CHAPTER 44

Blood Transfusions, Jehovah’s Witnesses, and the American Patients’ Rights Movement

Charles H. Baron
Boston College Law School, Newton Centre, MA, USA

As de Tocqueville observed in the mid-nineteenth century, the United States has been a fertile ground for the growth of an “innumerable multitude” of religious sects. America was founded and settled in great part by persons who were seeking religious freedom in the new world, which had been denied to them in the old world. The constitutions of the 50 states generally protect such religious freedom. And the first article of the Bill of Rights of the Constitution of the United States provides that “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof....” This language has been interpreted, among other things, to protect all religious beliefs from discriminatory governmental interference.

Thus, in theory at least, American law—as well as American history and tradition—encourages individuals and groups to seek after their spiritual well-being in accordance with the creed of their choice.

One of America’s most flourishing religious groups is the Watchtower Bible and Tract Society—commonly known as “Jehovah’s Witnesses.” Born in the early 1870s as a Christian Bible study group in western Pennsylvania, it has grown into a worldwide organization comprising over four million adherents in over 200 countries. A central tenet of the group is a commitment to the Bible as the word of God (Jehovah) representing literal truth. Members of the group devote a great deal of effort to bringing the word of the Bible to nonmembers. In the United States, they distribute literature from house to house and in public places. Because of these proselytizing activities and because their beliefs and practices they are sometimes perceived as disturbingly different from those of the majority (if not harmful); governmental agencies have often tried to regulate them in ways that were contrary to their beliefs. As a result, Witnesses have been involved in a great deal of constitutional litigation in the United States—much of it is before the

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1 This paper is an updated English version of two articles that have previously been published in French: Baron, C., Sang Peché et Mort: les Témoins de Jéhovah et le mouvement des droits des malades, in Revue Trimestrielle du ressort de la Cour d’Appel de Versailles, Octobre-Décembre 1993, p. 93, and Baron, C., Aspects relatifs au mouvement des droits des malades aux États-Unis in S. Gromb & A. Garay (eds.), CONSENTEMENT ÉCLAIRÉ ET TRANSFUSION SANGUINE (1996), p. 30.


3 See, for example, Church of the Lukumi Babalu Aye v. City of Hialeah, 508 U.S. 520 (1997) (holding unconstitutional a city’s ban on “ritual slaughter” of animals that was intended to discriminate against the Santeria religion which engaged in such practices).
Jehovah’s Witnesses, and Rights Movement

Supreme Court of the United States. Indeed, more American constitutional law may have been made by Jehovah’s Witnesses than by any other group. Among the beliefs that set Witnesses apart from most other Americans is their conviction that the Bible forbids them to accept blood transfusions—even to save their lives—because it would constitute the sin of “eating blood.” The line of thought that results in this conviction comprises two steps. First, Witnesses read the Bible as prohibiting Christians, as well as Jews, from eating blood. Second, they believe “eating blood” includes not only ingestion by mouth but also ingestion by other means—including blood transfusions.

There are, of course, scriptural provisions regarding the eating of blood that apply only to Jews. At Leviticus 17:10–12, for example, God says to Moses:

As for any man of the house of Israel or some alien resident who is residing as an alien in their midst who eats any sort of blood, I shall certainly set my face against the soul that is eating the blood, and I shall indeed cut him off from among his people, for the soul of the flesh is in its blood, and I myself have put upon the altar for you to make atonement for your souls, because it is the blood that makes atonement by the soul in it. That is why I have said to the sons of Israel: “No soul of you must eat blood and no alien resident who is residing as an alien in your midst should eat blood.”

This provision is part of God’s special covenant with Israel, and therefore, applies only to Jews. But the ban on eating blood, the Witnesses point out, antedates Mosaic Law. At Genesis 9:1–4, God says to Noah:

Be fruitful and become many and fill the earth. And a fear of you and a terror of you will continue upon every living creature of the earth and upon every flying creature of the heavens, upon everything that goes moving on the ground, and upon all the fishes of the sea. Into your hand they are now given. Every moving animal that is alive may serve as food for you. As in the case of green vegetation, I do give it all to you. Only the flesh with its soul—its blood—you must not eat.

This ban predates the covenant with Israel and is universal. God’s ban on eating blood is thus binding on everyone who worships him. It is not contingent upon acceptance of the covenant with Israel, and it applies to Christians as well as Jews.

Further scriptural authority for this is provided by Acts 15:28–29. There the first council of the new Christian church, in response to a question as to whether converts to Christianity were to be circumcised according to Mosaic Law, replies:

[T]he Holy Spirit and we ourselves have favored adding no further burden to you, except these necessary things, to keep abstaining from things sacrificed to idols and from blood and from things strangled and from fornication. If you carefully keep yourselves from these things, you will prosper.

For the Witnesses, it is clear that God has commanded all his people to abstain from eating blood. And if eating blood is wrong because it is wrong to nourish one’s self with the soul of another living being, they contend, how can it matter if the nourishment comes by way of one’s mouth or by way of a transfusion directly into one’s veins? Of course the Bible does not speak of blood transfusions because there was no thought of them at the time. But the principle is the same. “[T]he decree that Christians must ‘abstain from blood’ . . . covers the taking of blood into the body, whether through the mouth or directly into the bloodstream.”

After World War II, this part of the belief structure of Jehovah’s Witnesses began increasingly to come into direct conflict with the belief structure of modern medicine. Until then, doctors and surgeons had not regularly availed themselves of blood transfusions. A Frenchman—Jean Baptiste Denis—is credited with having performed the first

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4 Between 1919 and 1988, the Supreme Court of the United States heard 71 cases in which the sect’s practices raised important questions of federal substantive or constitutional law. In 47 of them, the Court ruled in favor of the Jehovah’s Witnesses.

5 For other authority to the same effect, see Watchtower Bible and Tract Society, Jehovah’s Witnesses and the Question of Blood. 1977, pp. 10–17.

successful blood transfusion in 1667.\(^7\) (It was “successful” in that the 15-year-old boy whom he transfused with a half pint of lamb’s blood did not die.) But the foundations of modern transfusion science were not laid until the early 1900s when the four basic blood type groupings were identified.\(^8\) And it was not until several decades later, after other scientific advances had been made and “the concept of blood banks was introduced and the exigencies of World War II stimulated the investigation of methods for blood preservation, that blood became readily available and blood transfusion became popular.”\(^9\) Not until that point did modern medicine begin to believe that blood transfusions were essentially benign and that refusal of blood, when “medically necessary,” was an irrational act.

The best-known early American court case acting out the conflict between the beliefs of modern medicine and those of Jehovah’s Witnesses is Application of the President and Directors of Georgetown College, Inc.\(^10\) Mrs. Jesse Jones, a 25-year-old mother of a 7-year-old child, had been brought by her husband to the emergency room of the Georgetown Hospital in the District of Columbia. She had lost two-thirds of her body’s blood supply from a ruptured ulcer. The doctors who took charge of her case believed that she had a very good chance of survival with a blood transfusion but that she would die without one. Mr. and Mrs. Jones were Jehovah’s Witnesses. They were eager to have the doctors treat Mrs. Jones, but they would not consent to a blood transfusion. The doctors considered this behavior to be medically irrational and wanted to override the Jones’ refusal in order to save Mrs. Jones’ life. They sought a court order allowing them to do so.

Judge J. Skelly Wright, a highly respected federal appeals court judge, gave them the order they wanted. A lower court judge had refused their request, and counsel for the hospital, a very famous and able attorney by the name of Edward Bennett Williams, had immediately appealed to Judge Wright, asking him for an emergency order to keep the patient alive—at least until the case could be fully heard on its merits. Several months after granting this order, Judge Wright filed an opinion in which he attempted to justify the emergency action he had taken. In it he cites two nineteenth century US Supreme Court decisions which state, in dictum, that First Amendment “free exercise” of religion guarantees do not prevent the government from making religiously-inspired suicide attempts illegal.\(^11\) However, as Judge Wright himself notes, District of Columbia law did not make attempted suicide illegal and Mrs. Jones did not want to kill herself. He also argues that, because she had a 7-year-old child, Mrs. Jones could be forced to stay alive since “[t]he state as parens patriae will not allow a parent to abandon a child.”\(^12\) However, no statutes or legal precedents could be pointed to suggesting that a parent’s medical treatment decisions could be overruled on the ground that they placed a child at risk of abandonment. As a “third set of considerations,” Judge Wright pointed to “the position of the doctors and the hospital. Mrs. Jones was their responsibility to treat. The hospital doctors had the choice of administering the proper treatment or letting Mrs. Jones die in the hospital bed, thus exposing themselves, and the hospital, to the risk of civil and criminal liability in either case.”\(^13\) However, as is pointed out in a later opinion by one of Judge Wright’s fellow judges, Mr. and Mrs. Jones had both “volunteered to sign a waiver to relieve the hospital of any liability for the consequences of failure to effect the transfusion.”\(^14\)

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\(^9\) Wintrobe M. Clinical Hematology, 8th edn., 1981.
\(^10\) 331 F. 2d 1000 (D.C. Cir. 1964) (hereinafter “Georgetown I.”).
\(^11\) Late Corporation of the Church of Later Day Saints v. United States (Romney v. United States), 136 U.S. 1, 49–50 (1890); Reynolds v. United States, 98 U.S. (8 Otto) 145, 166 (1878). The facts of the cases did not involve suicide. They involved state laws prohibiting the practice of religiously-inspired polygamy.
\(^12\) Georgetown I, p.1008.
\(^13\) Georgetown I, p. 1009.
\(^14\) Application of the President and Directors of Georgetown College, Inc., 331 F. 2d 1010, 1013–16 (D.C. Cir. 1964) (hereinafter “Georgetown II.”).
Jehovah’s Witnesses, and Rights Movement

The real basis for Justice Wright’s opinion seems to be that, like the doctors involved, he found the Jones’ position hard to understand and irrational—Mrs. Jones’ life was being thrown away for no good reason. At one point, he suggests that “Mrs. Jones was in extremis and hardly composit mentis at the time in question: she was as little able competently to decide for herself as any child would be.” At other points, he raises the possibility that the Jones really wanted someone else to make the decision for them—thus relieving them of their religious obligation.

