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Discussions on bioethics, criminal law, and Jehovah's witness patients

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Abstract

This study aims to reflect on the bioethical and juridical aspects tied to the doctor-Jehovah's Witness patient relationship. To that end, the work will focus, initially, on the doctor-patient relationship faced with the therapeutic obstacles of this group of patients, studying the relationship from the historical standpoint and elucidating the topics about the patients of this religion. Then, we will focus on the bioethical principles involved in the care for Jehovah's Witness patients, discussing each principle and its incorporation to the care for this group. Finally, we will focus on the juridical approach in the light of the patient's fundamental rights, characterizing the constitutional and criminal norms that apply to the care of health professionals to patients of this religion.

Keywords: Personal autonomy. Bioethics. Paternalism. Physician-patient relations. Religion.

Resumo

Discussões sobre bioética, direito penal e pacientes testemunhas de Jeová

Este estudo tem como finalidade refletir sobre os aspectos bioéticos e jurídicos implicados na relação médico-paciente testemunha de Jeová. Para isso, o trabalho abordará, inicialmente, a relação médico-paciente diante dos impasses terapêuticos desse grupo de pacientes, estudando essa relação do ponto de vista histórico e elucidando os pontos acerca dos pacientes adeptos à religião. Em seguida, abordar-se-ão os princípios bioéticos envolvidos no cuidado do paciente testemunha de Jeová, discutindo cada princípio e sua incorporação ao atendimento desse grupo. Por fim, será discutida a abordagem jurídica à luz dos direitos fundamentais do paciente, caracterizando as normas constitucionais e penais que se aplicam ao cuidado dos profissionais de saúde a pacientes adeptos a essa religião.

Palavras-chave: Autonomia pessoal. Bioética. Paternalismo. Relação médico-paciente. Religião.

Resumen

Debates sobre bioética, derecho penal y pacientes testigos de Jehová

Este estudio tiene como objetivo reflexionar sobre los aspectos bioéticos y legales involucrados en la relación médico-paciente de los testigos de Jehová. Para ello, se abordará inicialmente la relación médico-paciente ante los impasses terapéuticos de este grupo de pacientes desde la perspectiva histórica teniendo en cuenta a los pacientes practicantes de esta religión. Luego, se plantearán los principios bioéticos involucrados en el cuidado del paciente testigo de Jehová, discutiendo cada principio y su incorporación en la asistencia a este grupo. Por último, se discutirá el enfoque jurídico a la luz de los derechos fundamentales del paciente, caracterizando las normas constitucionales y penales que se aplican a la asistencia de los profesionales de la salud a los pacientes practicantes de esta religión.

Palabras clave: Autonomía Personal. Bioética. Paternalismo. Relaciones médico-paciente. Religión.

Research

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Known for preaching testimonies from house to house, Jehovah's witnesses (JW) correspond to a religious group that began in 1869, being initially a group of biblical studies, which later evolved into an extensive religious community. Its members must fulfill requirements as a form of commitment and fidelity to the kingdom of God, the best known being: avoid any type of civil interest, such as taking part in political parties and military service; and not undergo blood transfusion [1]. With all the peculiarities, JW are part of the users of health services, and therefore it is necessary to establish essential and unique care for these patients, and the health service must be prepared to welcome and care for them, respecting their autonomy.

Within the scope of medical practice, JW are considered a group that requires singular attention. This religious community has as an important foundation the position against treatments that involve blood transfusion, based on biblical writings present in the books of Genesis, Leviticus, and Acts, according to which receiving blood results in eternal damnation, as highlighted by Chehaibar [1]. For them, transfusion transforms them into polluted beings, allowing the community to implement punishments that may involve suspension of religious privileges, public censure, and disassociation, in which friends and family must avoid them [1].

In this scenario, bioethics serves as the basis for supporting the physician-patient relationship before this difficult situation. It brings with it principles defined as bioethical trinity, formed by autonomy, beneficence, and justice [2], in addition to proposals to be followed in this bond, always valuing a democratic and deliberative relationship, counting on the participation not only of the professional, but of all those involved in this bond, to choose the best intervention alternative.

