

ETHICS

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

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Arch Dis Child 2005;90:715-719. doi: 10.1136/adc.2004.067843

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.

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 fit⁶ and religious freedom.⁷ 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.⁸ Parental rights to raise children are qualified by a duty to ensure their health, safety, and wellbeing.⁹ Parents cannot make decisions that may permanently harm or otherwise impair their healthy development.^{10 11}

If treatment refusal results in a child suffering, parents may be criminally liable.⁹ 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*¹² 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..."¹³

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 treatment¹⁴ based on the avoidance of physical harm.¹⁵

United States

In the USA, the Free Exercise Clause of the First Amendment¹⁶ is relied on by parents when defending their right to refuse blood on their children's behalf. This defence is rarely successful:¹⁷ the freedom to believe is absolute; the right to act on that belief is not.¹⁸ 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

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.¹ The most rapidly growing religious organisation in the western world,² there are approximately 5 500 000 committed, baptised members,³ 125 000 of whom reside in the United Kingdom.⁴ 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,⁵ 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 excommunication.

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Accepted 18 January 2005

1951.¹⁹ The parents of a child with erythroblastosis fetalis refused to authorise a blood transfusion, adamant in their beliefs that God's law prohibited blood.²⁰ An initial court petition granted custody to the probation service, who gave consent for a transfusion. In the public's interest, the Illinois Supreme Court granted a hearing of the parents' appeal, and although recognising that "freedom of religion and the right of parents to the care and training of their children are to be accorded the highest possible respect in our basic scheme",²¹ the court upheld its view in *Prince*.¹²

In 1952, the matter was clarified further.²² Justifying compulsory blood transfusion based on four points—(1) minimal danger, (2) treatment efficacy, (3) lack of alternative treatments, and (4) based on religious beliefs—adults cannot choose to be responsible for the death of their children and, declaring no interest in Biblical interpretation, the court stated clearly that, if parental religious beliefs placed a child's life in danger then the state could intervene to protect the child.²³

Theoretically this case should have ended any discussion regarding the parental ability to refuse blood on their children's behalf, but cases continued to appear before the courts. Some cases reiterated old decisions;²⁴ others brought new decisions, increasing the state's ability to protect children by extending the right of protection to the unborn child²⁵ and introducing the concept of neglect into JW cases.²⁶ Declaring a child neglected under state law²⁷ allowed transfusion despite parental objection.

The next important case extended court authorised transfusion to the possible, rather than the definite, need for blood.²⁸ 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".²⁹ Unusually, the judge commented on JW's beliefs²⁹ 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,³⁰ concerning parental treatment refusal, to reach the US Supreme Court, challenged two statutes³¹ 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*¹² explaining, "the right to practice religion freely does not include liberty to expose...the child...to ill health or death".³²

The majority (with the exception of one³³) of subsequent cases³⁴⁻⁴¹ 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 treatment⁴²
- Parental rights do not give parents life and death authority over their children^{12 42}
- Parents do not have an *absolute* right to refuse medical treatment for their children based on their religious beliefs.^{12 43}

United Kingdom

Well established in British law, is the fundamental principle that every person's body is inviolate.⁴⁴ Traditionally, under British law, while regarding the child's welfare as paramount,⁴⁵ courts respect parental wishes concerning children's medical treatment.⁴⁶ Parents have the right *and the duty* to give proxy consent, where required, for a minor.⁴⁷ Some argue that when parents refuse treatment, any procedure is an assault on the child.⁴⁸ However, as parental rights and duties

are not absolute,⁴⁹ existing only for the child's best interests,⁵⁰ the court, ultimately, has overriding control.⁴⁵

Established in 1875,⁵¹ 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*,⁵² *Re S*,⁵³ *Re R*⁵⁴), 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,⁵⁵ without parental consent.⁵⁶ Unfortunately, inconsistencies in the wording of the legislation,⁵⁷ makes interpretation difficult. All four cases appearing before the New South Wales Supreme Court arose because of the inconsistent wording. The first case⁵⁸ 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 case⁵⁹ 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,⁶⁰ 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.⁶¹ 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 Act⁶² 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*⁶³ 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.⁶³ If they failed this competency 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".⁶⁴

The logical inference from *Gillick*⁶³ is that competent children are competent to both accept and refuse treatment; yet subsequent decisions^{65 66} suggest that 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.⁶⁶

*Re R*⁶⁷ 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,⁶⁸ and by suggesting that as both parents and children were keyholders to the door of consent,⁶⁹ 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.⁷⁰ Additionally, Lord Donaldson made it clear that the court, in addition to parents, could override a minor's decision.⁷¹ Essentially this case disempowered minors with regards treatment refusal.