Finally, he describes a confrontation between Mr. Jones and representatives of the hospital in terms that suggest that he felt the latter were being forced to deal with some naive person who simply did not understand the modern world:

The President of Georgetown University, Father Bunn, appeared and pleaded with Mr. Jones to authorize the hospital to save his wife’s life with a blood transfusion. Mr. Jones replied that the Scriptures say that we should not drink blood, and consequently his religion prohibited transfusions. The doctors explained to Mr. Jones that a blood transfusion is totally different from drinking blood in that the blood physically goes into a different part and through a different process in the body. Mr. Jones was unmoved.

Despite all its problems, the Georgetown decision came to wield an extraordinary influence in American law. The flaws are evident: No counsel was present to argue the Jones’ side of the case. (Although Judge Wright had advised Mr. Jones to seek counsel, he had declined to do so.) Judge Wright himself admitted that the case’s emergency circumstances required that he decide it in great haste. And several of Judge Wright’s colleagues, when a petition for rehearing was filed a month later, took the opportunity to write opinions critical of what he had done and the reasons he gave for doing it.

That the case has been so influential despite all this may have something to do with the eminence of the judge and the lawyer involved in it. But it probably has more to do with the fact that the decision seemed to provide legal endorsement to the growing hegemony of the medical profession in American society. Counsel for the Joneses on their petition for a rehearing had argued: “The precedent created here is a threat to so many other persons that judicial substitution of medical discretion for individual discretion should be examined in principle to see where it is leading.” When the court denied the petition for rehearing, its decision could be read as saying for all intents and purposes: “Doctors know best, and doctor’s orders (at least when life may be at risk) are to be followed.”

In the wake of the decision, other courts made themselves available to order Jehovah’s Witnesses to submit to blood transfusions.

15 Georgetown I, p. 1008.
16 Georgetown I, pp. 1007, 1009.
17 Georgetown I, p. 1007.
18 Georgetown II, pp. 1010–1018.

In fact, as the court points out, its denial of the petition for rehearing was not meant to suggest any position on the merits of Judge Wright’s decision. Georgetown II, p. 1010.

19 Georgetown II, p. 1013.
21 Compare In Re Brooks’ Estate, 32 Ill. 2d 537 (1964).
In 1976, with the celebrated decision of In Re Quinlan it might have appeared that the plight of Witness patients who refused blood transfusions had been ameliorated. In that case, the Supreme Court of New Jersey recognized the right of Karen Quinlan, a young woman in a persistent vegetative state, to “die with dignity.” The court allowed her family to have her removed from life support despite the unwillingness of her physician to agree to such a measure. The court based its decision upon the unwritten constitutional “right to privacy” which the US Supreme Court had developed in a series of cases—most prominently, the recent abortion rights case, Roe v. Wade.

Presumably,” said the court, “this right is broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman’s decision to terminate pregnancy under certain conditions.” On the surface, the Quinlan decision seemed a great victory for patient’s rights. But a close reading of the opinion revealed that the decision was not as great a victory for patients as it had seemed—and that it was not victory at all for Jehovah’s Witnesses refusing blood transfusions.

In its opinion, the Quinlan court made clear that the right to refuse treatment was not absolute. Two important state interests could outweigh it in appropriate cases. The first was the state’s interest in preserving human life. This interest was not strong enough to outweigh the right to choose death in the case before the court because Karen Quinlan’s life prospects were so poor and because the medical treatment being forced upon her was so invasive. But where such prospects were better or the treatment being recommended was less intrusive, treatment might still be forced on a patient. The second important interest of the state was that of protecting the professional ethics and discretion of the medical profession. That interest was not strong enough to outweigh the right to choose death in Karen’s case because it was not clear that the medical profession as a whole opposed allowing people in Karen’s condition to refuse treatment. Karen’s physician had said that he was opposed, but many doctors, if not all, were in favor of having patients in a persistent vegetative state removed from life support. And what made some doctors refuse, as Karen’s physician had, was fear of legal liability. By its decision in Quinlan, the court was removing that fear as a factor. If a particular patient’s doctor still refused, the court would not force him or her to comply with the patient’s wishes, but it would allow the patient’s family to find another doctor who would comply.

Thus, Quinlan was less a recognition of patient’s rights than of physicians’ rights. Treatment could be refused for Karen Quinlan because such a refusal was not “medically irrational.” However, patients refusing treatment which the medical profession believed to be life-saving and noninvasive could have treatment forced upon them. That this meant no change in the law for Jehovah’s Witnesses who refused blood transfusions was made explicit. A scant 5 years before Quinlan, the Supreme Court of New Jersey had decided in John F. Kennedy Memorial Hospital v. Heston that blood transfusions could be forced upon a Jehovah’s Witness patient even in a case where the patient had no minor children who might be abandoned by her death. The Quinlan court took pains to make clear that Heston was still good law. The Witness cases in general were approved because the medical procedure involved in them (a blood transfusion) “constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good.” And Heston in particular was reaffirmed because it involved “most importantly a patient apparently salvageable to long life and vibrant health—a situation not at all like the present case.”

But if Quinlan did not wreak a revolution for patient’s rights—including those of Jehovah’s Witnesses—it did provide a foundation upon which

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28 70 N.J. at 41, 279 A. 2d at 664.
29 70 N.J. at 39, 279 A. 2d at 663.
such a revolution could be wrought. *Quinlan* had at least recognized patient autonomy as an important right. And its reasoning offered a guide as to how the scope of that right might be expanded. The medical profession and the courts needed to be shown that patient refusal of treatment was not as irrational as it seemed. Even if refusal seemed irrational from the point of view of the medical profession, it was very often, if not always, perfectly rational in terms of the values of the patients involved. And more often than the medical profession and the courts suspected, refusal of treatment was rational from a medical point of view as well.

Since *Quinlan*, the Witnesses have earnestly and persistently worked at establishing their right to refuse blood transfusions by educating the medical profession, the courts, and the public as to the rationality of their views. Education regarding the scriptural basis for their position has, of course, been fundamental—as has education regarding the perceived “invasiveness” of blood transfusions from the point of view of their religious beliefs and the poor spiritual “prognosis” they suffer from having their earthly lives prolonged at the cost of their salvation. (In the words of the family of the patient in one case: “He wants to live in the Bible’s promised new world where life will never end. A few hours here would never compare to everlasting life.”)

However, they have also done a brilliant job of making the case for the medical rationality of their position.

First, they have worked at demonstrating that blood transfusions, from a purely scientific point of view, are not the completely benign treatment modalities they have been thought to be. In this effort, they have been helped, of course, by the advent of the blood-borne scourges of AIDS and Hepatitis B. But as the Witnesses have shown, blood transfusions have always been much riskier than the run-of-the-mill medical practitioner was aware of or was willing to admit. The evidence for this comes entirely from scientific literature—literature which had been largely ignored by the medical profession as a whole. In 1960, an article in one medical journal had warned: “Blood is a dynamite! It can do a great deal of good or a great deal of harm. The mortality from blood transfusion equals that from ether anesthesia or appendectomy. In the London area, there has been reported one death for every 13,000 bottles of blood transfused.”

In addition to the risk of death from hemolytic reactions (due to improper matching of blood types), there are the risks that result from the suppression of the body’s natural immune system caused by a transfusion. And there are the risks of a long list of diseases, in addition to AIDS and hepatitis B that can be carried by transfused blood.

Second, Jehovah’s Witnesses have worked with surgeons and physicians to develop and popularize methods of operating upon and treating patients without using blood transfusions. Not only had the run-of-the-mill physician downplayed the risks of blood transfusions, he had also exaggerated their necessity. For decades, anesthesiologists had, for example, routinely transfused patients preoperatively on the grounds of “medical necessity” whenever the patient’s hemoglobin had gone below 10 g/dL. They believed this practice had a basis in scientific fact. In reality, it had been based upon myth. “The etiology of the requirement that a patient have 10 grams of hemoglobin (Hgb) prior to receiving an anesthetic,” one scientist reported in 1988, “is cloaked in tradition, shrouded in obscurity, and unsubstantiated by clinical or experimental evidence.”

Members of Jehovah’s Witness hospital Liaison Committees, which have been established across the United States (as well as in many other countries, including France), have met with physicians and surgeons, providing them with information that disabuses them of mistaken notions regarding the necessity of transfusions and makes them aware of neglected techniques for treating patients without blood.

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Through the work of their Hospital Liaison Committees, the Witnesses claim to have secured the cooperation of over 13,000 American doctors in treating Witness patients without blood transfusions. Cooperating surgeons have discovered that even heart surgery can be performed without imposing blood transfusions on the grounds of “medical necessity.” The distinguished cardiac surgeon, Michael DeBakey, for example, has reported his experience that “in the great majority of situations [involving Witnesses] the risk of operation without the use of blood transfusions is no greater than in those patients on whom we use blood transfusions.” And the techniques learned with Witness patients are often, then, employed with patients generally. One orthopedic surgeon reports: “What we have learned from those (Witness) patients, we now apply to all our patients that we do total hips on.”

