

## The ethics of blood transfusion refusal in clinical practice among legal and medical professions in Japan

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### ABSTRACT

We investigated the differences in Japanese and United States medical and legal professional opinions on ethical support for clinical ethical issues using the refusal of blood transfusions on the grounds of religious principles as an example of a clinical ethical issue. In ethical support systems for medical institutions in Japan, 95.0% of “clinical training designation hospitals” have hospital ethics committees, and 63.1% have medical safety divisions; clinical ethical support is provided in accordance with their scale and function. In terms of clinical ethical support limits the discretion of physicians, 59.2% of lawyers responded “No” and 54.4% of doctors responded “Yes”. In addition, on the feasibility of government or academic guidelines in clinical practice, 37.7% of lawyers responded “Yes” and 63.0% of doctors responded “No”. In terms of “relative transfusion-free” policy, 83.2% of lawyers and 76.8% of doctors responded that it is “unavoidable,” while 81.6% of U.S. committee heads responded that it is a “violation of rights.” In terms of hospital transfers due to a hospital being unable to treat patients refusing blood transfusion, 62.6% of lawyers reported that it is “unavoidable” while 57.1% of U.S. committee heads reported that it “should be avoided”. The results of this study indicate that medical and legal professionals and U.S. ethics committee heads recognize clinical ethical issues in slightly different ways.

Keywords: clinical ethics, medical practice, hospital ethics committee, clinical ethical support, blood transfusion rejection

#### Abbreviations:

CEC: Clinical ethical consultation

GL: Guidelines

HEC: Hospital ethics committee

HSD: Medical safety division

MC: Multidisciplinary conferences

U.S.: United States (of America)

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### INTRODUCTION

In clinical practice, doctors often grapple with ethical issues such as the refusal of blood

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transfusions for religious reasons or halting life-sustaining treatment in the terminal phase of illnesses. In the past, doctors initiated treatment plans that prioritized the preservation of the patients' life first and did not have any trouble in the face of such ethical issues. However, in recent years, the right to patient self-determination is becoming increasingly important. Doctors need to regard the wishes of patients concerning treatment and may not assume life support as the first priority. Thus, doctors are faced with the difficulties of adopting new ethical values that respect patients' right to self-determination even if these values may conflict with traditional medical ethics. The existence of conventional medical ethics that embody the one-dimensional response of preserving life above all else has thus come into focus as an important issue.<sup>1</sup>

Such clinical ethical issues are closely tied to friction with moral or religious views, leading to difficulties acquiring the consent of society and all the parties concerned. Currently, there is a need for a systematic response from doctors to address these issues; decisions should be informed according to not only clinical staff but also according to laws and guidelines, as well as ethical committees. Furthermore, in contemporary Japan, there are occasional cases of medical staff being arrested for administering specific treatments. It is therefore important that doctors who have provided professional and ethical treatment that ultimately results in worsening symptoms or mortality not be legally liable.

Conversely, in clinical practice, ethical issues are extremely diverse due to the idiosyncratic circumstances of individual cases. When investigating an issue, a cooperative effort between medical professionals (doctors) and legal professionals (lawyers) is needed. In addition to medical investigations, we also need to investigate changes in ethical principles and laws. However, in Japan, where lawyers' contributions to clinical practice are passive, it is difficult to imagine the current state of affairs as a proactive joint effort involving both parties in a medical setting at a practitioner level.

The refusal of blood transfusions due to religious principles is one example of a clinical ethical issue that can be focused on. In this study, a survey was conducted on the doctors and lawyers in Japanese medical settings, as well as the heads of hospital ethics committees (HECs) in United States hospitals, to examine a variety of perspectives on clinical ethical issues in various professions.

