Moral Distress in Caring for the Jehovah's Witness Patient

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MORAL DISTRESS IN CARING FOR THE JEHOVAH'S WITNESS PATIENT

American society celebrates men and women who willingly lay down their lives for that in which they believe. We celebrate, for example, the lives of those who breathed their last in war, and we are humbled by the selfless witness of those who were martyred for their religious convictions. The words of such persons inspire in us great confidence. “From the moment they speak to us of what . . . [they] perceive deep down as the truth . . . [they] provide evidence of a love that has no need of lengthy arguments in order to convince.”¹ In light of this affirmation, we must ask why we often fail to honor those in our medical care who allow neither suffering nor death to “lead them to abandon the truth that they have discovered”²—a truth in which they place their faith, one for which they are willing to lay down their lives. For the Jehovah’s Witness patient, the search for meaning “looks not only to the attainment of truths that are partial, empirical or scientific. . . . Their search looks towards an ulterior truth that would explain the meaning of life. And it is therefore a search that can reach its end only in reaching the absolute.”³

Philosophy, theology, and, perhaps most explicitly, the law, are quite clear on the issue of informed refusal on the part of the competent Jehovah’s Witness patient (i.e., a person who possesses the capacity to understand the information before him, make a judgment about this information in light of his values, intend a particular outcome, and communicate freely his wishes to caregivers⁴): it would be “morally outrageous and criminal assault and battery to transfuse him” against his will.⁵

When the wishes of patients do not resonate or are incompatible with the values held by and/or duties required of caregivers, moral distress is sure to follow—but it need not have the last word.

For caregivers, one source of moral distress is accepting the fact that, in some cases, the best moral treatment does not include medical treatment.

For Jehovah’s Witness patients, one source of moral distress involves communicating effectively and embodying a belief at the very core of their being, namely, that physical life is not a value to preserved for itself, but is precisely the condition for another, higher value: eternal life. This sort of theological logic turns on the notion that “men and women are always called to direct their steps towards a truth that transcends them. Sundered from that truth, individuals are at the mercy of caprice, and their state as person ends up being judged by pragmatic criteria based essentially upon experimental data, in the mistaken belief that technology must dominate all.”⁶

². John Paul II, Fides et Ratio, no. 32.
⁶. John Paul II, Fides et Ration, no. 5.
“A religion that prohibits blood transfusions is not inherently inimical to life,” and though it might value eternal life more than physical life, “it is nonetheless a belief of a patient that deserves respect.” The truths sought in the interpersonal relationship between caregivers and Jehovah’s Witness patients ought not primarily to be empirical or philosophical. Rather, what ought to be sought “is the truth of the person—what the person is and what the person reveals from deep within. . . . It is in this faithful self-giving that a person finds fullness of certainty and security.”

Of particular help in discerning what ought to be done in the midst of ethical uncertainty is to seek common ground. The fact that, for the Jehovah’s Witness patient, eternal life is valued more than physical life does not de facto suggest or imply that she does not value physical life. Rather, physical life is simply not valued as an end in itself, but as a means to a greater end: eternal life. Physical life, then, understood in this context, is a penultimate, not an ultimate, reality. The endeavor to preserve, support, and promote continued living is not only, therefore, the concern of the caregiver; it is the equal concern of the patient.

It is the caregiver’s right—professionally, legally, and morally—to refuse to participate in any treatment with which he genuinely disagrees for a multitude of reasons, be it a disproportionate ratio of benefits and burdens, care thought to be futile, or the like. Indeed, medical practice would run amok if certain safeguards were not in place—if reason was lost, and with it, freedom. Medicine without freedom would lack morality, since persons without freedom lack the capacity for moral action. In a word, we are in favor of freedom if we are in favor of morality. The Jehovah’s Witness patient, much like the caregiver, is in favor of freedom, and is certainly in favor, as is clear by what she is willing to sacrifice for her beliefs, of morality. Hence, both the caregiver and the patient have more in common than is often imagined. Indeed, “we have two sets of basic values here, not just one ‘right’ one,” and certainly not one “for” and another “against.”

In situations such as the one under consideration, it may be beneficial to foster an ethical shift from principles to values. To be sure, values ought not to be honored at the cost of our duty to honor principles, but principles, and our fulfillment thereof, ought not to become ends in themselves. In ethics, values are our path and ultimate end, and principles our blueprint and compass, our means.

An ethics of care is not first concerned with the decisions before the person, but with the person who makes decisions. “The shift to the human person has allowed a movement away from basing moral conclusions on the finality of bodily structures and functions taken independently of the totality of the person. . . . In other words, in personalistic morality the person adequately considered is the criterion for discovering

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whether an act is morally right.”\textsuperscript{11} Thus, “an action is morally right if it is beneficial to the person adequately considered in himself or herself (i.e., as a unique, embodied spirit) and in his or her relations (i.e., to others, to social structures, to the material world, and to God).”\textsuperscript{12} As a result, ethics, and medical ethics in particular, “from a personalistic perspective must take into account the experiences of people over time in order to determine what sorts of activities best serve the person adequately considered.”\textsuperscript{13} Therefore, the ethics of care in healthcare “must include not only deductive but also inductive methods in order to take human experience seriously.”\textsuperscript{14}

Finally, we would do well to remember that “in understanding a complex situation, we must use intelligence to grasp relationships and details about the people, the circumstances [and intentions], and the problem. But equally important, we must use empathy to understand the concerns and feelings of the people involved. We must identify with those in need or conflict, see what is at stake from their point of view, and ascertain their worries and concerns. We must also bring to the situation of moral conflict or doubt such . . . [values] as caring, consideration, kindness, concern for others, compassion, understanding, generosity, sympathy, helpfulness, and a willingness to assume responsibility.”\textsuperscript{15} Difficult though it may be to comprehend for the medical mind, the best moral treatment at times includes no medicine at all. And simply because one is unable to put to use practical skills mastered does not imply that treatment has expired or lost its place. Indeed, it can be seen as an invitation to treat on the most profound level of which human beings are capable: from the depths of the heart. While medicine has its limits, care certainly does not.

REFERENCES


\textsuperscript{12} Gula, \textit{Reason Informed by Faith}, 73.

\textsuperscript{13} Gula, \textit{Reason Informed by Faith}, 73.

\textsuperscript{14} Gula, \textit{Reason Informed by Faith}, 73.