These gains for the Witnesses within the medical community have helped to produce gains for them within the legal system as well. After Quinlan, the development of “right to die” doctrine by American courts began to accelerate. In 1977, the Supreme Judicial Court of Massachusetts, in Superintendent of Belchertown Hospital v. Salkewicz, held that a patient had a constitutional right to refuse chemotherapy for cancer—even if the patient was likely to die significantly sooner without treatment than with it. Like Quinlan, the case involved a situation where the medical community might not have thought that refusal of treatment was “medically irrational.” And like Quinlan, the opinion talked of state interests that could outweigh the patient’s right to refuse treatment, adding to the interests in preserving human life and in protecting the medical profession the additional interests mentioned in Georgetown—preventing suicide and protecting third parties such as minor children. But the tone of the opinion was much more aggressive in asserting the right of patients to exercise their autonomy in medical decision-making. “The constitutional right to privacy, as we conceive it,” said the court at one point, “is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.”

Cases after Salkewicz increasingly emphasized the autonomy of patients and allowed them to refuse a wider range of treatments. Courts gradually moved from allowing refusal only of “extraordinary” or “unnatural” or objectively “intrusive” treatment modalities, to allowing refusal of any sort of treatment the patients felt to be intrusive in their particular case. Courts enforced the rights of patients, not only when they wanted mechanical respiration stopped, but also when they wanted hydration and nutrition stopped. But in one respect, nonetheless, the fact patterns of these cases threw into question the extent to which they were truly endorsing patient autonomy. The cases typically involved patients with a grim prognosis. Most of the patients were terminally ill, living with irreversible and degenerative physical conditions, or in a persistent vegetative state. In contrast to most of the Jehovah’s Witness patients who refuse blood, they were not likely to be, in the words of Quinlan, “a patient apparently salvable to long life and vibrant health.”

It is only recently that courts have begun clearly to demonstrate their commitment to patient autonomy by gradually giving full protection to the right of Witness patients to refuse blood transfusions. Although the courts of most jurisdictions have continued to recognize the possibility that state interests—particularly the state’s interest in protecting minors from abandonment by parents—can outweigh the right of Witnesses to refuse blood

transfusions, it is becoming very rare for courts to find the right actually outweighed in any given case. The highest courts of both Massachusetts\(^\text{39}\) and Florida\(^\text{40}\) have made clear that they will force the state to carry a very heavy burden when it attempts to show that a Witness' right to refuse a blood transfusion should be outweighed by his or her duty to parent minor children. And in 1990, the highest court of one state—New York—rejected wholesale the Georgetown device of employing an obligation to support one's children to restrict patient autonomy. “[W]e know of no law in this state prohibiting individuals from participating in inherently dangerous activities or requiring them to take special safety precautions simply because they have minor children,” said the court. “There is no indication that the State would take a more intrusive role when the risk the parent has assumed involves a very personal choice regarding medical care. On the contrary, the policy of New York, as reflected in the existing law, is to permit all competent adults to make their own personal health care decisions without interference from the State.”\(^\text{41}\)

Even in New Jersey, the Witnesses' efforts at educating the courts and medical profession seem to have turned the law around. In 1992, the Appellate Division of the Superior Court of New Jersey handed down In Re Hughes,\(^\text{42}\) a case involving a Witness patient whose surgeon, despite the patient’s earlier instructions to the contrary, had transfused her when complications arose in surgery. When the patient recovered competency, she sought reversal of a judge's order authorizing the transfusions during the time when she had been incompetent. The Appellate Division affirmed the order, but only on the narrow ground that the record before the judge had left doubt as to what the patient would have wanted under the circumstances. And, in very strong language, the court evidenced an attitude toward the rights of Jehovah’s Witnesses very different from that of Heston and Quinlan. “[A] competent Jehovah’s Witness or person holding like views,” said the court, “has every right to refuse some or all medical treatment, even to the point of sacrificing life... Should a patient decide, with full knowledge of the potential situation, to refuse life-sustaining medical treatment and the patient communicates this decision via clear and convincing oral directives, actions or writings, the patient’s desires should be carried out.”\(^\text{43}\) Unlike the opinions in Heston and Quinlan, the opinion in Hughes is full of language sympathetic to the “rationality” of the Witnesses’ position. This is likely to have been because of the excellent amicus brief filed in the case by the Watchtower Bible and Tract Society. Much of the court’s language was drawn from material contained in that brief.

Since 1993, further progress has been made by the Watchtower Bible and Tract Society in its struggle with American medicine over the issue of whether blood transfusions will be forced upon Jehovah’s Witnesses.

In the Hughes case, the New Jersey court had ultimately decided in favor of the physician-defendant on the ground that, despite Mrs. Hughes’ signing of the hospital’s standard written form for refusal of blood and her oral instructions, the physician had had a reasonable basis for doubting that Mrs. Hughes would have continued to refuse blood if she could have been made aware of the life-threatening emergency that followed her surgery. In an earlier case, Werth v. Taylor,\(^\text{44}\) the Court of Appeals of Michigan had also found in favor of a physician who had been sued under the Hughes circumstances. In that case, the Michigan court had set up what seemed an insurmountable legal hurdle for unconscious Witness patients. “[I]n a situation like the present,” the court said, “where there is an emergency calling for an immediate decision, nothing less than a fully conscious contemporaneous decision by the patient will be sufficient to override


\(^{40}\) Public Health Trust v. Wons, 541 So. 2d 96 ( Fla. 1989).


evidence of medical necessity.” But in Hughes, the New Jersey court had said “Should a patient decide, with full knowledge of the potential situation, to refuse life-sustaining medical treatment and the patient communicates this decision via clear and convincing oral directives, actions, or writings, the patient’s desires should be carried out.”

Counsel for the Watchtower Society responded to the challenge of Hughes by drafting and disseminating advance-directive “writings” which attempt to communicate in “clear and convincing” fashion a refusal of blood transfusions “with full knowledge” of the types of medical emergencies that might arise in the future. Written forms, tailored to conform to the laws of the each of the 51 American jurisdictions, have been made available through the Society’s Hospital Liaison Committees in every state and in the District of Columbia. By means of explicit language in such advance directives, the person executing the document informs all health care personnel:

I am one of Jehovah’s Witnesses. On the basis of my firmly held religious convictions, see Acts 15:28, 29, and on the basis of my desire to avoid the numerous hazards and complications of blood, I absolutely, unequivocally and resolutely refuse homologous blood (another person’s blood) and stored autologous blood (my own stored blood) under any and all circumstances, no matter what my medical condition. This means no whole blood, no red cells, no white cells, no platelets, and no blood plasma no matter what the consequences. Even if health-care providers (doctors, nurses, etc.) believe that only blood transfusion therapy will preserve my life or health, I do not want it. Family, relatives or friends may disagree with my religious beliefs and with my wishes as expressed herein. However, their disagreement is legally and ethically irrelevant because it is my subjective choice that controls. Any such disagreement should in no way be construed as creating ambiguity or doubt about the strength or substance of my wishes.

The person executing this directive also informs all health care personnel that “I accept and request alternative nonblood management to build up or conserve my own blood, to avoid or minimize blood loss, to replace lost circulatory volume, or to stop bleeding. For example, volume expanders such as dextran, saline or Ringer’s solution, or hetastarch would be acceptable to me.”

The person executing the form may also, (by choosing among options offered on the form), make clear to health care personnel whether or not he consents to the use of products containing minor blood fractions or non-stored autologous blood—blood therapies upon which the Society has taken no position and which it has designated “conscience matters.”

A four-page document explaining the use of the advance directive has also been prepared for distribution in each jurisdiction. The informative leaflet which accompanies the combined advance directive/health care proxy designed for use in Massachusetts (whose law authorizes the appointment of a health-care agent or “proxy” to make health-care decisions for an incompetent patient) urges prospective patients to discuss the details of their desires and their advance directives with the person they appoint as their health care agent. It also urges the prospective patient to “discuss with your doctor the same information you discuss with your agent. ... Be sure to discuss in depth the many medical alternatives for bloodless surgery that are available and acceptable to you .... Let your doctor know that you have thoroughly discussed these matters with your agent. (You may even want to introduce your agent to your doctor.) The better your doctor understands you, the less likely it is that problems

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45 190 Mich. App. 141, 475 N.W.2d 426 (1991) at 147, 475 N.W.2d at 429 [emphasis in the original].
Jehovah’s Witnesses, and Rights Movement

will arise.” To further avoid problems stemming from misunderstanding, prospective patients are urged to carry on their person at all times an “Advance Medical Directive/Release” card. “Thus, in the event of an emergency in which you are unconscious, the Advance Medical Directive/Release will identify you as one of Jehovah’s Witnesses, will make known your refusal of blood, and will identify your emergency contacts.” It is also suggested that the emergency contacts be the same people who have been granted health-care agency by means of the health-care proxy.