In addition to this, in the legal perspective, these patients have fundamental rights, which must be considered and observed by the doctor, since the The Federal Constitution of 1988 guarantees to all individuals the right to religious freedom, also bringing in the *caput* of its 5th article a general clause of freedom, which covers the private autonomy of individuals and, therefore, aspects inherent to the dignity of the human person [3].

On the other hand, one must consider that the right to life is an unalienable fundamental right and therefore cannot be the object of provision by its holder. Thus, if a patient expressly disposes of his or her right to life for the sake of his or her right to religious freedom, the physician or health professional who acts in collusion with such a will (by both commission acts and omission acts) would not be exempt from legal sanctions, especially criminal ones, since the consent of the offended person (the patient) is irrelevant when it comes to unalienable rights, such as the right to life.

Therefore, from a legal point of view, the doctor has the duty to respect the autonomy and religious freedom of the patient, while having the duty to take care of the patient's life, under penalty of criminal liability. Undoubtedly, this is a complex and peculiar situation, which inspires further discussions to clarify the limits of the doctor's or health professional's work when caring for a Jehovah's witness patient.

Given the personal and professional impact of the JW patient's therapy, this study seeks to correlate the bioethical and legal aspects with the relationship between physician and Jehovah's witness patient, bringing, to that end, a discussion about the bioethical principles and the physician-patient relationship before therapeutic impasses, in addition to a legal approach in the light of the fundamental rights of the patient, with emphasis on the constitutional and criminal norms that apply to the therapeutic or surgical intervention of doctors and health professionals on patients adhering to this religious community.

Since this is a qualitative and descriptive study, the deductive approach method was used to seek to prove its hypothesis. To that end, we carried out a review of the narrative literature via a bibliographic search in databases and a targeted search, mainly related to the legal doctrinal content and the Brazilian legal system.

Relationship between physician and Jehovah's witness patient

Medicine and the physician-patient relationship have experienced periods of different characteristics regarding the interaction between the professional and patient poles. Initially qualified as paternalistic, the physician-patient relationship was based on the asymmetry between professional and patient,

based on the technical knowledge with which the doctor was endowed. It was understood that patients, being lay people, were not able to understand their health problems and, therefore, were not prepared to decide the best therapeutic option for themselves, assigning the technical autonomy to the doctor [4,5]. This paternalistic conception has gained foundation in numerous moments of history, among them, the conception of the *Hippocratic Oath*, which did not bring the sharing of the decision with the patient in their recommendations, in addition to the medieval periods, in which the medical figure began to be associated with a priestly ethics, whose authority was of divine origin [4].

From 1945 onward and the publication of *Universal Declaration of Human Rights*, it was possible to observe a change in the panorama of the physician-patient relationship, with the inclusion of the rights and freedoms of choice of the patient, promoting an inversion of happened previously [6]. That is, the doctor attributed to patients the choice about their treatment, even if they did not present themselves in adequate conditions for such a decision. This phase of focus on the patient also included the informed consent form, an instrument that is associated with respect to the patient's autonomy, but also with the rhetoric of freedom of choice and consumption [4,6].

It was only in the 20th century that the tendency to establish a horizontal physician-patient relationship emerged, in an attempt to abandon the asymmetries between the poles that promoted the verticalization of the relationship. At this stage, we began to value the joint decision involving all parties present in this bond, with the health professional and their team having the responsibility of clarifying all the therapeutic components to be performed, and the patient having the choice to confront the options and declare their wishes. Therefore, consent is no longer informed and starts to be called free and informed consent, counting on the activity of the two poles of the relationship [6].

Currently, the establishment of a deliberative and democratic position in medical practice is based, among several documents, on the Code of Medical Ethics (CEM), when it states that *it is forbidden for the doctor* (...) *to fail to obtain consent from the patient or their legal representative after clarifying them about the procedure to be performed, except in case of imminent risk of death* (art. 22), as well as *failing to ensure the patient the exercise of the right to freely decide on their person or well-being, as well as to exercise their authority to limit it* (art. 24) [7]. Thus, CEM establishes the duty of the physician to clarify the procedures and respect the patient's decision regarding the available options.

