Should a Jehovah’s Witness Patient Who Faces Imminent Exsanguination Be Transfused?

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Introduction

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The right of every person to reject unwanted medical therapies, whether or not the choice is consistent with good clinical practice or medical judgment, is well established in ethics and law. The right to reject treatment can be exercised directly by the patient or indirectly by the patient’s surrogate or proxy decision maker. Generally speaking, first-person directives take precedence over surrogate/proxy decisions; that is, a valid directive by a patient, such as a living will or an organ donor card, cannot ordinarily be overridden by a surrogate/proxy unless the patient has given that person specific authority to do so.

A Jehovah’s Witness signature on a Jehovah’s Witness card refusing blood transfusion and on the operative permission form repeating her refusal ordinarily allows no wiggle room: the surgeon is obligated to honor her refusal, even in the face of life-threatening hemorrhage. But what if her Jehovah’s Witness husband demands that her life be saved with blood transfusions, claiming that she is currently incapacitated and unable to change her mind about transfusion, which he, as the person who knows her best and the one she has designated as her health care agent, is certain she would do if she were able to do so. Drs Keith Naunheim and Charles Bridges reach differing conclusions about what is the right thing to do under such circumstances.

Case

A 59-year-old Jehovah’s Witness with severe rheumatic mitral stenosis and insufficiency, Josephine Rutherford, has an advance directive naming her husband, Frank, who is also a Jehovah’s Witness, as her health care agent. She has a preprinted Jehovah’s Witness card that she signed 2 years previously, refusing blood transfusions. On the operative permission form, she signs the clause refusing transfusion and her husband signs as witness.

She undergoes mitral valve replacement, and unexpectedly suffers the rare complication of posterior perforation of the left ventricle with exsanguinating hemorrhage. The surgeon, Dr Percy Thomas, tells the family she is going to die without transfusions. Her Jehovah’s Witness husband states that his wife does not have the opportunity to change her mind, and, as her health care agent, he must make the decision for her. He is sure she would change her mind if she knew death from blood loss is now a certainty—she has often expressed to him how much she has to live for. The patient’s two adult children, a 25-year-old pregnant daughter (who is a Jehovah’s Witness) and 29-year-old son support the request to give the patient the blood she needs to survive.

Dr Thomas urgently calls the hospital attorney, who tells him that the state’s Uniform Health care Decisions Act (UHCDA) [1] provides protections that allow for a strong case to be made for legal immunity from civil or criminal liability, no matter what decision the surgeon makes. He should make his determination, the attorney says, on ethical grounds. What should the surgeon do?
Pro
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This Jehovah's Witness patient should be transfused. The problems surrounding transfusion in Jehovah's Witness patients are some of the most controversial ethical issues faced in medicine. The Jehovah's Witness religion was initially instituted under the name the Watchtower Bible and Tract Society founded in 1884 by Charles Taze Russell in Western Pennsylvania. In 1931, the Watchtower Bible and Tract Society was reincorporated by a society of international Bible students, and the name of the religion was changed to Jehovah's Witnesses. The religion is based primarily on the "end of the world" prophecy as interpreted from Bible readings. Teachings from this religion specify that Jehovah's Witnesses are the only "true" Christians, and that only such true believers will be saved at the time of Armageddon and the second coming of Christ. At that time, all those who are not true believers will be destroyed. Mr Russell first suggested Armageddon would occur in 1914 but it had not yet arrived at the time of his death in 1916. His successor, Joseph Franklin Rutherford, rewrote the doctrine and subsequently predicted Armageddon would occur in 1918, 1920, and 1925. The doctrine of this religion also specifies that only the Jehovah's Witness leadership can provide a true interpretation of the Bible, and this must be followed strictly by all believers; individualism is strongly discouraged. Also, any members of the religiously who openly criticize the leadership or their teachings are considered to be apostates and disloyal to God and thus subject to penalties such as excommunication and expulsion from the community. This latter punishment suggests the apostate will be shunned, not only by the society as a whole, but by family members as well.