To the extent that such documents are employed by Jehovah’s Witness patients, one would expect to see continuation of the existing trend toward increasing physician compliance with refusals of blood transfusions. Those physicians who do not comply certainly risk running afoul of another developing trend—the increasing tendency of courts to entertain suits for damages against physicians who force transfusions upon unwilling patients. For example, in the 1994 Ohio case of Perkins v. Lavin, a Witness patient brought an action for damages against her physician for having administered a blood transfusion while she was unconscious. At the time that she had entered the hospital for treatment of postpartum hemorrhaging, she had given the physician oral notice that she was not to be provided any blood or blood derivatives and had signed a form stating: “I REQUEST THAT NO BLOOD OR BLOOD DERIVATIVES BE ADMINISTERED TO [ME] DURING THIS HOSPITALIZATION, NOTWITHSTANDING THAT SUCH TREATMENT MAY BE DEEMED NECESSARY IN THE OPINION OF THE ATTENDING PHYSICIAN OR HIS ASSISTANTS TO PRESERVE LIFE OR PROMOTE RECOVERY. I RELEASE THE ATTENDING PHYSICIAN, HIS ASSISTANTS, THE HOSPITAL AND ITS PERSONNEL FROM ANY RESPONSIBILITY WHATSOEVER FOR ANY UNTOWARD RESULTS DUE TO MY REFUSAL TO PERMIT THE USE OF BLOOD OR ITS DERIVATIVES.” Nonetheless, the doctor had transfused her to save her life when her blood count dropped dramatically as a result of surgical complications. When the patient brought suit for money damages based upon theories of assault and battery and intentional infliction of emotional distress, the physician defended himself on the ground that he had not intended to inflict personal injury on the plaintiff. Rather, he claimed, he had intended merely to preserve plaintiff’s health and life and had, in fact, done so. The court held for the defendant as to the claim for intentional infliction of emotional distress on the ground that defendant’s behavior did not rise to the level of “outrageousness” required to make out a claim under that theory. However, as to the assault and battery claim, the court reversed a lower court finding for defendant, stating:

In arguing that it cannot be held liable for assault and battery if it did not intend to “inflict personal injury,” defendant has misapprehended the gist of the tort of battery. Battery not only protects individuals from harmful contact, but protects them from any offensive contact.

“a harmful or offensive contact with a person resulting from an act intended to cause the plaintiff or a third person to suffer such a contact, *** is a battery.”

“Battery” includes innocent intentional contact and even intentional contact meant to assist the complainant, if that contact is unauthorized.

And, in the 1994 case of Clark v. Perry, the North Carolina Court of Appeals entertained a suit for damages against a physician on grounds of malpractice and failure to obtain informed consent where the allegations of plaintiff were not that he had deliberately transfused a Witness patient against the latter’s will, but that he had negligently failed to discover that the patient was a Witness

49 “Questions & Answers about the Health Care Proxy (‘Combined Form’),” prepared by the Watchtower Bible and Tract Society to accompany the health care proxy form for Massachusetts at p. 2. The full four-page document is attached hereto as Appendix B.

50 “Questions & Answers about the Health Care Proxy (‘Combined Form’),” at l.

51 648 N.E.2d 839 (Ohio App. 9 Dist. 1994).

52 648 N.E.2d 839 (Ohio App. 9 Dist. 1994) at 841 [citations to authority omitted].

who had refused all blood and blood products. The patient’s principal physician had been made well aware of the patient’s religious beliefs, and the patient had taken steps to make sure that his views regarding blood transfusions were made manifest to hospital staff and had been entered in his hospital record. Nonetheless, a staff specialist who claimed to have been unaware of the patient’s religious objections ordered a blood transfusion administered at a point when the patient was unconscious or asleep. Ultimately, the court affirmed a dismissal of plaintiff’s claim. But it was solely on the ground that insufficient evidence had been introduced to prove that the defendant had been negligent in not knowing of the patient’s objection to blood transfusions.

Perkins v. Lavin also highlights another aspect of progress in this field since 1993. The Witness patient in that case refused a life-saving blood transfusion just after having given birth to a child. The child was clearly dependent upon the patient for her care. Nonetheless, the court made no mention of the state’s interest in preventing “abandonment of minor children” in discussing whether the plaintiff had a cause of action against her physician. Indeed, no such defense was raised by the physician. Likewise, no mention of such a defense was made in Werth v. Taylor, where the Witness patient had two young children at home and had just given birth to twins. This trend against giving critical weight to such an interest of the state is perhaps most manifest in some of the recent cases dealing with attempts to force cesarean births upon women who are experiencing troubled pregnancies. In the 1994 Illinois case of In Re Baby Boy Doe, doctors urged a c-section or an induced birth upon a patient on the ground that her 35-week, viable fetus would otherwise die or be born mentally retarded. The patient refused because of her personal religious beliefs and chose instead to await natural childbirth. Her physicians then applied to a court for an order compelling the patient to consent to a c-section. The court refused to grant such an order, and the Appellate Court of Illinois affirmed. “[A] woman’s right to refuse invasive medical treatment,” said the court, “is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. The potential impact upon the fetus is not legally relevant.”55 However, whether this degree of rejection of the state interest in protecting innocent third parties would extend to cases of refusal of blood was left open. In distinguishing a 1964 New Jersey case56 which had held that a transfusion could be forced upon a Witness patient so as to protect the fetus she was carrying, the court said: “This and other similar blood transfusion cases are inapposite, because they involve a relatively non-invasive and risk-free procedure, as opposed to the massively invasive, risky, and painful cesarean section. Whether such non-invasive procedures are permissible in Illinois, we leave for another case.”57

In the past 5 years, the right of adult, competent Jehovah’s Witnesses to refuse blood transfusions has become even more clearly established in American law. Case law issuing from state courts has continued the trend toward supporting patient interests in personal autonomy and religious freedom over state interests advanced in favor of forced transfusions. Thus, in 1997, in its opinion in In re Fetus Brown, the Appellate Court of Illinois moved beyond its 1994 decision in In re Baby Boy Doe to hold that a blood transfusion could not be forced upon a pregnant Witness patient in order to save the life of her fetus. In doing so, the court explicitly rejected the language in the Baby Boy Doe opinion that had suggested that a blood transfusion, unlike the cesarean section proposed

57 198 Ill. Dec. at 273, 260 Ill. App.3d at 402, 632 N.E.2d at 333.
in *Baby Boy Doe*, was a “relatively noninvasive and risk free procedure.”60 The court held in *Brown* that “a blood transfusion is an invasive medical procedure that interrupts a competent adult’s bodily integrity” and concluded that “[u]nder the law of this State... we cannot impose a legal obligation upon a pregnant woman to consent to an invasive medical procedure for the benefit of her viable fetus.”61

The right of competent Jehovah’s Witness to refuse transfusions has become so well established in the law that courts show increasing willingness to entertain actions for money damages against physicians who force transfusions upon unconsenting patients. Despite the difficulties such cases present for convincing juries that substantial damages have been suffered (the physician claims that he is being punished for having saved the life of a patient), large money damage awards are being recovered in a significant number of cases. In the 1994 case of *Sargeant v. New York Influnary-Beekman Downtown Hospital*, 62 a New York State jury awarded $500,000 to a Witness adult who was transfused against his will.63 In the 1997 case of *Jones v Wrona*, 64 an Illinois jury awarded the plaintiff $150,000. Between 1991 and 1998, at least 11 similar cases were settled out-of-court for amounts totaling in excess of $480,000.65 This trend is likely to be helped along by the 1999 decision of the highest court of Massachusetts in *Shine v. Vega*.66 In that case, the family of a young woman with asthma brought an action for money damages against a physician who claimed to have saved her life by forcibly intubating her when she presented herself at an emergency room suffering from an acute asthma episode. Two years after the forced intubation incident, the patient died as a result of another acute episode because her intense fear of hospitals caused by the earlier experience kept her from again seeking emergency room assistance. The trial court dismissed the family’s wrongful death action on the ground that the doctor had acted properly in light of the emergency situation. However, on appeal, the Supreme Judicial Court of Massachusetts reversed the lower court and reinstated the damage suit on the ground that the patient had made very clear to the physician that she would not consent to the intubation, even if, in the physician’s opinion, refusal might lead to her death. “In the often chaotic setting of an emergency room,” the court observed, “physicians and medical staff frequently must make split-second life-saving decisions. Emergency medical personnel may not have the time necessary to obtain the consent of a family member when a patient is incapable of consenting without jeopardizing the well-being of the patient. But a competent patient’s refusal to consent to medical treatment cannot be overridden whenever the patient faces a life-threatening situation.”67

Even in cases involving minor patients, American courts are demonstrating increased respect for Witnesses’ religious objections. In the United States, the statutory age of majority at which children are generally judged to be competent to make decisions for themselves is 18. However, by statute and by case law, children below the age of majority are under certain circumstances considered to be “mature minors” and empowered to make some medical decisions for themselves. The “mature minor” doctrine has begun to be extended by court decision to situations where minor Witness patients refuse blood transfusions for themselves. Thus, in the 1999 case of *In re Rena*,68 the Appeals Court of Massachusetts reversed a lower court decision ordering the administration of a blood transfusion upon a 17-year-old Witness patient because the lower court had failed to consider the level of

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61 In re Fetus Brown at 171, 689 N.E.2d at 405.
62 No. 16068/91 (Sup. Ct. N.Y. County, July 25, 1994).
63 A new trial was ordered in this case on the ground that the judge believed the verdict to be excessive, and it was later settled out-of-court for $75,000.
64 No. 94 L 2935 (Cir. Ct. Will County [III.], November 12, 1997).
66 709 N.E.2d 58 (Ma. 1999).
67 709 N.E.2d 58 (Ma. 1999) at 65 [emphasis supplied].
maturity of the patient in issuing its order. The patient’s level of maturity was relevant for determining whether or not she was competent to make the decision for herself. It was also relevant for deciding what was truly in her “best interest” even if she was not yet fully competent to make the decision for herself. “Although the judge did consider Rena’s wishes and her religious convictions in this matter, he made no determination as to her maturity to make an informed choice,” the court said.

