Refusing Blood, Establishing Relational Biocitizenship: Collectivizing Moments among Jehovah's Witnesses in Germany

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In recent years anthropology has increasingly focused its attention on the dynamics of refusal (McGranahan 2016): from studies of Israelis who refuse to serve in the military (Weiss 2016) to the Mohawks' refusal to recognize the state's understanding of community membership (Simpson 2007). Scholars in medical anthropology have paid special attention to vaccination refusals, a phenomenon that has been observed globally (Bazylevych 2011; Closser et al. 2016; Sobo 2015; 2016). Within the literature of bioethics, refusals of medical treatment, specifically of life-prolonging treatments and/or blood transfusions, have constituted a recurrent theme (Craigie 2011; Savulescu 2007). Patients may refuse medical treatments for different reasons, but refusals of blood transfusion are commonly identified by both medical professionals and the public alike with the religious organization of Jehovah's Witnesses (JWs).

Nonetheless, in addressing blood sociocultural and medical anthropologists have traditionally privileged the topic of blood *donations* (Copeman 2009a; 2009b; Reddy 2009; Simpson 2011). In Jacob Copeman's words blood donation is a "critical site of social change" and "act[s] as an instrument of re-composition of an array of associations, relationships and institutions" (2009a: 2). Indexing relatedness or "relationality", blood emerges simultaneously as both an object of biomedical procedures and kinship classifications (Carsten 2011). But what about those who refuse blood transfusion?

This issue remains surprisingly overlooked by medical anthropologists and other social scientists. On the other hand, mainstream bioethics' "discomfort" with refusals can be ascribed to the emphasis it places on the rational subject, who is itself a product of neoliberal philosophies and politics (Petersen 2013). Within this discourse, those who refuse tend to be viewed through the lenses of "irrationality" and "incompetency" (cf. Weiss 2016: 354-355). The notion of autonomy epitomizes ideas of self-determination and self-government valued by Western neoliberal democracies, particularly the U.S. This has started to change though. A recent "rational turn" in bioethics (Jennings 2016) has brought with it a more relational, socio-culturally embedded understanding of the individual.

In this contribution, I attend to my previous fieldwork with JWs in Germany who refused blood transfusions through the lenses of two concepts: the concept of "refusal" as recently analyzed by medical anthropologists and the concept of "relational citizenship" introduced by Jeanette Pols (2016). The latter, rendered here as "relational biocitizenship" allows us to better understand the creative and productive aspects of refusal and how "refusal produces and reproduces community" (McGranahan 2016: 322; see also Sobo 2015; 2016). JWs' attitude toward blood with its particular emphasis on "abstaining from blood" is viewed here as a

“collectivizing moment” (Rose & Novas 2005) of relational biological citizenship that foregrounds relationships between citizens over that of the state and the individual (Pols 2016).

Entanglements of Religious and Medical Imaginaries

One morning in June 2012, over 7,000 people were gathered at a congress of the Jehovah’s Witnesses, officially known as the Watch Tower Bible and Tract Society, held in a velodrome stadium in Berlin (Picture 2). Formally attired Witnesses, their relatives, and other interested people attentively watched speakers and scenes enacted on stage. The human heart thematically dominated the three-day congress entitled: “Safeguard Your Heart” [*Behüte dein Herz!*]. This is a recurrent topic in JW publications, at congresses, and in congregational lectures. On that day while we sat in anticipation of the opening lecture titled “Why do we have to look after [our] heart?” the resounding and continual thump of a beating heart was heard throughout the stadium.

An elder, as leaders of Witness congregations are called, opened his lecture with “hard” facts about the human heart, impressing us with the total count of daily cardiac cycles. Asserting that the word “heart” itself can be found about 1000 times in the Bible, he offered a close reading of its biblical meanings. The omnipresent beating heart thumped its way throughout the entire lecture. I noted a similar explanatory pattern in a series of short ten-minute lectures titled “Beware: Dangerous heart problems!” given by elders of various congregations before noon: each started with a medical description of a particular heart deficiency that was eventually likened to a paucity of favored biblical practices and attitudes. For instance, congestive heart failure [*Herzinsuffizienz*] was presented as half-heartedness [*Halbherzigkeit*] and equated to serving God (Jehovah) bereft of zeal, with only partial devotion. The following day, another lecture explicitly presented Jehovah as a healer or physician. Drawing on Psalms 147:3: “He heals the brokenhearted; He binds up their wounds” (Watch Tower 2013), an elder emphasized that Jehovah heals as a physician does. According to this speaker, Jehovah’s “actions” actually exceed physicians’ duties: He transmits hope via the Bible’s message, “our congregational meetings,” prayer, his Holy Spirit, and the hope imbued in the resurrection.

