



PROJECT MUSE®

---

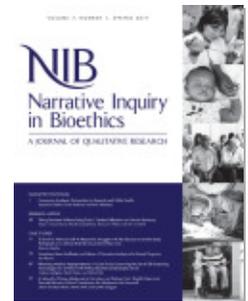
A Jehovah's Witness Adolescent in the Labor and Delivery  
Unit: Should Patient and Parental Refusals of Blood  
Transfusions for Adolescents Be Honored?

Johan Christiaan Bester, Martin Smith, Cynthia Griggins

Narrative Inquiry in Bioethics, Volume 7, Number 1, Spring 2017, pp. 97-106  
(Article)

Published by Johns Hopkins University Press

DOI: <https://doi.org/10.1353/nib.2017.0022>



➔ *For additional information about this article*

<https://muse.jhu.edu/article/664728>

# A Jehovah's Witness Adolescent in the Labor and Delivery Unit: Should Patient and Parental Refusals of Blood Transfusions for Adolescents Be Honored?

Johan Christiaan Bester<sup>\*\*</sup>, Martin Smith<sup>†</sup>, and Cynthia Griggins<sup>\*\*</sup>

<sup>†</sup>Cleveland Clinic—Department of Bioethics

<sup>\*\*</sup>University Hospitals—Clinical Ethics Service

\*Correspondence concerning this article should be addressed to Johan Christiaan Bester, MBChB, MPhil, PhD. Cleveland Clinic—Department of Bioethics, 9500 Euclid Avenue, JJ60 Department of Bioethics, Cleveland, OH 44195–5243.

jcbester@gmail.com

**Conflicts of Interest.** The authors declare no conflicts of interest.

**Abstract.** A 15-year-old was admitted to the labor and delivery unit for induction of a 41-week-gestation pregnancy. Her parents, members of Jehovah's Witnesses, and the patient, who had been studying the religion but had not yet been baptized, were adamant that no blood transfusions would be accepted even if a life-threatening hemorrhage were to occur. In our analysis, we examine the underlying ethical conflict and issues raised by this case. We considered two important ethical questions in analyzing the dilemma: first, whether adolescents are capable of providing autonomous and authentic refusals for lifesaving interventions; and second, whether parents can refuse such interventions for their adolescent children based on their religious beliefs. We provided justifications for not considering the adolescent's refusal as autonomous and for overruling the parental refusal, concluding that there was ethical support for providing potentially lifesaving transfusions should they become clinically indicated. We also suggested strategies to avoid blood loss and the need for transfusions in order to respect the stated values and preferences of the patient and her family to the greatest degree possible. In order to protect the privacy of the patient and her family, details in this case have been changed and no identifiable information has been used.

**Keywords.** Best Interests, Blood Transfusions, Jehovah's Witnesses, Principlism, Religious Conflict

## The Case

Chloe, a 15-year-old girl, was admitted to the labor and delivery unit for induction of a 41-week-gestation uncomplicated pregnancy. Although the pregnancy was unintended and the father of the baby, a boy of similar age, was no longer involved in her life, Chloe had come to accept the pregnancy and had the support of her parents, who were involved

in her care and decision-making and were readily available at her bedside.

During the admission process, the clinical team learned that Chloe and both of her parents were Jehovah's Witnesses. In accordance with their beliefs, Chloe and her parents were adamant that no blood transfusions should be given under any circumstances. Although Chloe had been receiving prenatal care, the issue of her and her parents'

religious beliefs was raised for the first time at this admission.

The clinicians in labor and delivery were distressed about performing an induction and delivery if blood transfusions were prohibited from the outset. Consequently, they requested guidance from the ethics consultation service (ECS). Medical team members acknowledged that the likelihood of Chloe needing a blood transfusion was low, but that it could not be ruled out. There is always a small risk of a major bleed during delivery, and in such circumstances blood transfusions would be standard care and would likely be lifesaving. On further questioning, the medical team related that they had no concerns over the need for transfusion to protect the life of the fetus, and felt that the baby would be delivered normally and without complication even if a blood transfusion were necessary to save Chloe's life.