Pointing to earlier decisions of the Illinois Supreme Court\(^69\) and the Maine Supreme Judicial Court\(^70\) in which the rights of mature minors had been protected under similar circumstances, the court concluded “we think [the trial judge’s action] was error particularly in the circumstances of this case where Rena will soon attain the age of 18. In addition, in assessing Rena’s preferences and religious convictions, he should not have relied solely on the representations made by her attorney and her parents but should have heard Rena’s own testimony on these issues where she apparently had the testimonial capacity to answer questions. Only after evaluating this evidence in light of her maturity could the judge properly determine her best interests.”\(^71\)

Where Witness parents wish to refuse blood transfusions for their minor children, American law generally does not permit them to do so if there is no alternative course of acceptable medical treatment. As the US Supreme Court observed in the 1944 case of *Prince v. Massachusetts*,\(^72\) “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 before they have reached the age of full and legal discretion when they can make that choice for themselves.” In 1968, the US Supreme Court affirmed, on the authority of *Prince*, a lower court decision that a minor could be transfused over the protest of his Witness parents.\(^73\) However, where alternative acceptable courses of medical treatment are available, cases have recognized the right of parents to make reasonable medical choices for their children different from those which attending physicians believe to be best.\(^74\) In a recent South Carolina decision, *Banks v. Medical University of South Carolina*,\(^75\) that right was explicitly held to apply to situations where Witness parents refuse blood transfusions for their children. In that case, the child died while being provided emergency treatment that included an unconsented-to blood transfusion. The parents sued the hospital and physicians involved for wrongful death and battery and introduced expert evidence that there had been no emergency requiring transfusion of blood plasma. The lower court found for the hospital, but the Supreme Court of South Carolina reversed on appeal. “Banks concedes that she had no authority to withhold necessary medical treatment from her child even if such treatment was contrary to her religious views,” the court said. “However, she contends that the transfusions were not necessary and, therefore, her consent was required. She presented testimony of an expert witness... to establish that there was no emergency justifying the transfusion of blood to Phaedra... We find that Banks has presented an issue of material fact as to whether Phaedra was in a life threatening situation which would have justified the administration of the transfusions without parental consent. Therefore, summary judgment was improperly granted.”\(^76\)

The willingness of the *Banks* court to consider the question of the reasonableness of a physician’s decision to transfuse in an emergency situation evidences another aspect of the progress being made in the United States by The Watchtower Society. As a result of the extraordinary

\(^{69}\) In re E.G., 133 Ill.2d 98, 549 N.E.2d 322 (1989).
\(^{70}\) In re Swan, 569 A.2d 1202 (Me. 1990).
\(^{72}\) 321 U.S. 158, 170 (1944).

\(^{73}\) Jehovah’s Witnesses v. King County Hospital, 278 F. Supp. 488 (W.D. Wash. 1967), aff’d, per curiam, 390 U.S. 598 (1968).
\(^{74}\) See, for example, In re Hofbauer, 47 N.Y.2d 648, 393 N.E.2d 1009 (1979).
\(^{75}\) 444 S.E.2d 519 (S.C. 1994).
\(^{76}\) 444 S.E.2d 519 (S.C. 1994) at 521–22.
work of the Society’s Hospital Liaison Committees, bloodless medical treatment (including bloodless surgery) is gradually becoming the “gold standard” of practice among top physicians and surgeons in the United States. Whereas, 5 years ago, bloodless medicine and surgery programs were established at only about 14 centers in the United States, there are about 100 such centers in the United States today. These centers are liberally distributed across the country. Sites include some of the most prestigious medical institutions in America, such as Ohio’s Cleveland Clinic, which has been rated as the top center in the United States for heart surgery. With help from the Hospital Liaison Committees, the American medical community is learning that bloodless medicine and surgery tend to produce better results for patients and significantly reduce medical costs as well. Patients who are treated without transfusions not only avoid the risk of contracting blood-borne diseases such as AIDS and hepatitis, they also recover more quickly from surgical procedures (transfusions tend to depress the body’s natural immune system) and spend fewer days in the hospital.

A study recently conducted by members of the Cleveland Clinic’s anesthesiology department concluded that using a bloodless surgery protocol 50% of the time “could save the healthcare industry up to $3.7 billion dollars a year. That includes savings of about $400 to $1400 for every unit of transfused blood from outside donors, factoring in the extra costs of treating postoperative fevers and infections.”

Clearly, it is not only Witness patients who benefit from the work of the Hospital Liaison Committees. “No one wants to get blood,” one heart surgeon was recently quoted as saying. “As patients become more informed, they’re going to specify they don’t want blood products. Maybe not to the extent of dying for it (as do Witnesses), but to reduce risks.”

One California bloodless surgery center reported this year that “one fifth of the patients requesting bloodless surgery are non-Witnesses.” Another California center, Alvarado Hospital, reported that only 35% of its patients in 1998 (compared to 97% in 1997) received blood or other blood products such as plasma. “The heart-lung surgery department at [Alvarado] has cut expenses by 40 percent by reducing transfusions, which cost up to $300 per unit for the blood and its storage and shortening hospital stays for patients,” a nurse-specialist stated.

Widespread use of bloodless medicine and surgery has been helped along by the development of new procedures for recycling the patient’s own blood, for increasing the oxygen-carrying capacity of red blood cells, and for stimulating the body to produce additional red blood cells. “But the most important technique,” say practitioners, “is simply good housekeeping—cutting cleanly and stopping the bleeding as it occurs.”

For this purpose, surgeons will frequently use electrocautery to stop bleeding as they cut or employ new harmonic scalpels, which use ultrasonic vibrations to cut and seal the wound at the same time.

Ironically, through their success in improving surgical and medical techniques for all patients, Witness patients seem to have caused a slight medical backlash against themselves. Now that the medical reasons for refusing blood transfusions have become so well known, attention has been distracted somewhat from the Witnesses’ religious objections. Even the Witnesses’ “blood refusal card” (carried by members to prevent blood from being administered

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77 Mary McGrath, Bloodless surgery answer to some patients’ prayers, Omaha World-Herald, August 10, 1999, at pp. 1, 8.
79 Ron Shinkman, More going bloodless, Modern Healthcare, November 9, 1998, at p. 57.
to them while unconscious during an emergency) gives among the reasons for refusal “the numerous risks and complications resulting from the use of blood.” For this reason, some doctors have suggested that they will not honor the blood refusal card in cases where they believe that the medical benefits of a blood transfusion outweigh its medical “risks and complications.” In an article published in 1998, two American physicians alleged that Witness patients who execute the cards do so after having heard only The Watchtower Society’s one-sided views of the medical risks of blood transfusions. They urge emergency physicians, as a result, not to comply with wishes expressed in a blood refusal card unless a Witness patient reaffirms them after having had medical choices fully explained to him or her at the time of the emergency. As Donald Ridley, Associate General Counsel for The Watchtower Society points out in an answering article, this line of reasoning, were it to be taken seriously, would put in jeopardy all of the progress in patients’ rights made in the United States in the last 25 years. Doctors in the United States do not have legal power to require patients to prove that a decision to refuse treatment is “medically rational” in order to have the refusal respected. And, ultimately, the Witness blood refusal card does not justify refusal on grounds of medical rationality. It relies upon the Witnesses’ reading of the Bible’s proscription against eating blood and states that the patient is willing to accept death over violation of that proscription.

In the end, assiduous protection of the rights of Witness patients depends at least as much upon the work of lawyers as it does upon the work of doctors. In this respect, The Watchtower Society has come a long way since 1964 when, in the George-town Hospital Case, Mr. Jones, who had been advised by Judge Wright that he should obtain a lawyer, “went to the telephone and returned in 10 or 15 minutes to advise that he had taken the matter up with his church and that he had decided that he did not want counsel.” A growing number of attorneys in the United States now represent Witness patients in blood refusal cases with assistance from the Society. Associate General Counsel Ridley has recently published a very helpful handbook for “Legally Defending Jehovah’s Witnesses’ Choice of Alternative Nonblood Management” that is made available to such attorneys. Ridley also has appeared as counsel for either Witness patients or The Watchtower Society as amicus curiae in the most significant refusal cases heard in the American courts in the last 10 years. And he contributes to journals of law, medicine, and hospital administration scholarly articles that effectively make the case for respecting refusal of blood transfusions on grounds of religious freedom and patient autonomy.

For the moment at least, the efforts of supportive medical and legal personnel have combined to produce a situation in the United States where nonconsensual transfusion of adult Witness patients has become extremely rare. “This is a dramatic change from just five or ten years ago,” Ridley reports, “when there was still a great deal of

86 Application of the President and Directors of George-town College, Inc., 331 F.2d 1000, 1007 (D.C. Cir. 1964).
89 See, for example, Donald Ridley. Treatment refusals by pregnant women, 15 Hosp. Law Newsletter # 9 (July 1998); Donald Ridley. Accepting patients’ refusal of treatment, 13 Hosp. Law Newsletter # 12 (October 1996); Donald Ridley. Working with Jehovah’s Witnesses on treatment issues, 12 Hosp. Law Newsletter # 4 (February 1995); and Donald Ridley. Accommodating Jehovah’s Witnesses’ choice of nonblood management. J Healthc Risk Manag 1990;Winter:17.
uncertainty about the law. Since then, as a result of the law’s repeated defense and protection of patient choice, I can only conclude that providers either are rarely going to court to obtain such orders or that courts, when so importuned, are not granting such orders. However, it would be mistaken to conclude that the need for vigilance has ended. Among other things, recent court decisions seem to open the door to greater participation by legislatures and executive agencies in defining rights in this area. Judges have lately shown a preference for avoiding constitutional questions, if possible, by protecting the right to refuse treatment under the common law of informed consent rather than by means of constitutional law. And they have shown as well a propensity to avoid weighing state interests favoring treatment against a patient’s right to refuse treatment where the state itself has not entered the case to press such interests. Thus these recent cases leave open the possibility that courts could rule differently if legislation were passed removing some of the protection provided by the common law or if the executive branch were to intervene in a case to press the importance of countervailing state interests. Were legislatures or executive agencies to consider taking such steps, efforts would have to be mounted to oppose them politically and legally. Happily, executive agencies have thus far shown no interest in intervening in such cases. And, to the extent that state legislatures have shown interest in passing legislation in this field, it has been more to add protections to the right to refuse blood transfusions than to take them away.