## METHODS AND MATERIALS

The 4,953 total participants in this survey consisted of 2,484 lawyers who were members of the bar associations in the Tokai region of Japan (Aichi, Mie, Gifu, and Shizuoka prefectures) (hereby referred to as "lawyers") and 978 Japanese doctors who were either acting as HEC chairpersons or were in charge of medical safety divisions at clinical training designation hospitals (hereafter referred to as "clinical training designation hospitals").<sup>2</sup> In addition, there were 332 directors of small-scale hospitals (i.e., 200 beds or less) in the Tokai region of Japan (hereafter referred to as "small-scale hospitals") and 1,159 directors of welfare-based nursing homes (geriatric health services facilities) that provide advanced care for the elderly in Japan (hereafter referred to as "elderly care facilities") (Table 1a).

Finally, this study included 244 HEC heads from hospitals in the United States with publicly known HEC heads; these HEC heads were from hospitals listed in the United States hospital rankings published in Becker's Hospital Review-100 Great Hospitals in America<sup>3</sup> and the United States News and World Report-Best Hospitals<sup>4</sup> (hereafter referred to as "U.S. committee heads") (Table 1b).

This study took place from March to August 2017. All questionnaires for the doctors, U.S.

**Table 1a** Response to a questionnaire in Japan

	Occupation	Questionnaires sent	Response (rate)
Lawyers	Lawyers (Aichi, Mie, Gifu, and Shizuoka Bar Associations)	2484	268 (10.8)
	Clinical training designation hospitals Those in charge of clinical ethical issues	978	379 (38.8)
Doctors	Directors of small-scale hospitals (200 beds or less) (Aichi, Mie, Gifu, and Shizuoka)	332	113 (34.0)
	Elderly care facilities (All Japan) (extended care facilities providing advanced care for elderly people)	1159	320 (27.6)
	Total	4953	1080 (21.8)

Table 1a shows the number of questionnaires sent and the response rate in terms of occupations.

**Table 1b** U.S. committee heads' response to the questionnaire

	Questionnaires sent	Response (rate)
HEC committee heads	244	42 (17.2)

Table 1b shows the number of questionnaires sent and the response rate of U.S. committee heads.

committee heads, and lawyers were sent via mail with the exception of the lawyers in the Aichi Prefecture Bar Association, for whom the questionnaires were directly deposited in the Aichi Prefecture Bar Association mailbox after obtaining the permission from its head. All of the participants' decision to participate in the survey was completely voluntary. Returning the completed surveys was considered an indicator of their consent to participate in this study.

## RESULTS

### *Response Rate*

Of all surveys distributed, 268 lawyers (10.8% response rate), 379 clinical training designation hospitals (38.8% response rate), 113 small-scale hospitals (34.0% response rate), and 320 elderly care facilities (27.6% response rate) returned their completed surveys (Table 1a).

Of the 268 lawyers that responded, 103 had been involved in medical malpractice litigation (38.4%), 56 had provided medical institutions with counsel (20.9%), 38 were members of HECs (14.2%), and 2 had experience in drafting guidelines for medical care (0.7%). Multiple answers were accepted for each respondent (Table 1c).

Forty-two U.S. committee heads (17.2% response rate) responded to our survey. The occupations of the U.S. committee heads were as follows: 11 clinicians (26.2%), 10 medical staff (23.8%), 5 lawyers (11.9%), 3 medical researchers (7.1%), 1 legal researcher (2.4%), and 12

**Table 1c** Contributions of lawyers to clinical practice

Contributions to treatment	Number (Rate)
Involved in medical malpractice litigation	103 (38.4)
Advisor for medical institutions	56 (20.9)
Ethics committee member	38 (14.2)
Creating medical care guidelines	2 (0.7)
None	124 (42.7)
Total	268 (100)

Table 1c shows the contributions of 268 lawyers to clinical practice (multiple answers were allowed).

**Table 1d** Occupation of U.S. HEC committee heads

Occupation	Number (rate)
Clinician	11 (26.2)
Medical Staff	10 (23.8)
Lawyer	5 (11.9)
Medical Researcher	3 (7.1)
Legal Researcher	1 (2.4)
Others	12 (28.6)
Total	42 (100)

Table 1d shows the 42 U.S. HEC committee heads classified into 7 groups in terms of occupations.