Although Chloe's parents were at her bedside, they did not object to her being interviewed alone. Chloe presented as an articulate teenager who appeared to be of average maturity and intelligence. She had no settled plans for her future, she enjoyed school, and she was an average student. She had been "studying" the Jehovah's Witness religion for a few years, and had begun to embrace its doctrines, but she did not feel ready to be baptized. She demonstrated a basic understanding of the religious prohibition against accepting blood transfusions: that is, that believers who accept blood cannot be admitted to "the Kingdom of God" (Heaven). Although Chloe understood that refusal of emergency transfusion could lead to death, she stated that she would not change her mind about receiving blood even if in some way it could be kept confidential. She felt that her parents supported her, and that she could count on their continued support.

Chloe's parents were interviewed separately and were adamant that they would not consent to a blood transfusion for Chloe, even if it would save her life. They explained that blood transfusions are strictly forbidden in their religion, that those who accept transfusions cannot be admitted to "the Kingdom of God," and that they would never subject their daughter to such a spiritual fate. They

were appropriately concerned for the well-being of their daughter and of her unborn baby, stating their intention to provide ongoing support and care for both and that they would look after the child if anything were to happen to Chloe.

The primary and immediate question for which the medical team sought advice from the ECS was whether Chloe and her parents' refusal of blood should be respected if an emergency, lifesaving blood transfusion became necessary during the course of her delivery and care.

### **The Jehovah's Witnesses and Blood**

The Jehovah's Witnesses interpret specific biblical passages prohibiting the ingestion of blood to be an injunction against receiving blood transfusions (Smith, 2004). Accordingly, receiving a blood transfusion is a grievous sin and has profound religious implications. There are nuances in how this injunction is interpreted, and some latitude is given to believers: for example, in the receipt of fractionated blood products (Smith, 2004). However, it was clear that Chloe and her parents adhered to a strict interpretation of the prohibition against receiving blood, in order to avoid what they saw as a spiritual fate worse than physical death.

### **Ethical Analysis**

In the context of the primary question that the clinical team addressed to the ECS, there were three subquestions to be considered. First, what was the underlying ethical dilemma in this case? Second, might Chloe have sufficient decision-making capacity (DMC) to make this specific decision (refusal of blood transfusions) such that her decision could be viewed as autonomous, authentic, and authoritative, and thus be respected? Third, if Chloe were not considered to have sufficient DMC, could her parents refuse a blood transfusion on her behalf? After addressing these three questions in this discussion, we will advance and justify our recommendations. We considered this case using a principle-based approach (Beauchamp & Childress, 2013), meaning

that we would ground and weigh values in relation to well-known bioethical principles.

Although our focus will be on ethical analysis, we will also reflect on the question of whether any helpful legal precedent exists to guide action or assist with deliberation.

### What is the underlying ethical dilemma?

A clinical ethics dilemma occurs when values are in conflict with one another, thus directing an individual health care professional or a clinical team to follow conflicting and mutually exclusive courses of action. Because a choice must be made about a course of action, and because different courses of action favor one value over another, one of the conflicting values must be given up, at least to some extent. To resolve such a dilemma, one must identify the underlying values in conflict, carefully weigh the justifications for each, and choose a course of action that minimizes value loss. In true dilemmas, it is impossible to uphold all values equally, and stakeholders may experience moral regret when they cannot identify an option that accomplishes this.

In the case of Chloe, we could readily identify two values that were in conflict with one another. The first value was the clinical team's commitment to patient well-being. Chloe's care providers had a *prima facie* obligation to provide treatment to her that optimally promoted her welfare. Another way this can be stated is that treatment options should be favored that provide the most net benefit over harms, or that promote Chloe's best interests. These values are based in the principles of beneficence and non-maleficence, a combination of obligations that directs care providers to offer options that provide benefit and limit harms to the greatest extent possible.