The Witnesses seem to be successfully recovering from the blow dealt them in Georgetown. The days when blood transfusions could be forced upon Witness patients on the ground that refusal was “medically irrational” are, hopefully, over. By dint of cases like Georgetown, the American medical profession had achieved something of the status of an established state church. Its dogma regarding the low risk and high benefits of blood transfusions had been forced upon unbelievers by the state. Through education and advocacy, the Witnesses have convinced the state to reconsider its position and to take a more neutral stance between the beliefs of their religion and those of American medicine. They have even managed to get American medicine to reconsider some of its beliefs in the light of further evidence. In the process, all of American society has benefited. Not only Jehovah’s Witnesses, but patients in general, are today less likely to be given unnecessary blood transfusions because of the work of the Witnesses’ Hospital Liaison Committees. Patients in general enjoy greater autonomy over a whole range of health care decisions because of the work done by the Witnesses as part of an overall patients’ rights movement. And the causes of freedom in general and religious freedom in particular have been advanced by the Witnesses’ dedicated resistance to efforts to force them to take action inconsistent with their religious beliefs.

92 Stamford Hospital v. Vega, 236 Conn. 646, 674 A.2d 821 (1996) and Harrell v. St. Mary’s Hospital, 678 So.2d 455 (D. Ct. App. FL 1996).
93 See, for example, New York Public Health Law, sec. 2803-c (a): “Every patient’s civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and the facility shall encourage and assist in the fullest possible exercise of these rights.” and (c) “Every patient shall have the right to receive adequate and appropriate medical care, to be fully informed of his or her medical condition and proposed treatment unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences.”
Appendix A

Durable Power of Attorney for Health Care
(Pennsylvania Statutes Annotated title 20, §§5601 to 5607)

(1) I, __________________________,_

Print your full name

am of sound mind and I voluntarily make this Durable Power of Attorney for Health Care. There are two parts to this document: Part 1 sets forth my health-care instructions; Part 2 appoints a person to make health-care decisions for me on matters not covered in my instructions. This document shall take effect upon my incapacity.

PART 1—Health-Care Instructions

(2) I am one of Jehovah’s Witnesses. On the basis of my firmly held religious convictions, see Acts 15:28, 29, and on the basis of my desire to avoid the numerous hazards and complications of blood, I absolutely, unequivocally and resolutely refuse homologous blood (another person’s blood) and stored autologous blood (my own stored blood) under any and all circumstances, no matter what my medical condition. This means no whole blood, no red cells, no white cells, no platelets, and no blood plasma no matter what the consequences. Even if health-care providers (doctors, nurses etc.) believe that only blood transfusion therapy will preserve my life or health, I do not want it. Family, relatives or friends may disagree with my religious beliefs and with my wishes expressed herein. However, their disagreement is legally and ethically irrelevant because it is my subjective choice that controls. Any such disagreement should in no way be construed as creating ambiguity or doubt about the strength or substance of my wishes.

Also, because many health-care providers view Jehovah’s Witnesses refusal of blood with disapproval and even hostility, I am concerned that someone may claim that I orally consented to a blood transfusion. Thus, I hereby state that it is my conscious decision that my absolute refusal of blood transfusion shall not be revocable by me orally. If anyone claims that I have orally consented to a blood transfusion, I demand that such claim be ignored unless confirmed in writing signed by me and subscribed by at least two disinterested witnesses.

(3) With respect to minor blood fractions* or products containing minor blood fractions, according to my conscience I ACCEPT: [initial one of the three choices below]

   (a) NONE.
   (b) ALL.
   (c) SOME. That is, I ACCEPT: [initial choice(s) below]

   Products that may have been processed with or contain small amounts of albumin (e.g., streptokinase, and some recombinant products [such as erythropoietin (EPO) and synthesised clotting factors, and some radionuclide scan preparations may contain albumin].

   Immunoglobulins (e.g., Rh immune globulin, gammaglobulin, horse serum, snake bite antivenins).

   Clotting factors (e.g., fibrinogen, Factors VII, VIII, IX, XII).

   Other: ____________________________

(4) I accept and request alternative nonblood medical management to build up or conserve my own blood, to avoid or minimize blood loss, to replace lost circulatory volume, or to stop bleeding. For example, volume expanders such as dextran, saline or Ringer’s solution, or hetastarch would be acceptable to me.

(5) With respect to non-stored autologous blood* (my own non-stored blood), according to my conscience I ACCEPT: [initial choice(s) below]
(a) DIALYSIS OR HEART-LUNG EQUIPMENT (diversion of my blood within an extracorporeal circuit that does not involve storage or more than brief interruption of blood flow and that is constantly linked to my circulatory system, provided any equipment used is not primed with stored blood).

(b) HEMODILUTION (dilution of my blood within an extracorporeal circuit that does not involve storage or more than brief interruption of blood flow and that is constantly linked to my circulatory system, provided any equipment used is not primed with stored blood).

(c) INTRAOPERATIVE OR POSTOPERATIVE BLOOD SALVAGE (contemporaneous recovery and reinfusion of blood lost during or after surgery that does not involve storage or more than brief interruption of blood flow, provided any equipment used is not primed with stored blood).

(d) NONE.

*Warning: Consult your doctor regarding potential health risks.

(6) With respect to providing, withholding, or withdrawing life-sustaining treatment at the end of life, and consistent with Pennsylvania Statutes Annotated title 20, § 5404, my declaration, which in no way alters my absolute refusal of blood as directed above, is: [initial one of three choices below]

(a) NOT TO PROLONG LIFE. That is, if to a reasonable degree of medical certainty my condition is hopeless (for example, if to a reasonable degree of medical certainty I have an incurable and irreversible condition that will result in my death within a relatively short time, or if am unconscious and to a reasonable degree of medical certainty will not regain consciousness, or if I have brain damage or a brain disease that makes me unable to recognize people or communicate and to a reasonable degree of medical certainty my condition will not improve), I do not want my life to be prolonged. Thus in such situations, I do not want mechanical respiration (ventilation), cardiopulmonary resuscitation (CPR), tube feeding (artificial nutrition or hydration), etc. However, I do want palliative care – treatment for comfort.

(b) TO PROLONG LIFE. That is, I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards, although I realize this means that I might be kept alive on machines for years in a hopeless condition.

(c) OTHER. [If you do not completely agree with either (a) or (b) above, you can initial here and write your own end-of-life instructions in the space provided. NOTE: Unless your agent knows your wishes about artificial nutrition and hydration, your agent may not be able to make decisions about these matters.]

(7) Other health-care instructions (e.g., your wishes regarding organ donation, current medication, allergies, other medical problems, etc.): __________________________

(8) I am primarily concerned that my refusal of blood and choice of alternative nonblood management be respected regardless of my medical condition. My rights under the federal and state constitutions and state common law require health-care providers to respect and comply with my treatment decisions. My rights are not dependant on, and do not vary with, my medical condition. Thus my decision to refuse blood and choose nonblood management must be respected even if my life or health is deemed to be threatened by my refusal. *Stamford Hosp. v. Vega*, 674 A.2d 821 (Conn. 1996) (Witness patient’s refusal of blood protected by state common law right of bodily self-determination); *In re Dubreuil*, 629 So. 2d 819 (Fla. 1993) (Witness patient’s refusal of blood protected by state constitutional rights of personal privacy and religious freedom); *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017 (Mass. 1991) (Witness patient’s refusal of blood protected by state

* [This footnote applies only to pregnant women.] If I am pregnant and there is a reasonable chance my fetus could survive, I want my life to be prolonged for the sake of my fetus, notwithstanding my instructions in Paragraph (6)(a). However, in no way does this change my wishes about nonblood treatment for both myself and my fetus. After any efforts to save my fetus, my instructions in Paragraph (6)(a) shall again control.

The United States Supreme Court has said that “[i]t is settled now … that the Constitution places limits on a State’s right to interfere with a person’s most basic decisions about … bodily integrity.” Planned Parenthood v. Casey, 505 U.S. 833, 849 (1992). In Cruzan v. Missouri Department of Health, 497 U.S. 261 (1990), the Supreme Court stated: “It cannot be disputed that the Due Process Clause [of the Fourteenth Amendment to the United States Constitution] protects an interest in life as well as an interest in refusing life-sustaining medical treatment.” Id. at 281. The Court also said: “The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.” Id. at 278. In addition, in Washington v. Harper, 494 U.S. 210 (1990), the Supreme Court said that prison inmates suffering from mental disorders possess “a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.” Id. at 221-22. The Court also observed that “[t]he forcible injection of medical into a nonconsenting person’s body represents a substantial interference with that person’s liberty.” Id. at 229.