“other” (28.6%) (Table 1d). Of the 12 “other,” 6 were ethicists, 1 was a clinical ethics consultant, and 5 were unknown.

#### *Clinical Ethics Support Systems at Medical Institutions*

Concerning the clinical training designation hospitals, 360 have HECs (95.0%), 44 provide clinical ethical consultation (CEC; 11.6%), 239 have medical safety divisions (MSDs; 63.1%), and 157 hold multidisciplinary conferences (MCs; 41.4%). Of the small-scale hospitals, 47 have HECs (41.6%), 4 provide CEC (3.6%), 62 have MSDs (54.9%), and 38 hold MCs (33.6%).

Of the elderly care facilities, 49 have HECs (15.4%), 7 provide CEC (2.2%), 107 have MSDs (33.5%), and 186 hold MCs (58.3%).

Finally, concerning the institutions of the U.S. committee heads (N = 42), 39 have HECs (92.9%), 39 provide CEC (92.9%), 8 have MSDs (19.0%), and 7 have "other" (16.7%). Multiple answers were accepted for all institutions (Table 2). Of the 7 "other," 2 were "ethics centers," 1 provided "preventive ethics rounds," 1 offered "ethics education," and 3 were unknown (Table 2).

#### *Clinical Ethics Support Systems and the Discretion of Medical Staff*

When queried whether or not clinical ethical support, such as guidelines, HEC, and CEC constrain the discretion of physicians in clinical practice, 81 of the 260 lawyers answered "Yes" (31.2%), while 154 answered "No" (59.2%). Moreover, of all the participating doctors (N = 794), 432 (54.4%) answered "Yes," and 295 (37.2%) answered "No" (Table 3).

#### *Benefit of Guidelines for Clinical Ethical Issues in Practice*

The results indicate that among the lawyers (N = 268), 101 (37.7%) answered that government/academic guidelines "are effective," while 83 (31.0%) answered that they are "not effective." On the other hand, of all the doctors (N = 812), 269 (33.1%) answered that guidelines "are effective," while 511 (62.9%) answered they are "not effective" (Table 4).

**Table 2** Clinical ethics support systems at medical institutions

Character of institution	Number of responses	HECs	CEC	MSDs	MCs	Other	None
Clinical training designation hospitals	379 (100)	360 (95.0)	44 (11.6)	239 (63.1)	157 (41.4)	17 (4.5)	1 (0.3)
Small-scale hospitals (200 beds or less)	113 (100)	47 (41.6)	4 (3.6)	62 (54.9)	38 (33.6)	9 (8.0)	22 (19.5)
Elderly care facilities	320 (100)	49 (15.4)	7 (2.2)	107 (33.5)	186 (58.3)	29 (9.1)	96 (30.1)
HEC committee heads (U.S.)	42 (100)	39 (92.9)	39 (92.9)	8 (19.0)	—	7 (16.7)	—

Table 2 shows the number and rate in parentheses of clinical ethics support systems at medical institutions.

**Table 3** Clinical ethics support systems (GL, HEC, CEC) and the discretion of doctors

Occupation	Number of responses (rate)	Yes	No	Other	Unknown
Lawyers	260 (100)	81 (31.2)	154 (59.2)	25 (9.6)	8 (3.1)
Doctors	794 (100)	432 (54.4)	295 (37.2)	67 (8.4)	17 (2.1)
Total	1054	513	449	92	25

Table 3 shows opinions on constraint of doctors' discretion by clinical ethics support systems.

**Table 4** The effectiveness of government/academic guidelines

Occupation	Number of responses (rate)	Effective	Not effective	Unclear
Lawyers	268 (100)	101 (37.7)	83 (31.0)	84 (31.3)
Doctors	812 (100)	269 (33.1)	511 (62.9)	31 (3.8)
Total	1080	370	594	115

**Table 5** Deterrent against criminal investigation by guidelines

Effect of guidelines on deterring criminal investigations	Number (rate)
Holds promise	132 (50.8)
Does not hold promise	109 (41.9)
Other	19 (7.3)
Total	260 (100)

Table 5 shows the efficacy of guidelines as a deterrent to criminal investigations by lawyers.