Therefore, in the relationship with a JW patient, the professional must have as a basis a deliberative position, offering the best options to the patient and accepting what is declared as their will, using the FIC as a tool. Faced with a patient with a clear capacity for understanding and decision-making and who does not present an imminent risk of death, the doctor should never violate their religious principles and, knowing that the philosophy of JW goes against blood transfusion therapies, the medical team should respect the autonomy and religious freedom of the patient, as well as their right to a dignified life, using alternative therapies to meet their needs. On the other hand, in cases of imminent risk of death, there is the exception brought by art. 22 of CEM [7], and the doctor can value the preservation of life and apply transfusion therapy without the patient's consent.

Bioethical principles

Care for the Jehovah's witness patient

In view of the technological advances involving the biological sciences, bioethics has come to ensure the responsible integration between life and biotechnology, considering the moral, social, and scientific dilemmas that arise in the midst of these associations. Bioethics is presented in the form of three principles, also called the bioethical trinity: autonomy, beneficence, and justice [1,2]. These are not regulatory, but serve as guidance for the reflection of professionals in their technical and scientific performance [2].

The principle of autonomy corresponds to respect and the right to self-government [2,5], that is, the right of patients to decide on their care, treatment, and everything that concerns their body [2]. The health professional and their team have the duty to respect the will of the patient or their legal representative, and must also respect their moral values and beliefs [8].

That is, faced with the reality of the treatment of a JW patient, it is up to the health professional to provide an integral and adequate reception of the patient, identifying their wishes, values, and particularities, so that the best therapeutic conduct is offered, consistent with the patient's wishes.

It is worth mentioning that, in this context, autonomy is present from the moment the professional fully and adequately explains to the patient and their families all the procedures to be performed, respecting the educational level of the patient and informing them with appropriate language. This is because, to make an adequate decision, the patient must fully understand the techniques, risks, complications, and alternatives, and it is up to the professional to enable them to deliberate and make their choices independently. It is in this context that the FIC stands out, which should always be used for the benefit of the patient and the professional, ensuring the autonomy of the physician-patient relationship [5,9].

The principle of beneficence has as its main focus to maximize the good of the other [2]. This principle guided the medical professional activity for years, founding Hippocratic ethics, being connected to another principle, that of non-maleficence, and both proved to be inseparable, since they constantly seek to obtain maximum benefits and minimum harms. Thus, according to these principles, health professionals should always evaluate the risks and benefits of their practices, exposing them to users of health services, so that they make the best choice considering the risk-benefit ratio.

Beneficence and non-maleficence should always be integrated with other bioethical principles, aiming at the non-use of beneficence in a paternalistic way, as occurred in past periods. That is, it is up to the doctor to technically evaluate the disease and analyze the best steps to be taken to solve the problem, based on beneficence and non-maleficence. From this, the patient and the family should be made aware of all the content that involves the options of choice, so that, among the best possibilities, the patient chooses the one that best matches their values.

The third principle, that of justice, can be defined by the phrase "we must treat equally the equal and unequally the unequal" [1], that is, the principle of justice is aimed at equity. It is based on freedom, equality, and balance of human relations, aiming at the equality of right to health services [2], by offering to each patient what presents itself as morally right, adequate, and ethically due [1]. Justice can be seen from different perspectives, and they can be utilitarian, liberal, egalitarian, or communitarian, allowing medical conducts and procedures not to be exempt from questions about the application of justice [1]. However, the reception and the construction of a good physician-patient relationship, based on bioethical principles and always valuing the practice of patient autonomy, will allow justice to be achieved, since professionals will guarantee singular care according to the singularities of each patient, whether they are JW or not.

In Brazilian law

Blood transfusion in Jehovah's witness patients

After a bioethical approach to the situations in which blood transfusion is necessary in JW patients, one should then proceed to a legal analysis of such a situation, to investigate the hypotheses in which, in addition to acting in violation of bioethical principles, the doctor or health professional also violates Brazilian legal norms. To that end, this study will address the context of blood transfusion in JW patients in light of the fundamental rights presented in the Federal Constitution [3], without loss to the assessment of possible criminal liability to the doctor who forcibly submits the patient to blood transfusion, so as to deny them the autonomy inherent in the physician-patient relationship today.