*Re W*⁶⁶ 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".⁷² All three cases concerning adolescent JWs refusing blood⁷³⁻⁷⁵ reinforce the decisions made in *Re R*⁶⁷ and *Re W*.⁶⁶

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.⁷⁶ 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 teenager⁷⁸ "conditioned by the very powerful expressions of faith to which all members of the creed adhere".⁷⁴ 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".⁷⁴

*Re S*⁷³ 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 thalassaemia major. Court intervention was requested and after careful consideration the judge declared S not "Gillick competent".⁷³ Despite an

outward portrayal of confidence,⁷³ 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,⁸⁰ and the seriousness of her decision (believing in miracles and not understanding that transfusion refusal would certainly result in death).⁸¹ The court should therefore authorise treatment *in her best interests*.

In *Re L*⁷⁵ 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 death⁷⁵ 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 apply to both consent to and refusal of treatment. Nevertheless, under English and Welsh law, minors have no absolute right to refuse medical treatment.⁸² 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.⁸³

Canada

Canadian cases involving adolescent JWs fall into two categories: those supporting the rights of adolescents to refuse medical treatment, and those refuting 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 1985,⁸⁴ 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 neglected⁸⁵ or sanction an unwanted transfusion. In 1993, the Newfoundland Family Court reached a similar decision,⁸⁶ declaring that blood was not essential,⁸⁷ that the child was a mature minor with a sincerely held belief,⁸⁸ and that a holistic approach to treatment was important.

Although the New Brunswick Court of Appeal's⁸⁹ 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 Act⁹⁰ 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 1996⁹¹⁻⁹³ support the English view that adolescents lack the maturity to refuse life saving treatment. The Ontario Court⁹¹ 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 rights⁹⁴ 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 consent⁹⁵⁻⁹⁶ and, in some states, make medical treatment decisions.⁹⁷ Unfortunately, the inconsistency of legal decisions regarding adolescent JW's 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.⁹⁸ Courts in Pennsylvania⁹⁹ and Illinois have legally recognised this doctrine, with the Illinois Supreme Court⁹⁹ 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".⁹⁹ Unfortunately for adolescent JW's, the court qualified this right, noting that it was not absolute and had to be balanced against state interests.¹⁰⁰ 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.¹⁰¹⁻¹⁰² Instead, they adopt the English court's approach declaring adolescent JW's immature and lacking in understanding of religious beliefs and the consequences of refusing treatment.¹⁰³ The most recent case confuses the issue further as the Massachusetts Appeals court granted minors the right to determine their own medical treatment.¹⁰⁴ 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.¹⁰⁵ Unfortunately, only three states¹⁰⁶ 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