Additionally, when asked if medical staff following guidelines could deter criminal investigation, 132 lawyers (50.8%) reported that they “hold promise” (Table 5).

#### *System Applied to Respond to Blood Transfusion Refusal Cases*

Among the lawyers sampled (N = 268), 107 (40.0%) answered “legislation/justice,” 39 (14.6%) answered “guidelines,” 141 (52.6%) answered “institutional policies,” 95 (35.4%) answered “HECs,” and 41 (27.2%) answered “CEC” (multiple answers were allowed). On the other hand, of all the doctors (N = 492, when excluding those from elderly care facilities), 194 (39.4%) answered “legislation/justice,” 117 (23.8%) answered “guidelines,” 262 (53.3%) answered “institutional policies,” 275 (55.9%) answered “HEC,” and 113 (23.0%) answered “CEC” (multiple answers were allowed). Finally, of the U.S. committee heads, 25 (59.5%) answered “guidelines,” 21 (50.0%) answered “institutional policies,” and 23 (54.8%) answered “HEC” (multiple answers were accepted) (Table 6).

#### *Evaluation of “Relative Transfusion-Free” Policy*

Next, we asked about a relative transfusion-free policy, wherein treatment is conducted without blood transfusions as far as possible, but when a blood transfusion is absolutely necessary to save a patient’s life, it is performed. Among the lawyers (N = 262), 34 (13.0%) responded that it is a “violation of rights,” and 218 (83.2%) responded that it is an “unavoidable circumstance.” On the other hand, of doctors (N = 474, excluding those from elderly care facilities), 88 (18.6%) responded that it is a “violation of rights,” and 364 (76.8%) responded that it is an “unavoidable

**Table 6** System applied when blood transfusions are refused

Occupation	Total	Legislation/ justice	Guidelines	Institutional policies	HECs	CEC	Other
Lawyers	268 (100)	107 (40.0)	39 (14.6)	141 (52.6)	95 (35.4)	41 (27.2)	16 (3.7)
Doctors	492 (100)	194 (39.4)	117 (23.8)	262 (53.3)	275 (55.9)	113 (23.0)	24 (4.9)
HEC Committee heads (U.S.)	42	–	25 (59.5)	21 (50.0)	23 (54.8)	11 (26.2)	–

**Table 7** Evaluation of “relative transfusion-free” policy

Occupation	Number of responses (rate)	Rights violations	Unavoidable (public)	Other
Lawyers	262 (100)	34 (13.0)	218 (83.2)	10 (3.8)
Doctors	474 (100)	88 (18.6)	364 (76.8)	22 (4.6)
Total	736 (100)	122 (16.6)	582 (79.1)	32 (4.3)
HEC committee heads (U.S.)	38 (100)	31 (81.6)	1 (2.6)	6 (15.8)

circumstance.” Finally, of the U.S. committee heads (N = 38), 31 (81.6%) responded that it is a “violation of rights,” and only 1 (2.6%) responded that it is an “unavoidable circumstance” (Table 7).

#### *Hospital Transfer Due to Blood Transfusion Refusal*

When asked about the transfer of a patient to a different hospital because the hospital cannot treat them due to the blood transfusion refusal, 111 (42.4%) of the lawyers responded that it is “appropriate,” 164 (62.6%) responded that it is “unavoidable,” and 41 (15.6%) responded that it “should be avoided.” Of the doctors (N = 492, excluding elderly care facilities), 250 (50.8%) responded that it is a “violation of rights,” 276 (56.1%) responded that it is an “unavoidable circumstance,” and 28 (5.7%) responded that it “should be avoided.” Finally, of the U.S. committee heads, 20 (57.1%) responded that it “should be avoided,” and only 3 (8.6%) responded that it is “unavoidable” (Table 8).