This ethnographic vignette exemplifies the entanglements of religious and “medical imaginaries” (DelVecchio Good 2007) within a global religious movement. The program’s focus on heart and heart-related problems could reflect a “cultural bias” of German biomedicine in contrast to its American, British, and French counterparts (Payer 1989). However, the same three-day program was presented not only at 53 congresses in 20 languages within the “German branch” that encompasses Austria, Germany, Luxemburg, Lichtenstein, and Switzerland, but also at numerous congresses worldwide. In 2011, the last three countries registered 2%, 31%, and 1% growth respectively in comparison to the previous year, the global growth of JWs being 2.4% and their worldwide membership amounting to over 7.3 million (Watch Tower 2012: 44-51).

The Point of Contention: Refusal of What and by Whom Exactly?

While I was conducting ethnographic fieldwork with Witnesses who had confronted the issue of blood transfusion during medical treatment, JWs nurses, and a number of physicians (both Witnesses and non-Witnesses) in Germany, I frequently saw a variety of posters displayed in public spaces that encouraged blood donation. Under the heading “Schenke Leben, Spende Blut” [Give Life, Donate Blood], the German Red Cross (GRC), like its counterparts worldwide (Simpson 2011; Copeman 2009b), called for voluntary blood donation and equated the procedure with giving “new” life and/or being loved (Picture 3). When I discussed the issue of blood and blood transfusions with physicians, they characterized blood transfusion as a “relatively risk-free treatment,” whereas a particular weight hinged upon the adverb “relatively.” While discussing the specific hemoglobin level that may serve as a threshold indicating the need of a blood transfusion, a non-Witness anesthesiologist who worked in one of Berlin’s larger hospitals noted:

> “Well, the idea that blood is something vitalizing, something good, that you do patients a favor when you raise their hemoglobin level, this [idea] has been gradually abandoned. Yes. But you order a transfusion when you see that one or more organs are not working properly. This usually is the heart. Often the brain.”

He further added: “Over the last decades we have become more reluctant [to give a blood transfusion].” Hence, blood or strictly speaking, blood transfusion is ideally applied to “severe cases,” i.e. often in life-or-death situations, when its advantages outweigh its possible disadvantages.

At the congress mentioned above, blood transfusions and “questionable treatment methods” were presented along with perilous life situations, “spiritual weakness,” problems at work and at school, unemployment, and the non-believing spouse, as circumstances that constitute a “real test of faith.” While facing such situations, Witnesses were reminded to follow the guidance of biblical principles. According to a JW physician:

> “Blood is a religious symbol. Looking at it religiously, blood is sacred. So, you don’t refuse blood because it’s a bad medicine or anything like that. But, because it’s a religious symbol that represents life. (…) It was clear to me that the use of blood in any form is not an option.”

The issue of (refusal of) blood transfusions was discussed in more detail during one of the JWs’ annual congregational meetings I attended in 2011. In preparation for this meeting, Witnesses usually view films produced by the Society such as “Transfusion Alternative(s)” (Watch Tower 2004), now available online and steep themselves in publications on the topic such as the internal publication “Our Kingdom Ministry” (2006). According to these publications Witnesses may completely refuse both whole blood (and its major components) and blood fractions isolated from major blood components, or they may refuse a transfusion of whole blood (and its major components) while still accepting blood fractions (such as albumin, hemoglobin) and

medications composed of them. Similar choice applies to medical technology such as cell-salvage and the heart-lung machine. During the meeting in which I participated, elders argued that “operations without blood are a gold standard of modern medicine,” a fact that is allegedly acknowledged by all good and experienced physicians nowadays. Witnesses were advised not only to consider their choices regarding refusals, but also to fill in their advance directives that they usually carry on their person or in their wallets along with their ID cards. The emphasis was put on a deeply considered decision on one’s “options” regarding refusals of blood and biomedical technologies.

