

CONSIDERATIONS REGARDING THE RELIGIOUS RIGHTS OF THE PATIENTS. MEDICAL AND LEGAL ASPECTS

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Abstract

If we were to describe our contemporary world by means of one single word that would, most certainly, be multiculturalism. All across the planet, cultures and religions unceasingly interact and more often than not clash and collide leading to covert as well as overt tensions and conflicts and their most extreme manifestations, terrorism and war. There are some places though, all over the world, where willingly or not these differences are brought together by common suffering: medical settings, especially hospitals, still governed by non-discriminating moral principles and professional guidelines. This may be a good point to start reconciliation, but will this be enough? Satisfying all these different requirements has ample legal support in national, European and international provisions. However, each individual is defined by a distinctive personality and a unique set of values and also by his own complex combination of medical problems. Close cooperation between physicians, religious representatives and organizations and social services, supported by the corresponding commissions defines an intricate yet much needed approach to the patient while furthermore struggling with inevitable time and financial limitations.

Key Words: *Patient's Rights, Autonomy, Refusing treatments, Religious Rights.*

JEL Classification: [K38, K32]

Case Report

On the 12 of November 2015, in Suceava (Romania), a young woman, GC, 19 years died, due to a train crash¹. The accident occurred on November 5, after the young woman's car was stuck on the train, hit by a train locomotive. As a result of the impact, the girl was seriously injured, having a cranio-cerebral trauma, with edema, costal fractures that affected the left lung, and femoral fractures on both legs. As a result of her admission to hospital, the patient was stabilized, with induced coma and she would be subjected to a surgery. The

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¹ See the case of a young woman, 19 years, who died, on the 12 of November 2015, in Suceava, after a train crash, available at <http://www.mediafax.ro/social/caz-dramatic-in-suceava-o-tanara-a-carei-familie-a-refuzat-transfuzia-de-sange-din-motive-religioase-a-murit-la-spital-14884387>, last accessed 12.02.2016.

family of the young woman belong to Jehovah's Witnesses community, and they refused blood transfusion. But there is also a document written by a young woman at the age of 18, in which she explicitly refused blood transfusion in case something bad happens. Meanwhile, a committee of doctors was set up to decide what to do, but it was too late for the young woman, who died shortly.

In 2011 another 30-year-old woman from Baia Mare, also belonging to Jehovah's Witness community, died in the hospital after doctors followed her decision and did not make blood transfusions.

The case analysis

In order to analyze this case and to identify the ethical and legal aspects that should be taken into consideration in these situations, we should punctually answer to the following sets of questions:

1. What kind of document drafted the patient when she got 18 years?
2. Do Romanian patients have the right to draft such documents?
3. Do patients have a religious right to refuse some kind of treatments?
4. The principle of autonomy versus the principle of beneficence. Which of them has priority?

Discussions

1. What kind of document drafted the patient when she got 18 years?

This document is an *advance directive* or a *living will*. Historically, the term was first connected to euthanasia issues. Thus, in 1967 Luis Kutner, a Chicago attorney active in a right-to-die organization, used for the first time the term living will, in his paper "Due process of euthanasia: the living will, a proposal"². It was intended, first, to take the burden of making end of life decisions from physicians and relatives. Second, a living will enabled a person to become part of the decision making process, even after they had lost capacity or, perhaps, merely the ability to communicate. And, third, the existence of living wills helped educate medical professionals that life-prolonging treatment is not always preferable³.

Advance directives allow competent persons to express their wishes concerning treatments, decisions, and to exercise their rights of self-determination in order to influence their future care⁴. This is a right set up by different legal frameworks in the international regulations. In 1976, the Council of Europe proposed the European Charter of Patients' Rights, where the Article 5 stated "the

² Kutner, L., *Due process of euthanasia: the living will, a proposal*, In: Indiana Law Journal, 44, 1969, pp. 539-554.

³ Capron, A., *Advance Directives*, In: *A companion to Bioethics* - 2nd ed., 2009., pp. 299-311, ed. H. Kuhse, and P. Singer. West Sussex, UK: Wiley-Blackwell Publishing.

⁴ Thiel M.-J., *Personal Capacity to anticipate future illness and treatment preferences*, in: P. Lack, N. Biller-Andorno, S. Brauer (Eds), *Advance Directives*, Springer, 2014, pp. 17-35.

right to personal dignity and integrity, to information and proper care, should be clearly defined and granted to every person”.