#### *Bloodless Medicine with no Japanese Health Insurance Coverage*

When asked whether or not treatment with no blood transfusions should be conducted in cases not covered by Japanese health insurance, of all the lawyers who responded, 35 (13.1%) answered “it should not be administered,” 12 (4.8%) reported “it should be administered at the cost of the medical institution,” and 202 (75.4%) reported “it should be administered at the cost of the patient.” Of the doctors (N = 492, excluding elderly care facilities), 209 (42.5%) answered “it should not be administered,” 23 (4.7%) reported “it should be administered at the

**Table 8** Hospital transfer due to blood transfusion

Occupation/ institution	Total	Appropriate	Unavoidable	Should be avoided
Lawyers	262 (100)	111 (42.4)	164 (62.6)	41 (15.6)
Doctors	492 (100)	250 (50.8)	276 (56.1)	28 (5.7)
Total	754 (100)	361 (47.9)	440 (58.4)	69 (9.2)
HEC committee heads (U.S.)	35 (100)	—	3 (8.6)	20 (57.1)

Table 8 shows the evaluations of hospital transfer due to blood transfusion refusal among legal and medical professions.

**Table 9** No blood transfusions with no Japanese health insurance coverage

Occupation	Total	Not necessary to implement	Implemented at the cost of the medical institution	Implemented at the cost of the patient	Insurance request	Other
Lawyers	268 (100)	35 (13.1)	12 (4.8)	202 (75.4)	41 (15.3)	7 (2.6)
Doctors	492 (100)	209 (42.5)	23 (4.7)	171 (34.8)	46 (9.3)	33 (6.7)
Total	760 (100)	244 (32.1)	35 (4.6)	373 (49.1)	87 (11.4)	40 (5.3)

Table 9 shows the management of no blood transfusion therapy with no Japanese insurance coverage at hospitals.

cost of the medical institution,” and 171 (34.8%) said “it should be administered at the cost of the patient” (multiple answers allowed) (Table 9).

## DISCUSSION

Focusing on doctors’ responses to the legal risks inherent to treatment is indispensable when providing clinical ethical support for clinical ethical issues. However, that alone is not enough. For clinical ethical support, we must satisfy not only the interests of the doctor by avoiding legal risks but also those of the patient. In other words, clinical ethical support can aid doctors in viewing ethical issues beyond the lens of risk management for doctors and medical institutions and help open up more avenues to safeguard against treatment risks through patients and medical staff cooperation toward finding the best treatment option for the patient.<sup>5</sup>

This survey showed that in clinical training designation hospitals that play a guiding role in their areas, 95% have HECs and 63.1% have medical safety divisions, while 58.3% of elderly care



facilities are involved with MCs (Table 2). The selection and implementation of clinical ethical support in accordance with the scale/function and manpower of medical institutions are currently seen in practice.<sup>6</sup> Medical conferences have the motivational power from medical institutions that are able to share issues and easily conduct comparisons. Therefore, these conferences are arguably suitable for elderly care facilities and small-scale medical institutions as a clinical ethical support measure. However, as maintaining transparency surrounding decisions is essential, they need to maintain a diverse membership to avoid only a minority of members taking initiative.

In Japan in the past, there were few medical institutions with HECs that dealt exclusively with clinical ethical issues.<sup>7</sup> In 2005, only 24.7% of clinical training designation hospitals had HECs, and these institutions did not have appropriate systems for immediate deliberation and decision-making concerning clinical ethical issues.<sup>8</sup> In this study, 95% of clinical training designation hospitals had HECs, and 63.1% had medical safety divisions. Medical institutions have come to recognize the importance of clinical ethical issues and have promoted means of clinical ethical support. As a result, these Japanese institutions arguably match the level of United States institutions that have had HECs since the 1980s.<sup>9</sup>