When considering a potential blood transfusion and the clinical team's commitment to Chloe's welfare, the following factors were relevant. Chloe was an otherwise healthy young girl, with a pregnancy that had thus far not had any complications. However, even normal deliveries can be complicated by serious hemorrhage. While uncommon, the

consequences are significant enough that providers conducting deliveries are vigilant and ready to activate an emergency hemorrhage protocol in case of a massive bleed (Santoso, Saunders, & Grosshart, 2005). Management of serious hemorrhages may necessitate, as a standard of care, the use of blood products to restore oxygen-carrying capacity and treat or prevent clotting disorders such as disseminated intravascular coagulation (DIC) (Santoso et al., 2005). Consequently, in cases in which hemorrhage leads to loss of substantial amounts of blood, the use of blood products can be lifesaving, and withholding blood products can lead to serious harm and even death. There is always a small risk of complications from blood transfusions (e.g., contracting blood-borne diseases such as hepatitis and human immunodeficiency virus), but with contemporary blood screening practices this risk is significantly diminished (Santoso et al., 2005). Beneficence and non-maleficence would direct the clinical team to give blood transfusions as needed to prevent serious harm.

The second value at stake in a case like Chloe's is a clinical team's obligation to respect patients as persons, which includes respecting their self-determination by honoring their expressed wishes and values. This is usually (but not exclusively) put into practice by respecting the choices of individuals who have sufficient DMC to make the specific health care decisions at hand. This value is grounded in the principle of autonomy. Individuals should be viewed as being sovereign over their bodies and lives, and care providers have the obligation to respect the autonomous choices of individuals with DMC.

The ethical dilemma can therefore be stated as a conflict between the clinical team's commitment to Chloe's welfare and their commitment to honoring her and her parents' expressed wishes and values. Before we could deliberate about which course of action was most justifiable, we first had to answer the two other questions we raised: Was Chloe capable of providing an autonomous, authentic, and authoritative refusal of blood transfusions? And, if not, should parental refusal be respected? The answers to these two questions were critically

important in assigning relative weight to the values in conflict.

*Could Chloe's refusal be considered an autonomous decision?*

To make autonomous choices, a person must have DMC. Generally, four cognitive abilities must be demonstrated before someone is thought to have DMC for a specific decision (Appelbaum, 2007): (1) understanding of information relevant to the choice; (2) reasoning with the disclosed information and one's values; (3) appreciation of the situation and consequences of the decision to one's life; and (4) ability to make a choice and communicate it.

Another important consideration is that DMC is not all-or-nothing, but rather decision-specific, and is assessed on a continuum or a sliding scale, depending on the decision at hand (Appelbaum, 2007; Drane, 1985). Accordingly, a person may have DMC for some simpler decisions with less serious consequences, yet lack DMC for more complicated decisions with life-or-death consequences. Familiarity with the condition and the intervention, the frequency and duration of the treatment, and the benefits and burdens involved may also contribute to the complexity of the decision. From this perspective, refusal of a lifesaving medical intervention that has a high likelihood of success would require demonstration of a higher level of DMC than refusal of interventions that have a significant likelihood of harm with small likelihood of benefit (e.g., some phase 1 research protocols) (Appelbaum, 2007; Drane, 1985).

Given this understanding of decision-making, the following question emerged: Could Chloe make an autonomous decision regarding the blood transfusion? That is, could an adolescent like her demonstrate the DMC to decide to accept or refuse a highly successful lifesaving treatment?