First of all, it should be borne in mind that the conduct of the JW patient, who refuses medical treatment for religious reasons, has constitutional protection. This is because the Federal Constitution of 1988 enforces, in its article 5, V, the fundamental right to freedom of belief, according to which *freedom of conscience and belief is inviolable, the free exercise of religious worship is guaranteed, and the protection of places of worship and their liturgies is ensured in the form of law* [3].

Therefore, the Constitution explicitly recognizes religious freedom, protecting the right to adhere or not to any transcendental faith and positively

welcoming the plurality of religious expressions in its constitutional system [10]. It should be noted that the refusal of blood transfusion by JW patients is understood as part of their dogmas and doctrines, thus belonging to the exercise of their religious faith.

In addition, the patient who refuses blood transfusion has at their side the principle of private autonomy, directly related to the bioethical principle of autonomy and considered the ethical element of the dignity of the human person. Such a principle is considered the foundation of the free will of individuals, which allows them to seek, in their own way, the ideal of living well and having a good life [11].

Because it is considered one of the elements of the principle of the dignity of the human person, private autonomy is present in the Federal Constitution of 1988, being established, in its article 1, III, as one of the fundamental principles of the Democratic State of Brazilian Law [3]. In this sense, private autonomy *expresses individual self-determination and results from the recognition of human beings as moral agents, capable of deciding what is good or bad for themselves, and with the right to follow their decision, as long as it does not violate the rights of others* [12].

Finally, private autonomy is related to the personal responsibility that each person has over their life, which includes making and executing final decisions that involve what type of life would be good to live [13]. It is understood that, in addition to not being able to violate the rights of others, private autonomy finds limits in unalienable rights, such as life. There is no question of private autonomy when a person asks the doctor for a lethal injection to end their own life. The inalienability of the right must therefore be considered a limit to this principle.

On the other hand, the conduct of rejecting blood transfusion can endanger two fundamental rights of extreme importance in the Democratic State of Brazilian law: the right to health and the right to life. The right to health urges the State to fulfill the demands that can provide citizens with a life without any compromise that affects their physical or mental balance. Thus, it can be said that its extent of incidence is very wide, since it encompasses all measures that protect the integrity of the human person [14].

It should be pointed out, therefore, that the right to health concerns not only the physical well-being of the individual, but also their mental and emotional balance. That is, the patient should not be understood by the doctor as a simply physical being, but rather as a complex existence, which includes physical, emotional, social, and spiritual aspects. If, on the one hand, the right to health of the individual is shown to be at risk by the fact that they deprive themselves of adequate treatment due to their religious convictions, there would be a violation of this fundamental right if the doctor unjustifiably imposed medical treatment on the individual, violating, in such a way, their mental well-being by subjecting them to treatment that affronts the teachings of their religion.

It should be borne in mind, given the above, that the fundamental right to health does not only give rise to the interpretation that there is an imposition on state entities in the sense of observing the right to health of individuals, whether in the defensive or service aspect. This is because the constitutional provision that concerns the right to health imposes on individuals themselves, in their horizontal relationships, the duty to respect the right to health of their equivalents, in order to guarantee the observance of the so-called horizontal effectiveness of fundamental rights [15].

Concerning the right to life, the *caput* of article 5 of the Federal Constitution of 1988 [3] advocates that the right to life will be considered inviolable, and that this will be guaranteed to Brazilians and foreigners residing in the country. It can be stated that the right to life consists in the right to be alive, to fight for living, to remain alive. Without loss, it is the right not to have the vital process interrupted, but by spontaneous and inevitable death [16].

In Brazil, the right to life is an unalienable fundamental right, that is, if a JW patient authorizes the doctor to take their life so that they do not have to undergo a blood transfusion, for example, even then this would be an illicit fact, since the consent of the victim cannot be valid in this case, because it is a right that cannot be provided by its holder.

In this context, there is a clear situation of collision of fundamental rights, since, if a Jehovah's witness individual decides to exercise their private

autonomy, preventing the health professional from submitting them to a blood transfusion, to guarantee the exercise of their religious freedom, their right to health and even their right to life may be impaired. Such a conflict situation must be solved by adopting the criterion of proportionality or by weighing the values involved.