Doctors firmly believe that clinical ethical issues should be solved in clinical practice. Some doctors view clinical ethical support negatively, as it may restrict their discretion in medical practice that was secured in the past.<sup>10</sup> Doctors who do not apply ethical consultation tend to believe that it is their responsibility to resolve ethical issues with patients and their families.<sup>11</sup> In Europe, doctors place particular importance on the autonomy of specialists. Therefore, clinical ethical support from outside sources should be conducted with care in such cases.<sup>12</sup> In this study, 54.4% of doctors expressed concerns that their “discretion in decision-making decreased” as a result of clinical ethical support, while 59.2% of lawyers opined that doctors’ discretion in decision-making did not decrease. To dispel doctors’ concerns, it is necessary to proactively demonstrate the benefits of clinical ethical support to doctors and thus the provision of optimal benefits to patients (Table 3).

Concerning government and academic guidelines for clinical ethical issues as a means of clinical ethical support, more than 60% of doctors responded that their publicity was insufficient and that the guidelines were not effective in clinical practice (Table 4). Thus, due consideration of the promotion of the guidelines for clinical practice and their application in practice is required.<sup>13</sup> Even clinical ethical support strategies, such as guidelines, do not have a direct effect on the legal liability of doctors.<sup>14</sup> Yet interestingly, 50.8% lawyers in this study reported that following government/academic guidelines could deter malpractice investigations (Table 5). In the United States, the legal liability of doctors tends to be recognized<sup>15</sup> due to clinical ethical support such as legislation, including the Death with Dignity Act and court decisions. Further future discussions of this is needed in Japan as well.

In this study, refusing blood transfusions on religious grounds was raised and investigated as an example of a clinical ethical issue. In Japan, there have been cases in the past where there have been struggles dealing with patients who refused blood transfusions due to their religious principles. As clinical ethical support for cases of blood transfusion refusal, the majority of lawyers and doctors responded that academic guidelines would be ideal as a systematic response (Table 6). The benefits of guidelines are that — compared to drafting legislation — it is not only easier to come to an agreement among all involved parties, but the issues inherent to individual cases can be dealt with flexibly. Moreover, as opposed to cases limited to only to tangible HEC hearings, if planned standards are made clear as rules, it is easy to obtain public authority simply through critical examination.<sup>14</sup>

When a blood transfusion is essential for treatment to preserve a patient’s life, it is difficult to reconcile the respect for the right of self-determination of the patient who refused the

blood transfusion and the demand for life support. In Japan, there is no precedent for cases of “forbearance” where a blood transfusion is not performed, thus respecting the patient’s right to self-determination and consequently the death of a patient.<sup>16</sup> Theoretical opinions on the matter are divided. Under these conditions and considering both the respect for life and the legal risks, doctors at major hospitals tend to hold the opinion that if it is necessary to save a patient’s life, the blood transfusion ought to be performed. Therefore, in Japan, many medical institutions do their utmost to adopt transfusion-free treatment, so they follow the “relative transfusion-free” policy, where a transfusion is performed only when it is necessary to preserve a patient’s life.<sup>17</sup> In this study, 83.2% of lawyers and 79.1% of doctors responded that the “relative transfusion-free” policy was “unavoidable.” Moreover, when considering the inevitable transfer of patients who do not accept the “relative transfusion-free” policy to a different hospital, 62.6% of lawyers and 58.4% of doctors responded that it is “unavoidable.” The results of this study show that the relative transfusion-free policy is widely accepted by the legal and medical professions in Japan.