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- 43 *Jacobson v Massachusetts* 197 U.S. 11 (1905).
- 44 *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 72E as per Lord Goff.
- 45 *In Re B (A Minor)(Wardship: Medical Treatment)* 1 WLR 1421 (1981).
- 46 *Re Z (A Minor) (Identification: Restrictions on Publication)* [1997] Fam 1, 32 as per Johnson J: "I would for my part accept without reservation that the decision of a devoted and responsible parent should be treated with respect. It should certainly not be disregarded or lightly set aside."
- 47 *Gillick v West Norfolk AHA* [1986] 1 AC 12 at 184G as per Lord Scarman.
- 48 *Re R (A Minor)(Wardship: Consent to Treatment)* [1992] Fam. 11 at 22 as per Lord Donaldson of Lymington MR.
- 49 "...the common law has never treated such rights as sovereign or beyond review and control". *Gillick v West Norfolk AHA* [1986] 1 AC 112 at 184A as per Lord Scarman.
- 50 *J v C* [1970] AC 668.
- 51 *The Queen v Robert Downes* (1875–1876) LR 1 QBD 25 Crown Cases Reserved. This case reversed a previous decision made in *The Queen v Wagstaffe* 10 Cox. Crim. Cas. 530 (1868) where the jury returned a not guilty verdict on parents who had allowed their child to die from a treatable illness because they were members of the "Peculiar People" who did not believe in conventional medical therapy. This case was responsible for the "Poor Law Amendment" which mandated the administration of conventional medical therapy for children whose health was imperilled, irrespective of religious beliefs.
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- 53 *Re S (A Minor) (Medical Treatment)* [1993] 1 FLR 376.
- 54 *Re R (A Minor) (Blood Transfusion)* [1993] 2 FCR 544.
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- 56 **Western Australia:** Human Tissue and Transplant Act 1982 section 21; **Queensland:** Transplantation and Anatomy Act 1979 section 20; **Tasmania:** Human Tissue Act 1985 section 21; **Victoria:** Human Tissue Act 1982 section 24; **Australian Capital Territory:** Transplantation and Anatomy Act 1978 section 23; **Northern Territory:** Emergency Medical Operations Act 1973 sections 2 and 3; **South Australia:** Consent to Medical and Dental Procedures Act 1985 sections 6(2), (3), (5), (6); **New South Wales:** Children (Care and Protection) Act 1987 section 20A.
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- 59 *Dalton v Skuthorpe* (unreported decision of Supreme Court of New South Wales, 17 Nov. 1992, No. 5094 of 1992).
- 60 *Marchant v Finney* (unreported decision of Supreme Court of New South Wales, 31 July 1992, No. 3599 of 1992).
- 61 Director General, Department of Community Services Plaintiff and BB Defendants [1999] NSWSC 1169 (19 November 1999).
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- 64 *Ibid* at 420.
- 65 *Re R (A Minor) (Wardship: Consent to Medical Treatment)* [1992] Fam. 11.
- 66 *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam. 64.
- 67 *Re R (A Minor) (Wardship: Medical Treatment)* [1991] 4 All ER 177.
- 68 *Ibid* at 187E by demonstrating "a full understanding and appreciation of the consequences, both of the treatment in terms of intended and possible side effects, and equally important, the anticipated consequences of a failure to treat".
- 69 *Ibid* at 246F: "There can be concurrent powers to consent. If more than one body or person has a power of consent, only a failure to, or refusal of, consent by all having that power will create a veto".
- 70 Family Law, All ER Annual Review, 176, 178–179 (1991).
- 71 **Fennell P, et al.** *Medical Law*, All ER Annual Review 230 at 235 (1991).
- 72 *Supra* note 66 at 94.
- 73 *Re S (A Minor) (Wardship: Medical Treatment)* [1994] 2 FLR 1065.
- 74 *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.
- 75 *Re L (Medical Treatment: Gillick Competence)* [1999] 2 FCR 524, [1998] 2 FLR 810.
- 76 Under the Family Law Reform Act 1969.
- 77 *Supra* note 74 "He is a boy of sufficient intelligence to be able to take decisions about his own well-being, but...there is a range of decisions of 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 well knowing that he may die 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 394F: "...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. [S] 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."
- 82 **Harper RS.** *Medical treatment and the law. The protection of adults and minors in the family division.* Bristol: Family Law, Jordan Publishing Limited, 1999:88.
- 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. 66, 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 for 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".
- 86 *Re Y.(A.)* (1993) 111 Nfld. & PEIR 91, 348 APR 91.
- 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."
- 89 *Walker (Litigation Guardian of) v Region 2 Hospital Corp.* (1994) 4 RFL (4th) 321, 116 DLR (4th) 477, 150 NBR (2d) 366, 385 APR 366.
- 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 TH*) 9 OTC 274, 37 CRR (2d) 270.
- 92 *U (C.) (Next Friend of) v Alberta (Director of Child Welfare)*, 2000 ABQB 626, [2001] 3 WWR 575, 273 AR 106, 87 Alta LR (3d) 144, 3 WWR 575, [2000] AJ No. 1067.
- 93 *Alberta (Director of Child Welfare) v H (B)*, 2002 ABPC 39, [2002] 11 WWR 752, 6 Alta LR (4th) 34, 31 RFL (5th) 16.
- 94 **Hawkins SD.** *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes.* *Fordham Law Review* 1996;64:2075–6.
- 95 *Planned Parenthood v Danforth* 428 US 52 (1976).
- 96 **Felsman JP.** *Eliminating parental consent and notification for adolescent HIV testing: a legitimate statutory response to the AIDS epidemic.* *JL & Pol'y* 1996;5:339.
- 97 **Batterman N.** *Under age: a minors right to consent to health care.* *Tourola Rev* 1994;10:637.
- 98 Ark. Stat. Ann. § 20-9-602(7)(Michie 1991); Nev. Rev. Stat. § 129.030(2) (1991).
- 99 *In re EG* 549 N.E.2d 322 at 328 (Ill. 1989).
- 100 Namely: preserving life, protecting third parties, preventing suicide and protecting the medical profession.
- 101 *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (Sup. Ct. 1990).
- 102 *Novak v Cob-County-Kennestone Hospital* 849F Supp 1559 (NDGA 1994).
- 103 *Ibid* Child was unaware of the relevant Biblical passages, stated several times that a court-ordered transfusion absolved him of responsibility, and classed himself as a child.
- 104 *In re Rena* 705 N.E. 2d 1155 (Mass. 1999).
- 105 *Ibid* at 1157 (stating "(1) the patient's expressed preferences, if any; (2) the patient's religious convictions, if any; (3) the impact on 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 incompetency of the patient in making that decision").
- 106 *In re EG* 549 N.E.2d 322 at 328 (Ill. 1989), *Belcher v Charleston Area Med. Ctr.*, 422 S.E.2d 827 (W. Va. 1992) and W. VA. CODE § 16-30C-6 (1998); *Cardwell v Bechtol* 724 S.W.2d 739 (Tenn. 1987).



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

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Arch Dis Child 2005 90: 715-719
doi: 10.1136/adc.2004.067843

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