It is very common to mention the principle of proportionality as a criterion intrinsic to the weighting of fundamental rights or even as a synonym for it. However, it should be understood that the principle of proportionality, developed by German jurisprudence and externalized in a rationally defined structure, with independent subelements, namely, analysis of adequacy, necessity, and proportionality in the strict sense [17], should only be applied when the restriction to a fundamental right is conveyed in the form of a rule present in an infra-constitutional normative text [18], so that the constitutionality of the infra-constitutional restrictive norm of fundamental rights is analyzed by analysis of its proportionality.

Despite this, there are cases in which there is no constitutional or infra-constitutional rule that disciplines the collision between fundamental rights. That is, it may be that a given collision situation has not yet been the subject of consideration by the legislator. In these cases, the application of the principle of proportionality is not appropriate, and one must adopt the technique of weighing between the potential principles applicable in the solution of the specific case [18].

The Federal Council of Medicine (CFM), a regulatory agency for the practice of Medicine in Brazil, ends up indirectly disciplining the attitude to be taken by the physician in the occasion of collision of rights, even if such provisions do not have legal scope, since it entails only physicians, and its infringement would generate only administrative responsibility to the offender. In this sense, as previously seen, the art. 22 of CEM [7], prohibits the doctor from not obtaining consent from the patient or their legal representative after clarifying to them the procedure to be performed, except in case of imminent risk of death.

Therefore, the expected conduct of a physician is that the will of the patient, in a horizontal physician-patient relationship, is respected by the health professional, even if such an attitude contradicts the prescription given by the physician based on the diagnosis. The patient's will may be waived only in case of imminent risk of death, when the fundamental right to life shall prevail over the patient's religious freedom.

Despite not having legal scope, the provisions contained in the CEM [7] are indirectly present in other legal acts. Art. 22 of CEM finds correspondence in art. 146 of the Criminal Code [19], which typifies unlawful constraint, that is, *compelling someone, by violence or grave threat, or after having reduced, by any other means, their capacity to resist, not to do what the law allows, or to do what it does not command* [19].

The penal legislator, however, excludes, in paragraph 3, I, of the article [19] analyzed, the typicality of the conduct of the intervening doctor or surgeon, *without the consent of the patient or their legal representative, if the intervention is justified by imminent danger to life*. Because it is provided for in the very device that provides for typified conduct, this is a legitimate legal cause for exclusion of typicality.

Nevertheless, the exclusion addressed can be clearly justified by one of the four exclusionaries of wrongfulness: the state of necessity. Article 24 of the Brazilian Penal Code provides: *one is considered to be in a state of necessity the one who practices the fact to save from actual danger, which they did not provoke by their will, nor could they otherwise avoid, their own or someone else's right, whose sacrifice, in the circumstances, it was unreasonable to demand* [19]. In this sense, the state of necessity is characterized by the collision of legal goods of different values, *with one of them having to be sacrificed for the sake of the preservation of the one who is reputed to be most valuable. (...) With this configuration, the delimitation of the state of necessity and the required safeguard conduct is usually done by the criterion of weighting of goods* [20].

Such a situation fits perfectly with the conduct of the physician who intervenes on the patient without their consent in case of imminent risk of death, since they practiced the fact to save from actual danger (death), which they did not cause by their will (the disease arises from natural causes, and not from the doctor's action) nor could they otherwise avoid, a right of others whose sacrifice was not

reasonable to demand (that is, the patient's life). Note, however, the passage in which the legislator provides that the agent could not otherwise avoid the present danger. That is, if there is a way to avoid the death of a patient who authorized it, the physician must try to execute it, and not choose a non-consensual intervention, under penalty of removing the incidence from the state of necessity and, thus, from the exclusion of typicality of art. 146, § 3, I, of the Criminal Code [19].

Therefore, we presented the requirements so that there is no criminal liability of the doctor who intervenes in a Jehovah's witness patient in order to forcibly submit them to blood transfusion. In short, one must seek to apply practical agreement between conflicting fundamental rights to harmonize the interests at stake. Thus, blood transfusion in absentia of the patient will only be possible in exceptional situations in which, cumulatively, there is a risk of death, blood transfusion is the only possible treatment, and, finally, when there are sufficient medical reasons to justify transfusion [21].