Children develop cognitive sophistication as they age, including cognitive capacities to engage in at least some medical decision-making as they grow older (Buchanan & Brock, 1990; Diekema, 2011a; Harrison, Kenny, Sidarous, & Rowell, 1997). Some

authors have specifically argued that adolescents (ages 14 to 17) have cognitive abilities similar to those of adults and can therefore have sufficient DMC to make many or most of their own health care decisions (Buchanan & Brock, 1990; Diekema, 2011a; Harrison et al., 1997). Consequently, it is argued that a case can be made for including adolescents in the decision-making process, and considering at least some health care decisions made by adolescents to be autonomous (Appelbaum, 2007; Diekema, 2011a; Drane, 1985). This recognition of adolescents' emerging DMC is reflected in both research and clinical settings. Researchers are now required to obtain adolescents' assent in order for them to participate in clinical trials, meaning that the teen's veto would be honored, even if the parents wished their son or daughter to participate. In clinical settings, mature teens are often allowed to make medical decisions that are less risky or that carry less serious consequences. An adolescent might even be allowed to refuse a lifesaving intervention under certain circumstances (for example, if there is a low likelihood of success, if the patient has extensive experience with the treatment and no longer wants it, or if it requires repeated administrations and thus his or her sustained cooperation).

However, when the decisions are complex or carry serious consequences, questions are often raised about adolescents' ability to make their choices independently. Diekema (2011a) advances an argument that adolescent refusals of lifesaving treatment should not be seen as autonomous. He asserts that adolescent decision-making capacities are still in development; even though cognitive structures for decision-making exist, adolescents do not utilize these abilities in the same way as adults. Diekema cites evidence in this regard, noting that various neurological structures needed for fully mature decision-making are still in development during adolescence, with a resultant imbalance between emotional and cognitive areas of the brain. This leaves adolescents more vulnerable to engaging in risky behaviors, not necessarily because of reasoning deficits, but because they weigh risks, rewards, and emotions differently from adults. With immature executive function and limitations

in considering future consequences, they are prone to impulsivity and are more susceptible to peer pressure (Diekema, 2011a).

Indeed, adolescence is characterized by continuing brain development, a period of transition toward mature and autonomous behavior, during which adolescents are prone to making risky and immature decisions (Christakou, 2014). Adolescents, then, do have an emerging DMC, justifying their involvement in decisions regarding their health care. However, in situations in which stakes are high or pressure from peers, family, or friends exists, the DMC of adolescents may be overwhelmed and seriously compromised (Christakou, 2014).

We thus are left with significant doubts as to whether adolescents can meet Appelbaum's criteria for decision-making capacity at a high level, and autonomously refuse lifesaving interventions in most cases. The adolescent brain is developing, and adolescents in all likelihood are unable to employ their cognitive decision-making abilities in the same way as adults. We are not convinced that adolescents can attain the high threshold for decision-making required to refuse likely lifesaving interventions, and we agree with Diekema when he writes: "In most situations, adolescents should not be allowed to refuse treatment that is likely to be lifesaving, even when supported by a parent" (2011a, p.223).

These considerations lead us to present the following framework. Adolescents below the age of majority should generally be presumed to lack decision-making capacity for refusal of lifesaving treatments, unless sufficient evidence exists to rebut this presumption. That is, unless an adolescent is assessed as clearly having the required DMC to refuse such treatment, he or she should be considered unable to provide an autonomous refusal.

Returning to Chloe, she appeared to be an average 15-year-old with the cognitive and emotional capacities expected of someone her age. She had no settled plans for her future, underlining the degree to which she was still establishing her identity and refining her values, as is typical for younger adolescents. There was no clear evidence known to

the medical team to rebut the presumption that she lacked the necessary DMC to provide an autonomous refusal of a lifesaving treatment.

There was also an additional concern. The DMC of adolescents may, as we have referenced above, be overwhelmed by pressure from peers or family members. Chloe's parents were strongly insisting that no blood transfusion should be given, and Chloe was raised in a cultural and communal context that views blood transfusions as forbidden. It was therefore likely that she experienced substantial pressure to agree with her parents and her religious community, and to prioritize the decision that they would consider the right one. At the very least this would represent a substantial swaying influence that might compromise Chloe's DMC. In its worst forms, if there were fears of being ostracized by the community, it could reach the level of coercion. This was yet another reason to doubt that Chloe's decision was sufficiently autonomous.