Drawing on biblical directives that command them to “abstain … from blood,” JWs refuse blood transfusions on religious grounds irrespective of donor identity (see, e.g. Genesis 9:3-4, Leviticus 17:1-2, and Acts 15:28-29) while they simultaneously insist on obtaining the best possible medical treatment. This differentiates them from both Christian Scientists who reject biomedical services and medications relying instead on healing prayers (Klassen 2011), and members of the Navajo Nation—the largest Native American group in the U.S.—who refuse blood transfusions from non-Navajo donors (Schwarz 2009). For JWs I met blood transfusions encapsulated disloyalty and disobedience to God for they severely undermine their relationship with “Him”, as some Witnesses put it, “the creator of the blood.” Nonetheless, while the public in Germany and elsewhere seems to embrace or does not question at least the rationale of the Red Cross public campaigns in support of blood donations, by refusing to participate in this state-supported “bioeconomy,” JWs like others who refuse (cf. McGranahan 2016; Sobo 2016) not only highlight their religious point of view. They also raise their critique and point towards necessary changes within transfusion policies and practices, such as “managing” anemia and “transfusion-free” surgeries that should bring health benefits to all patients. In April 2012, I interviewed two Witness physicians who were involved in the establishment of the Patient Blood Management (PBM) program in one of the local hospitals in Germany. They both highlighted the “pioneering” nature of their endeavors in Germany. In short, PBM’s overall goal may be characterized as twofold: to improve patients’ care and to reduce the use of blood and blood components. Identifying, evaluating, and managing anemia plays a crucial role within this approach. Its implementation has been recommended by the WHO resolution of 2010 (WHA 2010). One of the physicians I talked to highlighted that “anemia is always bad and should be treated.” According to her, “This is not only the issue of bloodless treatment,” but:

> “Whether you detect anemia before surgery and treat [it]. As a result, of course, the risk of getting a transfusion is much lower and [getting] an infection and all that stuff too. And this is what we offer. (…) It’s said that in Germany often nothing happens between the normal hemoglobin level and the transfusion trigger, and we fill this gap.”

Creating Affiliations through Relational Biocitizenship

The relational turn has not only allowed for the re-conceptualization of autonomy within bioethics, but also citizenship as Jeannette Pols (2016) shows in her ethnographic study among residents of mental health care institutions in the Netherlands. According to Pols (2016: 183),

the concept of relational citizenship allows the foregrounding of “concrete interactions” as well as “forms of sociality” that are created through people’s engagement with each other and their material surroundings. Unlike autonomous citizens, for their relational counterparts “relationships, their nature, and the mechanisms that hold them together replace the idea of a sociality of people independent of others” (Pols 2016: 182). In Pols’ analysis engaging in such relationships allows people experiencing mental health problems to become citizens.

I argue that for JWs, their stance on blood is a “collectivizing moment” of biological citizenship (Petryna 2002; Rose & Novas 2005). Witnesses I met emphasized their interest in receiving the best medical care available. For them, refusing blood transfusion was by no means indicative of a shared death wish or a rejection of medical treatment altogether. Similarly to parents of un- and under-vaccinated children from Waldorf schools in the U.S. analyzed by Elisa Sobo, blood transfusion refusals serve as “a declaration of identification with the social setting of import to the individual” (2016: 345). Furthermore, they emphasized “refusal as abstention” (Weiss 2016) from engaging in this particular biomedical practice in favor of “bloodless” surgery. In Germany, their search for suitable treatment options has been facilitated by two biopolitical strategies. First, in 2009 a law on patient disposition was introduced into the German Civil Code (Bürgerliches Gesetzbuch §1901a ff.) that stipulates that the living will of a patient who is of legal age and “legally competent” is binding for the physician. To strengthen patient rights further measures were introduced in the Patients’ Rights Act [*Patientenrechtegesetz*] of 2013 (Rajtar 2016a). These state-adopted laws may be described as “making up biological citizens ‘from above’” (Rose & Novas 2005: 446) as they have validated patients’, including Witness patients’ “advance directives.”