Let us now turn to the analysis of possible criminal liability to the doctor who intervenes in absentia of the patient to subject them to forced blood transfusion, especially in cases that involve any bodily injury resulting from such a therapeutic method. The Brazilian Penal Code [19] typifies, in its art. 129, bodily injury as a crime, which, at first, could generate criminal liability to the doctor who left bodily injuries in the patient undergoing blood transfusion. However, the doctrine [22] has defended the incidence of a theory capable of excluding the typicality of the conducts of health professionals who intervene in their patients for therapeutic purposes. It is the theory of conglobating typicality.

According to this theory, the judgment of typicality requires, in addition to legal typicality, a conglobating typicality, that is, consistent in the investigation of the prohibitive scope of the norm, which cannot be considered in isolation, but along with the legal order [23]. In this sense, it is verified that the Brazilian legal system, systematically analyzed, not only does not prohibit, but also encourages medical intervention in its patients for therapeutic purposes.

Law 8,080/1990 [24] (SUS Law) provides, in its art. 6, I, *d*, that a *comprehensive therapeutic care, including pharmaceutical one*, is included in the scope of the Brazilian Unified Health System (SUS). In addition, art. 19-M of the same legal act specifies comprehensive therapeutic care in *dispensing of medicines and products of interest to health* and the offer of therapeutic procedures, at home, outpatient, and inpatient regimes [24]. That is, the SUS law itself provides for the offer of comprehensive therapeutic care by doctors to their patients.

Interventions with therapeutic purpose are *those that pursue the conservation or restoration of health, the prevention of greater damage, or, in some cases, the simple attenuation or disappearance of pain* [25]. In this sense, interventions that end up generating some bodily injury to the patient also have a therapeutic end, when they pursue any of these objectives, even if they fail in their purpose.

In all therapeutic interventions that do not involve imminent risk of death, the doctor is obliged to ask for the patient's authorization, under penalty of bearing administrative liability. Nevertheless, it is worth discussing the criminal liability of the doctor in cases where, without the patient's authorization, the health professional intervenes for therapeutic purposes and ends up causing bodily injury (which can happen in the case of blood transfusion). The doctor may commit, in this case, a crime against personal freedom, more specifically, a crime of illegal constraint, according to art. 146 of the Criminal Code [19].

It should be pointed out, however, that, due to the fact that the Brazilian legal system encourages therapeutic medical intervention, no type of bodily injury resulting from such practice, regardless of the patient's consent, is punishable, as it lacks typicality due to the application of the conglobating typicality theory. Therefore, in cases that do not involve imminent risk of death, medical intervention on the patient should always be consensual, otherwise the health professional will be subjected to administrative accountability. In addition, criminal liability may be assigned *if it configures some type of offense against personal freedom, but never criminal typicality of injuries, because the therapeutic purpose excludes these interventions from the scope of prohibition of the type of injuries* [25].

Final considerations

Recognizing Jehovah's witness patients as endowed with their particularities through the therapeutic approach, especially before techniques involving blood transfusion, the need for the team to adapt the care to continue offering the best options to the users of health services is evident. The contrary expression coming from the patient is justified by their right to freedom of religion, as well as by the bioethical principle of autonomy, and, therefore, the doctor must respect and always act aiming at the bioethical principles and the patient's rights.

Such a will could only be disregarded in case of imminent risk of death, under the terms that art. 22 of CEM[7] and art. 146, § 3, I, of the Criminal Code[19] establish. However, in other circumstances, the disobedience of the health team to the patient's request would constitute a crime of illegal constraint, provided for in the Criminal Code, in addition to being a conduct subject to administrative liability for flagrant noncompliance with the CEM. In addition, a medical action that unduly violates the patient's will decisively hurts the fundamental right to health, especially in its social and spiritual aspects. Finally, by preventing a patient who is not at risk of death from having control over their own body, one of the fundamental elements of the dignity of the human person is disrespected: the principle of private autonomy.

Thus, it is up to the professional to act based on bioethical principles, always with a view to maintaining the patient's rights. A horizontal relationship must be built between both poles, in which the professional recognizes the patient as an entity beyond the disease and, given their particularities, offers convenient therapeutic options for the case. With this, the professional can be in accordance with the ethical and legal ideals established for the profession and patients can receive an adequate medical approach, considering them a biopsychosocial and spiritual being.

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