Contrastingly, 31 (81.6%) of the U.S. committee heads responded that the relative transfusion-free policy is an “infringement upon patient rights,” and 20 of them responded that hospital transfers “should be avoided” (Tables 7, 8). One of the reasons for this may be that in the United States, medical practices that infringe upon the right of self-determination based on religion are established through legal cases regarding the right of self-determination concerning religious beliefs.<sup>18</sup> Until the early 1970s in United States cases, courts tended to order blood transfusions to respect the interest of the state. If an adult Jehovah’s Witness has competently withheld their consent to blood transfusions, there appears to be no legal justification for complete denial of their right to refuse a transfusion.<sup>19</sup> However, more recently, the courts have tended to recognize Jehovah’s Witnesses’ right to refuse to consent to a blood transfusion, even when their lives are at risk, because the right of individual self-determination have weighed against the paternalistic concerns of the state.<sup>20</sup> When confronted by a situation where a competent adult refuses a blood transfusion for religious reasons, most hospitals will try to protect themselves from liability by turning over the decision on whether to transfuse to the courts. This is only to be expected; if the hospital goes against the patient’s wishes and transfuses, it may be liable for assault, but if it follows the patient’s wishes and does not transfuse, it could be liable criminally and/or for damages to the survivors if the patient dies. The decision not to perform a life-saving procedure when it can be done is diametrically opposed to the philosophy and ethics of health professionals. It is contrary to the most fundamental teachings of medicine to allow a patient whose life could be saved to die. Therefore, rather than making such a difficult decision on its own, a hospital will generally look to the courts for instructions on how to proceed.<sup>21</sup> Guidelines for transfusion options and alternatives by the New York State Council state that the courts have ruled that patients who are competent adults have the right to make their own health care decisions and endorse hospitals that have successfully obtained court orders to appoint a guardian to make health care decisions that may allow transfusion against the parents’ wishes when confronted with ethical dilemmas. Moreover, doctors are strongly advised to consult with their legal counsel to establish an institutional policy on these matters.<sup>22</sup> In Japan, the discretion of doctors to make decisions concerning treatment is regarded as important. Therefore, the right of self-determination concerning religious beliefs may be restricted.

In cases of bloodless treatment that are not covered by Japanese medical insurance, for example “administering a hematopoietic drug for a bloodless surgery,” 75.4% of lawyers reported that such treatment “should be conducted at the patient’s expense.” Conversely, among doctors, 42.5% stated that “it should not be administered,” and 34.8% reported “it should be administered at the cost of the patient,” revealing a difference in opinion between the professions (Table 9). One factor that may lead to this difference is that doctors actually administer treatment in a

clinical setting, while lawyers operate outside of clinical settings. There are two factors leading to doctors avoiding treatments with no blood transfusion. The first is that in Japan, providing treatment that is partially covered by health insurance and partially paid out of pocket is not allowed. The second is that when providing no blood transfusion treatment in practice, there are various restrictions, including various hurdles in securing materials and employees.

The ethical issue of refusing blood transfusions for religious reasons is an issue of the right of patients' self-determination being infringed upon concerning the patient's religious principles. However, restrictions, such as medical laws and the medical insurance system, as well as the demands of the governance of medical institutions and operational decisions, make it difficult to address this issue, as it requires the management of both private and public interests.<sup>23</sup>

## CONCLUSIONS

Clinical ethical support can be seen as a medical public framework necessary for the cooperation between patients and doctors to maximize patient benefits. Medical institutions in Japan are promoting the establishment of clinical ethical support, but there is a need to educate doctors that clinical ethical support does not decrease doctors' discretionary powers in decision-making; it is beneficial to both the patient and the doctor.

In cases where blood transfusions are refused due to religious principles, many medical institutions in Japan have adopted the "relative transfusion-free" policy, the limits of which can be seen as restraining the right of the self-determination of patients. To respect patients' rights to self-determination in the future, it is necessary to create an environment that allows public decisions to be made and systematic restriction due to medical law and the medical insurance system. The demands of management and business decisions can be addressed with various public and private interests.

This study has certain limitations. A difficult point concerning the questionnaires and not presenting questions to users face-to-face is that each respondent may have interpreted the questions differently. Without a researcher to explain the questionnaire fully and ensure that each individual has the same understanding, results can be subjective. Respondents may have trouble grasping the meaning of some questions that may seem clear to the researcher, because this study deals with clinical ethics, which can be complicated and ambiguous issues. This possible miscommunication can lead to unreliable results and therefore, another confirmatory study is required.

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## DISCLOSURE STATEMENT

The author has no conflicts of interest to disclose.

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