Given Chloe's adolescence and how her life was situated, and given the high stakes of a refusal of blood transfusion, we doubted that she was able to provide an autonomous refusal of such a lifesaving procedure.

#### *Could Chloe's parents refuse blood transfusions on her behalf?*

When adolescents lack DMC to make autonomous decisions, their parents (or their legally appointed guardians) make decisions on their behalf. There are two relevant standards for ethically supportable guidance as well as limits for parental authority: the best interests standard (Buchanan & Brock, 1990; Diekema, 2011b) and the harm principle (Diekema, 2011b).

The best interests standard requires that parents choose health care options that optimize benefit over harm for their children (Buchanan & Brock, 1990). Therefore, parental decisions not in keeping with their children's best interests should be challenged (Buchanan & Brock, 1990). The best interests standard, which should guide both parents and health care professionals, is grounded in the principles of beneficence and non-maleficence.

Diekema (2011b) argues that the best interest standard does not always provide clear guidance as to whether a parental decision should be overruled. There may be differing conceptions of a child's best interests and conflicting notions of what is "maximal benefit." Instead, Diekema argues that the harm principle should be used as the standard to determine when parental authority should be limited. Simply stated, the state and its agents (and health care professionals) should challenge parental decisions if such decisions will lead to significant harm accruing to the child. Diekema grounds the harm principle in the work of John Stuart Mill: free choices may be interfered with if such choices harm others.

Diekema's harm principle fits within the framework of the principle-based approach, and does not need to be grounded in Mill's Utilitarianism. If a child is at risk of substantial harm, the principles of beneficence and non-maleficence obligate those charged with promoting the welfare of children, such as clinicians and agents of the state, to protect the child from harm. If the risk of harm is high and the nature of the harm severe, this obligation becomes even more compelling, and may overrule other ethical obligations such as respecting parental decision-making authority. Thus, if the risk of harm to a child from a parental decision is very high, the obligations conferred on care providers through beneficence and non-maleficence compel them to protect the child against the harms resulting from such parental decisions.

Chloe's parents' refusal of potential blood transfusions was based on their religious convictions. They considered such a refusal to be in keeping with Chloe's spiritual best interests, because acceptance of blood products is forbidden by their religious community. Voluntarily accepting blood products is seen as sinful by Jehovah's Witnesses, and can lead to loss of eternal life (Woolley, 2005). However, this parental analysis of Chloe's best interests is not universally accepted. The state, Chloe's care providers, and society at large judged Chloe's best interests differently, and in most instances would consider the life-saving benefit from blood transfusions to be in her best interests. When parents and society

have differing conceptions of best interests, parents usually defend their authority by appealing to the right to raise their children as they wish and, as in the case of Chloe, to their religious liberty (Woolley, 2005). But, as stated above, such liberty is limited by the harm principle; if parents make decisions that place their children at risk of serious harm, such decisions should be challenged and overruled (Diekema, 2011b).

In Chloe's case, the benefit from blood transfusions, should they be needed, would be significant, and the harms that would accrue from not having transfusions could be devastating. Foregoing a life-saving blood transfusion cannot on balance pass the tests of best interests and the harm principle. Chloe's parents' refusal of a life-saving blood transfusion on her behalf therefore should not be honored. Parental authority is limited when it leads to choices that are clearly harmful to their children; in Chloe's case her parents were making such a choice. However, as we note below, there might be practical strategies of accommodation that could communicate to Chloe and her parents that their religious beliefs were being taken seriously and not totally disregarded.

Is there a settled legal precedent that provides guidance?

The legal right of adult Jehovah's Witness patients to refuse blood products for themselves is clear; autonomous refusals by competent, informed adults should be respected. But parents cannot make the same choice for their children: when parental refusals of life-sustaining treatment are based on religious beliefs, courts can order compulsory treatment based on the justification of preventing physical harm to the child (Diekema, 2011a; Diekema, 2011b; Woolley, 2005).