World Health Organisation (WHO) in “A Declaration on the Promotion of Patients’ Rights in Europe”, adopted in 1994 states in the Article 3.3: “When a patient is unable to express his or her will and a medical intervention is urgently needed, the consent of the patient may be presumed, unless it is obvious from a previous declared expression of will that consent would be refused in the situation”. After almost two decades, in 1997 the Council of Europe adopted the Convention of Human Rights and Biomedicine signed in 1997 (referred hereafter as the Biomedicine Convention), where in Chapter II – Consent, the Article 9 states: “The previously expressed wishes relating to medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account”.

Parliamentary Assembly of the Council of Europe adopted, on the 25th of January 2012, a new Resolution 1859 (2012), through they recommended, again, that the member States should promote advance care directives, with the purpose of avoiding the euthanasia practices. As we can see, in terms of European legal frameworks, it is an encouragement for states to regulate such documents in order to clarify and facilitate the medical practice.

Advances care directives can take different forms, which are not necessarily exclusive of each other. They are oral or written statements in which people declare their treatment preferences in the event that they will lose decision-making capacity.

They are generally of two types: health care proxy, or durable powers of attorney for health care, which allows people to appoint a specific individual (a health care agent, for example a relative or a friend) to make health care decisions for them should they become unable to speak for themselves; living will specifies in writing the kind of treatment that a patient who has become incapacitated does or does not want. Both proxy and living will are invoked only if the patient has lost the decision-making capacity.

In European countries, these documents are drafted, generally, in written, by a competent, who usually makes these statements in front of two witnesses⁵, or a witness in United Kingdom for persons who lack capacity and draft an advance decision (1). In the Anglo-Saxon area, there is not the obligation to draft them in written, they could be even oral statements. The wishes of the patient, his or her preferences, expressed in any occasions when he or she had the full capacity to make a competent decision are considered as valid. In the Continental Europe instead, generally is the physician who makes the final decision for its patients, and advance directives are taken into account only if they are in written, the substituted judgement or preferences expressed in different occasions, are not

⁵ Blondeau, D., *Testament de vie*, in *Les mots de la bioéthique. Un vocabulaire encyclopédique*, Bruxelles, De Boeck Université, 1993, pp. 333 - 335.

compatible with norms and with legal principles of civil law system⁶. Because without a specific written directive, health care professionals have no independent verification that the legal representant is making a true substituted judgement of the patients's beliefs and desires or it will decide on its own interests.

2. Do Romanian patients have the right to draft such documents?

The autonomy of the patient, the right of a patient to the informed consent and advance directives are concepts assumed in the national legislation from 2001, when Romania has ratified the Biomedicine Convention, through the Law no. 17 from February 22, 2001. Before this time, no legal framework in Romania made any mention to these concepts. At present, Romania has no special laws concerning advance care directives, and it is unusual to base clinical decisions regarding incompetent patients on their previously expressed wishes, if they don't have any written document. But in Romanian legislation there are some favourable aspects to the autonomous patient and who could be the basis for future legal developments on advance directives.

The first one is the Constitution, in Article 26 (2) states: "The individual has the right to dispose of himself, if he/she doesn't violate the rights and the freedom of others, public order or moral".

According to these laws, in principle, any forced treatment (somatic or mental) should be excluded, due to the fact that medical care is granted solely on the basis of free and informed consent, given in writing, under the Article 144 of the Law no 95 from 2006 on Health Reform.

The second one is the Law no. 46/2003 on Patient's Rights, Article 13 provides: "The patient has the right to refuse or stop medical intervention assuming, in writing, responsibility for its decision, the consequences of refusing or stopping medical documents must be explained to the patient". Article 14, the same law: "When the patient cannot express his/her will, but it is necessary to perform an emergency, medical staff must deduct the consent of the patient from a previously expressed will".

In 2006, Romania adopted the new legal framework on Health Reform, Law no. 95. Article 2 shows that the goal of public care is the promotion of health, the prevention of diseases and the increasing of the quality of life.

The new Medical Deontology Code, adapted in 2016, in force from January 2017, states in Article 16 that patient's wishes, decided in advance, will be taken into account if he/she is not able to express it.

The expression "taken into account" with reference to advance directives is too vague and general. For health care professionals it is not clear if they need to put it into act or to ask to someone else to interpret the wishes of patients. For legal practices is also difficult to understand and interpret the legal implications

⁶ Amato, S., *Eutanasie. Il diritto di fronte alla fine della vita*. Torino, Italy: Giappichelli Editore, 2011.

and consequences of such documents. This particular provision fails to provide any clear guidance as to what extent, or under what conditions, advance care directives must be really “taken into account”⁷. It could be only an additional argument for physicians who understand to respect the patient’s autonomy.