The Jehovah's Witness leadership has held many controversial views regarding medical issues, views that have gradually evolved over the last few decades. There was a time in which the Jehovah's Witness leadership considered the American Medical Association to be representatives of Satan and "tricksters" who tried to mislead the population into inappropriate medicines and surgical procedures. There had been prohibitions against the utilization of aluminum cookware, which was reported to cause cancer and insanity. Vaccinations were characterized as "pus cocktails," and organ transplantation was equated with "cannibalism." Over the last several decades, these latter two treatment modalities have become accepted by the Jehovah's Witness leadership and are now "matters of conscience" for all of the Jehovah's Witness membership.

The prohibition for utilization of blood was first announced in 1945, and has been based on at least three citations from the Bible: (1) Genesis 9:4 “But you must not eat meat that has its life blood still in it.” (2) Leviticus 17:2 “None of you may eat blood, nor may any foreigner residing among you eat blood.” (3) Acts 15:29 “You are to abstain from food sacrificed to idols, from blood, from the meat of strangled animals and from sexual immorality.”

The transfusion of blood products is interpreted by the Jehovah's Witness leadership as equivalent of “eating blood” because the patient receiving a transfusion is the one who consumes the blood product. Even this prohibition has evolved somewhat over the past 2 decades. Originally, all forms of blood products were banned, including specific clotting factors (as administered to hemophiliacs), immunoglobulin, and even albumin. Consumption of any these or the more standard types of transfusions (whole blood, packed red blood cells, platelets, or fresh frozen plasma, whether heterologous or autologous) were thought to warrant excommunication from the religion and eternal damnation at the time of judgment. However, at present, the Jehovah's Witness leadership believes that albumin, immunoglobulin, and specific clotting factors can be administered if the individual practitioner's conscience allows.

Many critics have attacked the transfusion prohibition as being “an irrational belief” and thus an inappropriate foundation for making any medical decision regarding receiving blood products. However, Jehovah's Witness religious dogma does not appear any more “irrational” than the belief of many other religions. Christian Scientists believe in spiritual healing and will shun the aid of physicians and surgeons. Buddhists believe in Samsara (the cycle of reincarnation) despite a dearth of supporting evidence. Roman Catholic faith is rooted in the miracle of transubstantiation, the process by which bread and wine is transformed into the actual body and blood of Jesus Christ during a religious ceremony. Practitioners among the Latter Day Saints wear special undergarments which they believe give them spiritual protection. Finally, Scientists believe that there are extraterrestrials (Thetans) living among us. None of these beliefs can be objectively substantiated scientifically, and thus no religion appears to be any more or less rational than the other. Arguing against the transfusion prohibition on the basis of “irrational beliefs” appears somewhat hypocritical for any practitioner of religion whose basic tenets require faith, for example, the blind belief in a nonprovable entity or practice.

I believe there are three important issues pertaining to the administration of blood in Mrs Rutherford’s case and questions that must be answered: (1) Was the consent voluntary or was it given under duress? (2) Did the patient fully grasp the gravity and scope of the operation? (3) Can the family supersede the decision of the patient?
Was the Consent Given Under Duress?

With regard to voluntary consent, the patient did sign the consent outlining the prohibition of transfusion and also carried a card in her wallet documenting same. The question of duress, however, is a more subtle one. There can be a little doubt that the religious practices of Jehovah’s Witnesses can be considered somewhat coercive. The prospect of being expelled from one’s community and even from one’s family can be frightening; such a concept will exert great emotional pressure upon the patient making decisions regarding blood products. In many instances, a pastor or church member will accompany the patient and his or her family to make certain that “the whole truth” is revealed to the patient and the physician involved does not “mislead” or “trick” them into accepting transfusions. There have even been instances in which hospital employees who are Jehovah’s Witness practitioners have reported on other Jehovah’s Witnesses who have agreed to receive transfusions, thus condemning them to harsh punishment within their community. Is this type of peer pressure not duress? Can one confidently assume that the consent was entirely voluntary? At the very least, some doubt exists regarding the voluntary nature of such consent.