There is no indication in these Supreme Court cases that a person must be in a terminal, irreversible, incurable or untreatable condition, or in a permanently unconscious or vegetative state in order to exercise his fundamental Fourth Amendment right to refuse treatment or otherwise control what is done to his body. Indeed, Nancy Cruzan herself was not terminally ill. See 497 U.S. at 266, n.1. Moreover, implicit throughout the majority opinion in Cruzan and expressly stated in Justice O’Connor’s concurrence and all the dissents (except Justice Scalia’s) is the acceptance of advance written directives as clear and convincing evidence of a formerly competent person’s wishes. Therefore, because I have prepared this advance directive while competent, if I become incompetent, my wishes as expressed herein must be respected as if I were competent.

(9) [This paragraph applies only to pregnant women.] In Planned Parenthood v. Casey, 505 U.S. 833, 860 (1992), the Supreme Court confirmed that “viability marks the earliest point at which the State’s interest in fetal life is constitutionally adequate to justify a legislative ban on therapeutic abortions.” Thus, since I have the right to abort my pregnancy before viability I necessarily have the lesser right to refuse blood transfusions before viability. In addition, even if my fetus is viable, the Supreme Court has said that mothers cannot be exposed to increased medical risks for the sake of their fetuses and that the state’s interest in the potential life of the fetus is insufficient to override the mother’s interest in preserving her own health.
Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 768–71 (1986); see Planned Parenthood v. Casey, 505 U.S. 833, 846 (1992). Also, in the cases of In re A.C., 573 A.2d 1235 (D.C. 1990), and In re Doe, 632 N.E.2d 326 (Ill. App. Ct.), cert. denied, 114 S. Ct. 1198 (1994), refusals of treatment by women with viable fetuses were upheld. Although both of these cases involved Caesarean sections, as a matter of principle and logic they show that it is the pregnant woman who should decide what is to be done to herself and her fetus. Therefore, I demand that my refusal of blood and choice of alternative nonblood management be followed and that my doctors manage my care and the care of my fetus without transfused blood.

(10) In sum, based on federal and state constitutional law and state common law, I demand that the instructions set forth in this document be followed regardless of my medical condition. Any attempt to administer blood to me contrary to my instructions will be a violation of my Fourteenth Amendment liberty interest in bodily self-determination, my First Amendment right of religious free exercise, my state constitutional rights of personal liberty or privacy and religious freedom, and my state common law rights of bodily self-determination and personal autonomy.

PART 2–Appointment of Health-Care Agent

(11) I hereby appoint the following person as my health-care agent: [Notice: You may choose any adult to be your agent, but it is recommended that you not choose your doctor, any of your doctor’s employees, or any employee of a hospital or nursing home where you might be a patient, unless the individual is related to you by blood, marriage, or adoption.]

Agent’s full name: ____________________________________________________________
Agent’s address: ____________________________________________________________
Work Telephone: (__) _______ Home Telephone: (__) _______ Other: (__) _______

(12) If the agent appointed above is unavailable, unable, or unwilling to serve or continue to serve, then I appoint the following alternative agent to serve with the same powers: [See “Notice” in Paragraph 11 above.]

Alternate agent’s full name: _____________________________________________
Alternate agent’s address: ________________________________________________
Work Telephone: (__) _______ Home Telephone: (__) _______ Other: (__) _______

(13) To the extent this document sets forth my health-care instructions, there is no need or reason to look to my agent for a decision. However, I grant my agent full power and authority to ensure that the wishes expressed in this document are followed by health-care providers. Further, I grant my agent full power and authority to make health-care decisions for me on matters not covered by this document. My agent’s authority is effective as long as I am incapable of making my own health-care decisions.

(14) In harmony with the limitations in the preceding paragraph, my agent’s authority shall include but not be limited to the following:

(a) To consent to, refuse, or withdraw consent to any or all types of medical care treatment, surgical procedures, diagnostic procedures, medication, and the use of other mechanical or other procedures related to health care. This authorization includes the power to consent to pain-relieving medication for relief of severe and intractable pain.

(b) To request, review, and receive any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

(c) To employ or discharge my health-care providers; to authorize my admission or discharge from any hospital, nursing home, mental health or other medical care facility; and the take any lawful actions that may be necessary to carry out my wishes, including the granting of releases from liability to health-care providers.
(15) A copy of this document shall be as valid as the original. I ask that a copy of this document be made part of my permanent medical record. I have provided copies of this document to my health-care agent and alternate agent. It is my intention that this document be honored in any jurisdiction in which it is presented and that it be construed liberally to give my agent the fullest discretion in making health-care decisions in my behalf consistent with my instructions.

(16) If my health-care providers cannot respect my wishes as expressed in this document or as otherwise known to my agent and a transfer of care is necessary to effectuate my wishes, I direct my health-care providers to cooperate with and assist my agent in promptly transferring me to another health-care provider that will respect my wishes. In such circumstances, I direct my health-care providers to transfer promptly all my medical records, including a copy of this document, to the other health-care provider.

(17) This document revokes any prior health-care power of attorney or health-care proxy executed by me.

(18) The provisions of this entire document are separable, so that the invalidity of one or more provisions shall not affect any others.

(19) I understand the full import of this document and I am emotionally and mentally competent to execute it.

(20) SIGNED: ____________________________  ____________________________

Your signature  Date

Address

(21) STATEMENT BY WITNESSES

I declare that the person who signed this document (the principal) or the person who signed on behalf and at the direction of the principal knowingly and voluntarily signed this writing by signature or mark in my presence. Also, I am not the person appointed as agent or alternate agent by this document.

______________________________  ________________________________
Signature of witness 1  Signature of witness 2

______________________________  ________________________________
Print name  Print name

______________________________  ________________________________
Address  Address
Questions & Answers
about the Durable Power of Attorney for Health Care (DPA*)

What is a Durable Power of Attorney for Health Care (DPA*)? It is a single document designed to serve two functions: (1) to let you put your specific health-care instructions in writing, and (2) to let you appoint someone to make other health-care decisions for you in the event you are unable to do so. Patients could accomplish the above two functions by filling out two separate documents. However, the accompanying DPA form simplifies this by combining these two functions into one form.

What is “Part 1—Health-Care Instructions”? This part of the form sets forth your written instructions to others (doctors, nurses, etc.) about your specific health-care wishes. Your instructions do not take effect unless you become unable to make or communicate your health-care decisions yourself. No one except you can change your written instructions, not even the person that you appoint to make health-care decisions for you.

What is “Part 2—Appointment of Health-Care Agent”? This part of the form is used to appoint another person to make other health-care decisions for you in the event that you are unable to make or communicate such decisions yourself. The person you appoint thus becomes your “health-care agent.” (For more details, see the questions and answers under the “HEALTH-CARE AGENT” heading below.)

Do I need a lawyer or doctor to fill out the DPA? No. This question-and-answer guide is designed to enable you to complete the DPA without the assistance of lawyers or doctors. However, you should feel free to consult with anyone you think might be able to help you fill out the form.

Are there instructions or some sort of checklist to help me fill out the DPA? Yes. There is a checklist. (See Figure 1 on the last page of this question-and-answer guide.) However, you should thoroughly read through these questions and answers before using the checklist. Thereafter you may use the checklist when filling out the DPA. The checklist refers to both theocratic articles and specific questions about this guide. Look up the references if you are unsure about the choice or decision to be made.

What should I do with my completed DPA? Make several good, clear photocopies of the completed form. (You may want to note on the photocopies where the original is kept.) Keep the original in a secure yet accessible place—not a safe-deposit box. Give a copy to your health-care agent, alternate agent, your doctor (ask your doctor to make it part of your permanent medical record), and any other family members or close friends you want. You may also want to carry a copy with you and put a copy in the glove box of your car. Also, if you know you are going to be hospitalized, you should give a copy of your form to hospital administration.

How is the DPA different from regular power of attorney? Powers of attorney generally are used for business and financial matters, not health-care matters. The DPA, however, is for health-care matters, not for business or financial matters.

If I already have a living will or other advance directive for health-care, why should I execute the DPA? Living wills and other advance directives for health care established by state laws typically limit a person’s right to refuse ‘life-sustaining’ treatment to terminal illnesses. This means that unless your condition is terminal (i.e., you have no hope for recovery and death is imminent), you would not be allowed to refuse blood. Even in state that have laws that do not limit a person’s right to refuse treatment to terminal illnesses, their advance directives forms do not address your refusal of blood and choice of alternative nonblood management as thoroughly as the DPA.

Does the DPA replace the “Advance Medical Directive/Release” card? No. These two documents work with each other. The Advance Medical Directive/Release card is small in size so that it can be carried with you at all times. Thus, in the event of an emergency in which you are unconscious, the Advance Medical Directive/Release will identify you as one of Jehovah’s Witnesses, will make known your refusal of blood, and will identify your emergency contacts.

The DPA, on the other hand, contains important information that could not be included on the Advance Medical Directive/Release card. Thus, it would be wise to make the emergency contacts on your Advance Medical Directive/Release

* The titles of the forms the Society’s Legal Department has prepared vary from state to state depending on state law. For example, California calls its form a “Durable Power of Attorney for Health Care,” Michigan calls its form a “Health Care Directive and Designation of Patient Advocate,” New York calls its form a “Health Care Proxy,” etc. However, since the majority of the titles use the words "power of attorney" or "proxy," the Society’s Legal Department generally refers to them as either “DPA” (durable power of attorney) or “Proxy” forms.