By way of legal precedent, courts have ordered blood transfusions in cases in which parents who were Jehovah's Witnesses refused life-sustaining blood transfusions for their children (Woolley, 2005). For example, in the United States, in *People Ex Rel. Wallace v. Labrenz* (1952), the Illinois Supreme Court held that an 8-day-old infant was

a dependent child whose life was endangered by the refusal of her parents to consent to a necessary blood transfusion. Reasoning from *Prince v. Massachusetts* (1944) is quoted in *People Ex Rel. Wallace* as follows: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."

Such precedent cases and conclusions are well established for younger children. But for adolescents such as Chloe, what guidance might a clinical team derive from the law? The legal situation for adolescents who refuse blood transfusions (and whose decisions are supported by their parents) is less clear. Different countries and jurisdictions have treated cases of this nature differently, with some jurisdictions on occasion allowing such refusals and others not (Woolley, 2005). For instance, in a widely publicized case from 2007, Superior Court Judge John Meyer of Skagit County, Washington, allowed 14-year-old Dennis Lindberg to refuse blood transfusions based on his religious beliefs (Diekema, 2011a; Tu, 2007). In other cases, courts have overruled adolescent and/or parental refusals of blood transfusions based on religious beliefs (Spike, 2011; Woolley, 2005).

Some states recognize a "mature minor" doctrine according to which minors can be allowed to make decisions about their health and welfare, if they can demonstrate that they are mature and able enough to make such decisions independently (Spike, 2011; Woolley, 2005; "Mature-Minor Doctrine Law," 2016). However, courts have qualified the mature minor doctrine, stating that it is not absolute and must be balanced against state interests, such as that of preserving life (Woolley, 2005). The mature minor doctrine did not provide clear guidance in Chloe's case, however, because the state in which she was hospitalized and resided does not have a mature minor law.

We conclude that there are no settled legal precedents for adolescent Jehovah's Witness patients who refuse blood transfusions, and that we could not look for clear guidance to the law in Chloe's case.

Should a transfusion be mandated in the interests of an unborn child?

We do not consider this question as central to our ethical analysis. The medical team caring for Chloe judged that non-transfusion during or after delivery would not pose substantial risks of physical harm to her baby. Furthermore, Chloe's parents indicated that they would raise and care for the baby should Chloe die or experience a significant and permanent disability such that she could not care for her child. The unborn baby was therefore not at risk of physical harm, and sufficient parenting arrangements were in place. The interests of the unborn child therefore were not as central as the other ethical questions we have explored. The legal case of *Fosmire v. Nicoleau* (*Fosmire v. Nicoleau*, 1989; *Matter of Fosmire v. Nicoleau*, 1990) supports this conclusion. In this case it was judged that transfusions cannot be forced on a Jehovah's Witness woman after delivery, even in the interests of her newborn. Even though the *Fosmire v. Nicoleau* case involved an adult Jehovah's Witness while our case involves an adolescent, it provides some legal guidance that the interests of the newborn should not be a determining factor in deciding whether to give or to withhold a blood transfusion.

## Conclusion

The ethical dilemma in the case of Chloe involves a conflict between a commitment to patient welfare and a commitment to respecting patient and parental values. In principle-based terms, it can be seen as a conflict between beneficence and non-maleficence on the one hand, and autonomy and parental authority on the other. We summarize the ethical arguments and analysis provided above in Table 1.

If blood transfusions were clinically indicated, they would likely be lifesaving interventions that would confer significant benefit while preventing serious harm. This fact provided ethical justification for giving priority to Chloe's welfare. The benefit from blood transfusions is so high, and the harm avoided so severe, that beneficence and non-maleficence should be seen as carrying significant ethical weight.