3. Do patients have a religious right to refuse some kind of treatments?

Before dealing with this issue, it must be noted that regardless of religious belief, there are believers who admit intellectually, wholly or in part, the beliefs of their religion, and its practice in cult, rite, and behavioral precepts is inconstant (so-called *nominal* believers). And there are believers who want the plenary living of the doctrines and precepts of that cult (the real believers). There are cases where nominal believers choose to practice a particular commitment of that religion, ignoring others (for example, the case of a Muslim who wants to keep ritual food but does not want to make the five daily prayers or the pilgrimage to Mecca, all being commandments of Islamic religion).

In Romania, at least four cults, two of which have historical presence on, have mandatory cultic prescriptions for their adherents, which involve limitations or consequences on certain therapeutic acts. These are: Mosaic Cult, Muslim Cult, Seventh-day Adventist Church, and Jehovah’s Witnesses Association.

(1) The mosaic cult, considering the source of the Revelation the Old Testament as well as the Talmud, provides between other sanitary provisions, the *kashrut* rule, the ritual diet. The Bible provides in the Old Testament the category of clean and unclean foods, which need to be avoided, how to prepare the food, the ban on eating blood, or rules of food hygiene⁸. These rules were amplified by *Mishna* (part of the Talmud, finalized at 200 AD) under the *Tohorot Treaty*⁹, available in 10 chapters. An Israelite can not eat pigs, meat prepared with milk, certain species of birds, fish or quadrupeds. Dairy foods should be prepared in separate dishes and consumed some time before meat-based diet. The principles of kosher food were explained by the famous doctor and rabbi Moshe Maimonide (1135-1204)¹⁰, translated in Romanian. An interesting principle is that kosher food can be suppressed in the case of incurable patients with bad prognosis, but it must be maintained in the case of severe patients who have a chance of recovery¹¹. A Jewish patient could refuse pork foods. Religious Jews will prefer

⁷ Andorno, R., Biller-Andorno, N. and Brauer, S., *Advance Health Care Directives: Towards a Coordinated European Policy?* In: *European Journal of Health Law*, 2009, no. 16, pp. 207-227.

⁸ See *Holy Bible*: Genesis IX:4, Leviticus XI, XVII: 10, 11, 14, XX: 25, Deuteronomy XII:15-16, 22-25, XIV.

⁹ *The Mishnah*, translated from the Hebrew with Introduction and Brief Explanatory Notes by Herbert Danby, D.D., London Oxford, 1938, Humphrey Milford, Oxford University Press, p.714-732.

¹⁰ Maimonide, M., *Călăuza rătăciților*, București, Ed. Hasefer, 2000, p. 216-219.

¹¹ Hacothen, Menahem, Tercatin, Baruh, *Cartea vieții omului*, Ed. II, București, Ed. Hasefer, 2014, p. 234-238.

hospitalizations in specialized units patronized by Jewish religious organizations, in order to comply with kashrut rules.

(2) The Muslim cult is based on the Koranic revelation. The Qur'an provides strict food rules¹². Muslims are forbidden wine and alcoholic beverages, pork, flesh, etc. The rules are similar to those of the Old Testament. The Sunni Muslims have, through their tradition (Sunnah), even provisions¹³ that postulate how certain foods should be eaten, the position at the table, etc.

(3) The Seventh-day Adventist Church, in its Fundamental Beliefs, paragraph 21, related to the behavior of the faithful, provides for a sanitary reform and diet. Adventist believers can not consume alcohol and its derivatives, coffee, tein, drugs or excessive medication. Principles of the food Hebrew rituals are re-enacted, with a predominantly vegetarian regime. Coca-Cola drinks, etc. are also excluded. Adventist believers, in addition to strict observance of Saturday, must also adhere to strict dietary rules.

(4) The Association of Jehovah's Witnesses, who has legal recognition from the 9th of June 1990, proclaims certain principles of faith, one of the most known is the refusal of blood transfusions¹⁴. The biblical paragraphs quoted (Genesis IX: 4, Leviticus XVII: 11, Deuteronomy XII: 23-25) benefit from a particular forced exegesis, but the right of the Jehovah's believers to refuse blood transfusions by legal recognition of their cult is protected by law. Their religious literature urges them to warn their medical doctors about their religious affiliation, the impossibility of accepting blood transfusions, to make a written request to the physician, to whom they must address firmly but politely¹⁵. Moreover, Jehovah's Witnesses have and offer scientific studies on alternative blood transfusion treatments¹⁶.

4. The principle of autonomy versus the principle of beneficence. Which of them has priority?

One of the ethical issues emerging in our case is the conflict between two fundamental principles of medical ethics: the autonomy and the beneficence.

¹² Surahs: II: 168, 172-174, III: 93, IV: 160, V:1-5, 87-89, VI: 118- 19, 121, 138-146, XVI: 114-116.