CONTENTS

GENERAL (Questions 1-4) ..............................................1

BLOOD-RELATED (Questions 15-17) ..............................2

END-OF-LIFE DECISIONS (Questions 18-20) ..................2

HEALTH-CARE AGENT (Questions 21-26) .................3

CHECKLIST ......................................................................4
the same persons you appoint as health-care agent and alternate agent on your DPA. In this way your health-care agent will be contacted in an emergency and will be able to provide immediately a copy of your DPA to health-care providers, if a copy is not with you. (See Figure 2 on the last page of this guide.)

10. Should I discuss my instructions and appointment of health-care agent with my doctors? Yes. Basically, discuss with your doctor the same information you discuss with your agent. (See Question 23.) Be sure to discuss in depth the many medical alternatives for bloodless surgery that are available and acceptable. (See Question 16.) Let your doctor know that you have thoroughly discussed these matters with your agent. (You may even want to introduce your agent to your doctor.) The better your doctor understands you, the less likely it is that problems will arise.

11. Are my doctor and other health-care personnel protected from legal liability if they honor the wishes expressed in my DPA? Yes. A doctor or any other health-care provider is protected from legal liability when acting in accordance with your wishes as expressed in your DPA; indeed, they are legally obligated to respect your wishes. They need be more concerned about liability if they were to act contrary to your DPA.

12. Could my DPA be overridden by my family members or other relatives? No. You alone have the right to control what is done to your body. A family member’s or relative’s disagreement with your health-care decisions is legally irrelevant. If you have appointed a health-care agent, only he has the legal authority to make other health-care decisions for you.

13. Will my DPA be honored with I travel to another state? It should be. The U.S. Supreme Court has said that the U.S. Constitution gives competent persons the right to refuse medical treatment. Thus, your DPA should be honored in any state. However, because of the potential for uncertainty on this point in some states, there is a thorough discussion of your constitutional rights in the DPA.

14. What if I want to change or cancel my DPA? All you need to do is fill out another DPA. Your new form will contain your changes and will automatically cancel your previous DPA. (To be on the safe side, you may want to ask for your old DPA’s back from those to whom you gave one. You should discard your old forms and distribute your new ones.) If for some reason you are unable to fill out a new form, you may simply tell your doctor(s), agent or others about your changes (or that you have decided to cancel your existing form altogether.) It is best, however, to put any changes in writing by filling out a new form.

**END-OF-LIFE DECISIONS**
(DPA, Paragraph 6)


17. Where can I get information about autologous blood procedures such as hemodialysis and intraoperative blood salvage? Information on autologous transfusion therapy can be found in *The Watchtower* of March 1, 1989, pages 30-31.

18. What are end-of-life decisions? End-of-life decisions are potential life-or-death decisions patients may face because of deteriorating health (perhaps due to old age) or because of a serious accident. For example, if you are hopelessly ill, would you want to be kept alive on a respirator? If you are terminally ill, would you want to be fed intravenously or by other artificial methods? If your situation is hopeless, would you want all financial means available to you or your family to be expended to pay for treatment, perhaps involving transportation to a distant center to receive the most advanced treatment? These and other questions about end-of-life decisions are addressed in *Awake! of October 22, 1991*, pages 3 to 9.

19. Why should I think about end-of-life decisions now? Questions about end-of-life care can arise suddenly and unexpectedly. Thus, it only makes sense to think about these matters while you are capable of doing so. Although discussing end-of-life decisions may not be easy for some, imagine the difficulties your spouse or family would face if your wishes were unknown. You can make your wishes known, of course, by recording your instructions in Paragraph 6 of the DPA. You can also make your wishes known by appointing a health-care agent in Paragraph 11 of the DPA and discussing your wishes about end-of-life care with your agent.

20. Are there any circumstances where a Christian may choose NOT to prolong life? Yes. For a Christian, questions about whether life should be prolonged or not arise only if his medical condition has been clearly determined to be hopeless. See *Awake! of September 8, 1986*, pages 20-21. Examples of hopeless situations might include the following: (1) to a
reasonable degree of medical certainty you have an incurable and irreversible condition that will result in your death within a relatively short time, (2) you are unconscious and to a reasonable degree of medical certainty you will not regain consciousness, or (3) you have brain damage or a brain disease that makes you unable to recognize people or communicate and to a reasonable degree of medical certainty your condition will not improve.

**HEALTH-CARE AGENT**  
*(DPA, Paragraphs 11-14)*

**What will my health-care agent do?** Your agent will make health-care decisions for you. However, because your written instructions in Part 1 of the DPA set forth your health-care wishes, your agent will make decisions only on matters not covered by your instructions.

To illustrate, if you are unconscious but your doctor, who knows that you are one of Jehovah’s Witnesses, wonders if you will refuse blood in a life-threatening situation, your written instructions in Part 1 clearly answer this, so your agent has no authority in the matter. However, your agent can direct the doctor to your instructions and ensure that your wishes are respected. On the other hand, if you are in a coma and the doctor wants to know what kind of treatment to give you, your agent would make decisions for you if your written instructions in Part 1 do not cover this.

For decisions your agent makes that are not covered by your instructions, your agent will be guided by your personal beliefs and values. As you might well imagine, acting as a health-care agent is an extremely serious matter since the agent could be required to make life-or-death decisions for you.

**Whom should I appoint as my health-care agent?** Your agent should be someone you trust and are close to, someone who understands your personal beliefs and values, such as a close family member or a good friend. Before appointing an agent, ask yourself:

1. If questions arise about my health-care that are not covered by the instructions set forth in my DPA, can I trust that my agent will make decisions consistent with my beliefs and values as a true Christian?

2. If someone challenges my written instructions, is my agent capable of taking steps to see that my wishes are upheld? How would my agent react to a hospital or courtroom in which my instructions are questioned?

Thus, before appointing an agent, it would be good to talk with the person you have in mind to make sure he understands your wishes and is willing to assume the responsibility of acting as your agent.

| What should I discuss with my prospective health-care agent? You should discuss your personal beliefs and values, and you should be sure your prospective health-care agent understands you. |
| Discuss the health-care instructions that appear in Part 1 of the DPA. The discussion should review your specific instructions about homologous blood, minor blood fractions, nonblood alternatives, and autologous blood. Also, discuss your instructions about end-of-life decisions, since doctors will look to your agent if questions arise that are not addressed in your written instructions. In addition to discussing and explaining the instructions in Part 1 of your DPA, express your general feelings about medical treatment and explain WHY you feel the way you do. |
| Discuss Part 2 on the DPA. That is, the responsibilities (described in the form) and decisions your prospective agent may be faced with in the event your instructions in Part 1 do not cover a situation that arises. |
| **Why is it so important that I talk with my health-care agent in advance?** It is important to talk to your agent because the guidelines set forth in your instructions (especially with regard to end-of-life decisions) cannot cover every situation. If you fail to discuss such matters with your agent, serious problems could arise. Obviously, if you avoid thinking about these matters it does not mean different situations will not come up. It only means that someone else will have to decide without the benefit of your general views and feelings on the matter. Therefore, meaningful discussions you have with your agent can guide him in the event a situation comes up that is not covered in your written instructions. |
| If I became unable to communicate or make decisions myself, would my doctor be obligated to consult with my health-care agent? Yes. Your health-care agent has legal authority to make medical decisions for you in harmony with your wishes as stated in your DPA. Your doctor is therefore legally obligated to consult with your health-care agent and to respect his decisions as if they were your own. |
| Could my health-care agent be held legally liable for decisions he makes for me? No, your health-care agent will not be liable for treatment decisions made in good faith on your behalf. Also, he cannot be held liable for the costs of your care. |
Chapter 44

Checklist for Filling out Durable Power of Attorney for Health Care
(check off each box below as section is completed)

Paragraph (1) • Print your full name……………………………………………………………. self-explanatory

Paragraph (3) • Initial one of the three choices regarding minor blood fractions.*…………… w94 10/1 p.31, w90 6/1 pp. 30-1

Paragraph (5) • Initial choices(s) regard autologous blood.*………………………………… w89 3/1 pp. 30-1

Paragraph (6) • Initial one of the three choices regarding end-of-life decisions……………….. q&a #18-20, g91 10/22 pp. 3-9, g86 9/8 pp. 20-1

PART 2–Appointment of Health-Care Agent

Paragraph (11) • Name a health-care agent, list address, and telephone numbers……………… q&a #3, 21-26

Paragraph (12) • Name an alternate health-care agent, etc. …………………………………….. self-explanatory

Paragraph (20) • Sign your name in the presence of two witnesses, etc. ………………………. self-explanatory

Paragraph (21) • Your two witnesses sign, etc. ………………………………………………….. self-explanatory

Abbreviations: w = The Watchtower; g = Awake!; q&a = Refers to this 4-page guide with its questions and answers.
*This is a conscience matter and may not be acceptable to some of Jehovah’s Witnesses. PA 1/97

(You may wish to type or write in the language indicated below on your Advance Medical Directive/Release to indicate that you have executed a health-care power of attorney. –See question and answer #9 on first page of this guide.)

Allergies:___________________________
Current medication:___________________
Medical problems:____________________

MEDICAL DIRECTIVE
(Signed document inside)
I have also executed a health-care power of attorney (or proxy).

NO BLOOD

IN CASE OF EMERGENCY,
PLEASE CONTACT:
Name:______________________________
(health-care agent)
Telephone:__________________________
Address:____________________________

ALTERNATE CONTACT:
Name:______________________________
(alternate health-care agent)
Telephone:__________________________
Address:____________________________

Open to signed document