## Table 1

### Summary of ethical analysis of the case

---

1. The benefit/burden ratio of blood transfusions strongly supports using transfusions as needed. The benefits of transfusions (saving Chloe's life) outweigh the risks of transfusion. Foregoing transfusions could potentially lead to significant harm (death).
  2. The potential consequences of the specific decision (death) set the bar high for assessing decision-making capacity (DMC).
  3. Adults can refuse treatments, including those that are lifesaving, provided that they are adequately informed and have sufficient DMC.
  4. Adolescents should be involved in their own health care decisions, and for some decisions they may have sufficient DMC. But assessments of DMC should take into consideration the fact that most adolescents have limited executive functioning, judgment, and ability to appreciate consequences; they are also more susceptible to peer and family pressure and emotionality. For decisions with serious and significant consequences, most adolescents are unlikely to have sufficient DMC.
  5. When adolescents are considered to have insufficient DMC to provide an autonomous decision, parents (or guardians) assume decision-making for these patients. In accordance with the harm principle, parents should not be allowed to refuse likely beneficial treatments when refusal will result in significant harms for adolescents.
- 

Furthermore, we are persuaded that the arguments for respecting patient and parental autonomy are less compelling. While acknowledging individual case particularities, we believe that there should be a presumption that adolescents generally lack DMC to provide autonomous refusals of lifesaving interventions. Also, parental authority is limited by the welfare of the adolescent, in keeping with the best interests standard and the harm principle. These considerations are reasons for giving lower priority to the set of values in the conflict related to patient autonomy and parental authority than to the saving of a life and protection from harm. From a legal perspective, courts have not been sufficiently consistent regarding Jehovah's Witness adolescents to be able to provide definitive conclusions and guidance.

We therefore recommended that the balance of reasons favored giving blood transfusions should they be clinically indicated. We were not convinced that Chloe could make an autonomous refusal, and Chloe's parents' refusal violated the harm principle. Given the extremely high stakes of this decision and of the consequences should a massive hemorrhage occur, we recommended that Chloe's refusal

of blood products not be honored should there be bleeding that required lifesaving transfusions. Based on the importance of truth-telling and transparency in provider-patient relationships, we also recommended that Chloe and her parents should be informed ahead of time that despite efforts to accommodate their beliefs, in a life-threatening situation their wishes would not be honored.

From a clinical management perspective, there are interventions that could minimize blood loss and the need for blood products. These interventions include limiting phlebotomies or using pediatric needles for blood draws, perioperative blood conservation techniques, and the use of non-blood volume expanders if clinically appropriate (Smith, 2004; Watch Tower Bible and Tract Society, 2002). Such interventions would have the potential of communicating to Chloe and her parents that the clinical team, within the limits of their ethical responsibilities to promote Chloe's physical well-being, wanted to be as respectful as possible of the family's religious beliefs.

In cases that involve Jehovah's Witness patients, such clinical management techniques may be

useful. Further, care providers should remember that persons can have varying degrees of commitment to religious doctrines, and because Jehovah's Witness leaders leave some decisions to individual judgment, care providers should explore with individual patients their limits and desires for specific interventions (Smith, 2004). Finally, many Jehovah's Witness congregations and circuits have Hospital Liaison Committees whose goals include providing guidance, based on peer-reviewed published literature, about alternative medical methods that could obviate the need for blood transfusions. Such a committee might be able to assist patients who are Jehovah's Witnesses and their care providers with decision-making around the use of blood products.

Another clinical consideration would be exploring with the medical team whether induction of labor was immediately necessary, or whether there were other options with a lower risk of hemorrhage and need for blood transfusion. However, a decision to delay induction might not have necessarily resolved the ethical question; for example, if Chloe went into labor spontaneously, there would be some risk for a major bleed and the question of a transfusion would still be raised. Settling the ethical analysis as we have done above therefore remained important, even if a decision were to be made to delay induction and wait for spontaneous labor.

As with any true ethical dilemma, there is always value loss and the possibility of subsequent moral regret. In this case the value lost was the honoring of the expressed wishes and preferences of Chloe and her parents. We believe, however, that this course of action would be ethically preferable over the alternative in this case. In the end, we have found the duty arising from beneficence and non-maleficence compelling, and the uncertainties surrounding an autonomous refusal and the limits of parental authority insufficient to supersede this duty.