The second strategy may be called a strategy “from below” that is utilized by the Society as a biosocial grouping (Rose & Novas 2005: 442) and includes the establishment of an active network of Hospital Liaison Committees (HLCs) that acts as an “information filter(s)” (Rafaettà & Nichter 2015: 1). Employing literature provided by the Society, media publications (e.g. physician rankings regularly published by magazines such as “FOCUS”), and personal contacts among others, members of HLCs, all male, seek physicians who agree to bloodless treatment and pass this knowledge to JWs in need of medical intervention. They are also responsible for publicizing the Society’s position on blood transfusions and advising doctors and patients on treatment alternatives (Rajtar 2016a). Analogous to psychiatric nurses in the Netherlands described by Pols (2016) who in their role as mediators in family matters played a significant role for mental health patients, HLC members consolidate the relational (bio)citizenship of Jehovah’s Witnesses. In Pols’ words “If citizenship no longer means ‘do it on your own,’ the importance of professional support can be made visible again” (2016: 187).

By highlighting the concept of biocitizenship, I privilege one particular perspective from which Witness refusals can be analyzed. Although “the sacredness of life and blood” is one of the Society’s “major doctrines” (Penton 1985: 202-206), Witness identity is not determined solely by their relationship to blood, but also, for instance, by their evangelizing practices (Kirsch 2008) that – like refusals – produce and reproduce global community. Analyzing literary and reading practices among JWs in Zambia, Thomas Kirsch argued that the standardization of literacy practices allows JWs “a homogenous interpretation of their publications” (2008: 156). I argued elsewhere (Rajtar 2016b: 184) that such engagement with literary and audiovisual media

produced by the Society does not act as “top-down projects, but also allows local, in this case German, Witnesses to situate themselves within and read their medical experiences into the global community of believers.” This was particularly visible in reference to what my interviewees called “beautiful examples” [*schöne Beispiele*] of patients (often young adults or Witness families from all over the world) who remained steadfast in their refusal of blood transfusion. During the summer of 2010, I spent an afternoon speaking with two JWs: a nurse in her mid-fifties and a woman aged seventy-two who had been living in the U.S. for many years and whose child had served as a “pioneer” (a Witness missionary) in East Asia. After emphasizing that God’s commandment?“Blood is sacred”?constitutes the main reason for refusal, the latter added:

> “We once had such beautiful examples in [our] journals [that showed] 16-and-18-year-old youth who were very sick and had to be operated and defended their standpoint. And physicians were pleased that these weren’t the parents who said, listen, you have [to do this and that]. No, they were convinced and they were able to communicate their convictions to physicians [themselves]. And this was respected.”

Emphasis on evangelizing practices as one of JWs’ characteristics adds another layer to the “relationality” of their biocitizenship. It also distinguishes them from, for instance, survivors of Chernobyl analyzed by Adriana Petryna (2002), who indeed may be examined and “grouped” primarily through citizenship claims referring to their damaged biological identity and suffering. Thus, this emphasis bypasses some criticism aimed at the understanding of “biocitizenship” according to which “to frame these mobilizing actors as ‘biocitizens’ would be to emphasize one aspect of their identity” (Plows & Boddington 2006: 117). Acknowledging this possible bias entailed in the concept of “biocitizenship,” I nonetheless find its ‘extended’ version, “relational biocitizenship” useful in illuminating Witnesses’ attitude towards blood. To abstain from blood is—like other refusals analyzed by recent anthropological scholarship—to generate affiliations and to criticize with an eye open to change. Unlike military refusal by abstention practiced by many Israeli youths analyzed by Weiss (2016), however, it is anchored in (bio)citizenship and does not “constitute an antipolitics” that “seeks to bypass the state” (Weiss 2016: 357). Witnesses’ desire to change biomedical practices of blood transfusion should eventually transform state healthcare policies that apply to them and their fellow co-citizens alike.

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