¹³ *Riyad As-Salihin (Grădinile credincioșilor)* – Antology by Imam bin Sharaf-ud-Din a Nawawi, București, Ed. Islam, 1999, p. 245-255.

¹⁴ On the prohibition of blood transfusions, see: *** *Uniți în închinarea adusă singurului Dumnezeu adevărat*, Taunus (RFG), International Bible Students Association, 1987, p.154-160, ****Cunoștința care duce la viață veșnică*, Roma, Watchtower Bible and Tract Society of Pennsylvania, 2002, p. 128-129. Even if Jehovah's Witnesses change periodically the doctrine (cf. *Minuti, Lorenzo – I Testimoni di Geova non hanno la Bibbia*, Foggia, 1992, s.ed.), the position on transfusions has been maintained until today, despite requests for change done by many of their believers.

¹⁵ *Uniți în închinarea adusă singurului Dumnezeu adevărat*, Taunus (RFG), International Bible Students Association, 1987, p. 158.

¹⁶ See, *Clinical Strategies to Avoid Blood Transfusion. Hospital Information Services for Jehova's Witnesses*, Brooklyn, Watch Tower Bible and Tract Society of Pennsylvania, 2012.

The respect for the autonomy means giving weight to the opinions and choices of autonomous persons; refraining to obstruct their actions unless, obviously, these actions cause harm to others¹⁷. And the beneficence is the obligation to act for the well-being of patients.

In this case the medical doctors are facing with a conflict: what to do? Respecting the autonomy, free choices of the patient or save her life?

In the daily medical practice, this conflict is frequently¹⁸. Logically will be that the doctor, because of his knowledge and professional experience, should rationally and objectively evaluate the medical situation of his patient and to give solutions that lead to improving the patient's condition¹⁹.

Respecting autonomy assumes that the patient was informed about consequences of such decision. The question here is who informed this patient before taking the decision to refuse blood transfusions? The problem of "freedom" and "accurate information" when somebody drafts these documents is a challenge. Living wills specify what medical interventions are accepted to be done on a patient who is not anymore able to express his or her choice. And as the young woman was not yet a patient, with a medical condition, when she took this decision, she did not have any health professional who can inform her, adequately, about her present and future life. So, whose responsibility of informing individuals, the future patients, on interventions or treatments that they could refuse in advance is? This is a very problematic issue for patients and also for physicians.

Advance directives are usually incomplete, misfit, misunderstood²⁰. Like any unilaterally and revocable legal act, they are often incomplete, unsuitable, and difficult to understand and interpret. These acts would constitute a new concern for physicians; they could be more interested on legal requirements and on searching such documents than saving lives of patients and required treatment application. Also, the instructions may not match the current clinical complexities. In such circumstances, the document must be interpreted if it is not to be ignored. But health professionals may be uncertain whether to assume that anything unstipulated is unwanted and thus perhaps withhold measures that may actually be desired, or to assume to opposite and thus subject the patient to unwanted interventions. As living will concerns, in most of the time, to a hypothetical situation and it is signed before the occurrence of the condition in which the patient will lose the capacity to express his or her preferences, terms used by

¹⁷ Aluas, M., *Slovakia forced sterilization on roma women practices. An ethical case analyzes*, In: "Studia Universitatis Babeș-Bolyai, Bioethica", no. 60.2 (2015), p. 110.

¹⁸ See also: Aluas, M., Gherman, C., *Informarea pacientului și realizarea consimțământului informat în intervențiile vasculare și endovasculare*, in Gherman, C., *Angiologia și chirurgia vasculară*, Ed. Casa Cărții de Știință, Cluj-Napoca, 2016, pp. 243-264.

¹⁹ Aluas, M., *Bioetica medicală*, Ed. Medicală Universitară "Iuliu Hațieganu", Cluj-Napoca, 2016, p. 55.

²⁰ Ibidem, p. 72.

patients are to general and vague. The ambiguity determines interpretations and many questions for whose will apply or not treatments. The used terminology limits the application of this document and excludes certain situations, such as patients who never had the ability to express themselves, minors and mentally disabled patients.

Conclusions

What we learn from this case? Physicians are facing difficult problems and issues in the day-by-day practice. They need clear regulations and procedures in order to can make right decisions and do their best practice. But the legal framework in Romania is far from this purpose. Romania does not have yet a domestic regulation on advance directives. This text, limited as to extension and contents, does not aim to offer final answers to all these questions and challenges of contemporary medical practice. This is an invitation to raise more questions and open subjects prone to debate, which await much needed answers in our country as well as elsewhere. Ethical and legal issues are more and more a reality in the medical practice in Romania.

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