### Reflection Questions

1) The authors have defended a principle that it should generally be presumed that adolescents lack the necessary decision-making capacity to provide autonomous refusals for life-saving treatments,

unless convincing evidence to rebut this presumption is present. Do you agree with this principle, and if so, why? What would count as convincing evidence? If not, what reasons can you provide for dismissing this principle?

2) In the article a threshold is described for parental decision-making. Beyond that threshold, it is the duty of clinicians to challenge the parental decision, and the duty of the state to overrule the parental decision. Do you agree that the threshold to overrule parental decision-making was reached in this case? Why or why not? What might have changed your view?

3) Different jurisdictions have reached different conclusions in cases regarding the authority of adolescents to refuse life-saving treatments. States also have different stances on the "mature minor" rule. How does the neurodevelopment and cognitive development evidence the authors briefly discuss in the article influence your thinking on these issues, and specifically on whether states should have a "mature minor" rule and how they should interpret and apply it?

### References

- Appelbaum, P. S. (2007). Assessment of patients' competence to consent to treatment. *New England Journal of Medicine*, 357(18), 1834-1840.
- Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press.
- Buchanan, A. E., & Brock, D. W. (1990). *Deciding for others*. Cambridge, UK: Cambridge University Press.
- Christakou, A. (2014). Present simple and continuous: Emergence of self-regulation and contextual sophistication in adolescent decision-making. *Neuropsychologia*, 65, 302-312.
- Diekema, D. S. (2011a). Adolescent refusal of lifesaving treatment: Are we asking the right questions? *Adolescent Medicine: State of the Art Reviews*, 22(2), 213-228, viii.
- Diekema, D. S. (2011b). Revisiting the best interest standard: Uses and misuses. *Journal of Clinical Ethics*, 22(2), 128-133.
- Drane, J. F. (1985). The many faces of competency. *The Hastings Center Report*, 15(2), 17-21.

- Fosmire v. Nicoleau, 144 A.D.2d 8 (1989).
- Harrison, C., Kenny, N. P., Sidarous, M., & Rowell, M. (1997). Bioethics for clinicians: 9. Involving children in medical decisions. *Canadian Medical Association Journal*, 156(6), 825–828.
- Matter of Fosmire v. Nicoleau, 75 N.Y.2d 218 (1990).
- Mature-minor doctrine law & legal definition. (2016). Retrieved from <http://definitions.uslegal.com/m/mature-minor-doctrine/>
- People ex rel. Wallace v. Labrenz, 104 N.E.2d 769 (Ill. 1952).
- Prince v. Massachusetts, 321 U.S. 158, 170 (1944).
- Santoso, J. T., Saunders, B. A., & Grosshart, K. (2005). Massive blood loss and transfusion in obstetrics and gynecology. *Obstetrical and Gynecological Survey*, 60(12), 827–837.
- Smith, M. (2004). Jehovah's Witness refusal of blood products. In S. Post (Ed.), *Encyclopedia of bioethics* (3rd ed.) (pp. 1341–1346). Farmington Hills, MI: Macmillan Reference.
- Spike, J. P. (2011). When ethics consultation and courts collide: A case of compelled treatment of a mature minor. *Narrative Inquiry in Bioethics*, 1(2), 123–131.
- Tu, J. I. (2007, November 30). Are teens old enough for life/death decisions? *The Seattle Times*. Retrieved from <http://www.seattletimes.com/seattle-news/health/are-teens-old-enough-for-life-death-decisions/>
- Watch Tower Bible and Tract Society. (2002). *Clinical strategies for avoiding and controlling hemorrhage and anemia without blood transfusions in obstetrics and gynecology*.
- Woolley, S. (2005). Children of Jehovah's Witnesses and adolescent Jehovah's Witnesses: What are their rights? *Archives of Disease in Childhood*, 90(7), 715–719.