of harm if child was not periodically monitored for cancer was sufficient to permit juvenile court’s jurisdiction to order monitoring.
15 In re McCuskey, 565, N.E.2d 411 (Mass. 1991) (ruling that best interests of child, coupled with state’s strong interest in securing a life-saving blood transfusion, outweighed parents’ constitutional objections); State v Perricone, 181 A.2d 751 (N.J. 1962), cert. denied, 357 U.S. 890 (1962) (holding court-ordered blood transfusion did not violate parents’ constitutional rights of religion or parental autonomy when the child’s life was in danger); Wallace in Labrenz, 104 N.E 2d 769 (Ill. 1952), cert. denied, 344 US 824 (1952) finding that when parents refuse medical treatment for their child, the lack of which will almost certainly cause death or, at best, lifelong mental impairment, the child is neglected and the court may order the necessary treatment without violating the parents’ constitutional rights); Morrison v State, 222 SW 2d 97 (Mo. 1949) (holding that state has power to preserve a child’s life and health when medical treatment is as necessary for the child’s survival as is food); Commonwealth in Cottom, 616 A.2d 988, 1000 (Pa. Super. Ct. 1992) (ruling that in criminal cases against defendant parents over death of children due to neglect, validity and sincerity of religious beliefs of defendants and children are not relevant to issues presented at trial for failing in legal duty to provide for children, resulting in starvation death of son and severe malnutrition of daughter).
16 US Constitution amendment 1: “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof.”
19 People ex rel. Wallace et al. v. Labrenz et al., 104 N.E 2d 769 (Ill 1952).
20 Ibid at 772: “We feel that we would be breaking God’s commandment, also destroying the baby’s life for future, not only this life, in case the baby should die and breaks the commandment, not only destroys our family but also the baby’s chances for future life. We feel it is more important than this life.”
21 Ibid at 773.
23 Ibid at 101–2.
26 Santos in Goldstein 227 N.Y. S.2d 450 (NY 1962). “The parents, because of religious convictions, refused to give consent to a blood transfusion, which may have been required given the nature of the surgery.”
27 “Neglected” within the meaning of section 2 (subd. [17], par. [a]) of the New York City Domestic Relations Court Act. The court stressed that the parents were not negligent in any other way.
28 In re Clark 185 N.E.2d 128 (OH C. of Com. P1., Div. Of Dom. Rel. 1962) Ploy in State 79 So. 2d 684 (Fla. 1952) holding that state has power to preserve a child’s life and health when medical treatment is as necessary for the child’s survival as is food; Commonwealth in Cottom, 616 A.2d 988, 1000 (Pa. Super. Ct. 1992) (ruling that in criminal cases against defendant parents over death of children due to neglect, validity and sincerity of religious beliefs of defendants and children are not relevant to issues presented at trial for failing in legal duty to provide for children, resulting in starvation death of son and severe malnutrition of daughter).

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which some are outside his ability fully to grasp their implications. Impressed as I am by his obvious intelligence, by his calm discussion of the implications, by his assertion that he would refuse knowledge that he may as a result, in my judgement (he does not have a full understanding of the whole implication of what the refusal of that treatment involves’.

78 Supra note 74 at 394E: ‘‘I have to take account of the fact that teenagers often express views with vehemence and conviction—all the vehemence and conviction of youth…remember the convictions we have loudly proclaimed which we now find somewhat embarrassing’’.

79 Supra note 74 at 394E: ‘‘I find it essential for his well-being to protect him from himself and his parents’…

80 Ibid. ‘‘There were a lot of things that concerned me, the patness of her replies, some of her phrases. She and her mother were using exactly similar phraseology. [I] was not able to explain her thoughts except that, ‘it was said in the Bible’. She had no understanding of the manner in which she might die.’’

81 Ibid at 615: ‘‘She does not understand the full implications of what will happen. It does not seem to me that her capacity is commensurate with the gravity of the decision which she has made. It seems to me 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.’’


83 BRB v JB [1968] 2 All ER 1023 at 1025D Lord Denning MR: ‘‘…the views of the child should be taken into consideration; but the child’s views are never decisive’’.

84 Re LDK, Children’s Aid Society of Metropolitan Toronto v K and K [1985] 48 RFL (2d) 164, 23 CRR 337.

85 Defined by the Child Welfare Act RSO 1980 c. 6, s. 19 sub-clause (ix): ‘‘a child where the person in whose charge the child is neglects or refuses to provide or obtain proper medical, surgical or other recognized remedial care or treatment necessary to save the child’s health or well-being, or refuses to permit such care or treatment to be supplied to the child when it is recommended by a legally qualified medical practitioner, or otherwise fails to protect the child adequately’’.


87 Ibid as per Wells J: ‘‘I am not satisfied that in this particular case that the use of blood products as a follow up to the chemotherapy is considered essential by the qualified medical practitioner from whom I have heard, and in whom I have every confidence’’.

88 Ibid as per Wells J: ‘‘I am satisfied that he believes, with all his heart, that to take blood would be wrong, and that to be forced to take blood in the circumstances about which we are speaking, would be an invasion of his body, an invasion of his privacy, and an invasion of his whole being, to the extent that it would impact severely on his strength and ability to cope with the dreadful ordeal that he has to undergo, whatever the outcome’’.


90 The Medical Consent of Minors Act was enacted in 1976. New Brunswick is the only province that has enacted the Act.

91 H (T) v Children’s Aid Society of Metropolitan Toronto [1996] 138 DLR (4th) 144 (sub nom. Children’s Aid Society of Metropolitan Toronto v H) 9 OTC 274, 37 OR (2d) 270.


93 Alberta (Director of Child Welfare) v H (8), 2002 ABPC 39, [2002] 11 WWR 752, 6 Alta LR (4th) 34, 31 RFL (5th) 16.


99 In re EC 549 N.E.2d 322 at 328 (Ill. 1989).

100 Namely: preserving life, protecting third parties, preventing suicide and protecting the medical profession.


102 Novak v Cobb County-Keneston Hospital 584 P.2d 1559 (NDGA 1978).

103 If Child was unaware of the relevance of the medical passages, stated several times that a court-ordered transfusion absolved him of responsibility, and classified himself as a child.

104 In re Reno 705 N.E. 2d 1155 (Mass. 1999).

105 Code § 117(1) stating: ‘‘(1) the patient’s expressed preferences, if any; (2) the patient’s religious convictions, if any; (3) the impact the patient’s family; (4) the probability of adverse side effects from the treatment; (5) the prognosis without treatment; and (6) the present and future incompetence of the patient in making that decision’’.

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