Did the Patient Grasp the Gravity and Scope of the Operation?

A complete informed consent includes a thorough discussion of the procedure. That entails an outlining of the nature of the intervention, all reasonable alternatives to the treatment, and recommendations as well as the risks and potential benefits of the procedure. The complication outlined in the above clinical scenario (posterior perforation of the left ventricle) is both exceedingly rare and remarkably complex. It is very difficult to believe that the patient actually could comprehend that a complication with a less than 1% incidence could eventually endanger her to the point where her survival chances were less than 50/50 even with the benefit of transfusion. Studies have shown that the process of informed consent is in and of itself basically flawed. Many patients cannot recount what they were told even within the hour after the informed consent process. Because of this, I believe the best guide regarding the level of comprehension for this patient would come from the family. Indeed, both the husband and the daughters stated that the patient did not fully grasp the ramifications of her transfusion decision and insisted that, had she truly understood the possibilities, she would want to be transfused. I, for one, would not suggest my judgment regarding the patient’s state of mind was more accurate than that of the family with whom she lived. The family’s insistence that she did not understand in this case is critical; thus, I cannot be certain that her consent was fully informed considering their attestation to the contrary.

Can the Family’s Decision Regarding Transfusion Supersede the Previous Decision of the Patient?

In 1993, the National Conference of Commissioners on Uniform State Laws drafted and approved the UHCDA. This act has been ratified by several states and defines the specific powers of health care agents during the time of incapacity on the part of a patient. It was in effect at the time of this clinical scenario. The act specifically states that an appointed “surrogate shall make the decision in accordance with the surrogate’s determination of the patient’s best interest.” In this case, the husband and daughters all agreed that transfusion was in the patient’s best interest, and the hospital attorney confirmed that such a decision was arguably legal and appropriate. Thus, under the dictates of this act, it is wholly appropriate for the family’s decision to supersede that of the patient.

In summary, there is nothing clean and certain about the ethical issue within the scenario. The basic ethical values that are usually referred to in such clinical situations include the following: autonomy—the patient has the right to refuse or accept offered treatments; beneficence—a practitioner should act in the best interest of the patient; nonmaleficence—“first do no harm” (primum non nocere); justice—fair and equal distribution of treatment and health care resources; dignity—the patient and the doctor both have the right to dignity; and truthfulness—patients must be informed regarding all options and ramifications.

While it is sad, it is also true that in difficult situations such as the clinical scenario above, not all the ethical values can be fulfilled simultaneously. Transfusing the patient to save her life fulfills the value of beneficence while at the same time potentially violating the value of autonomy. However, the decision by the husband and daughter on behalf of the incapacitated patient certainly fulfills the legal definition of appropriate practice and, in my opinion, fulfills the ethical value of autonomy as well. I believe that, in this case, transfusion of this Jehovah’s Witness patient is both justifiable and correct.

Con

Charles R. Bridges, MD, ScD

This Jehovah’s Witness patient should not be transfused. The Jehovah’s Witness faith has grown remarkably since its inception in 1869, now including more than 7 million followers in 236 countries [2]. The Watchtower Society is the governing body of the Jehovah’s Witnesses, and in 1945, this body introduced a ban on accepting blood transfusions. As a result, Jehovah’s Witnesses nearly universally refuse to receive blood prod-
ucts. In fact, most are quite dogmatic about the fact that they would rather die than receive a transfusion [3]. Their refusal to accept blood products is based on a literal interpretation of the passages in the Old Testament that forbid them to do so. In fact, even the option of preoperative autodonation and banking of blood for perioperative use is excluded as once the blood has been disconnected from the body’s circulation, it is no longer acceptable [2]. These restrictions notwithstanding, innovative blood conservation techniques [4] including meticulous surgical technique, use of miniature heart-lung circuits, retrograde and antegrade autologous priming, autologous normovolumic hemodilution, and use of an in-line cell saving device for red cell salvage during cardiopulmonary bypass, can be utilized with excellent results even in complex cardiac surgical procedures in these patients [5]. Moreover, the Watchtower Society has left the decision to accept fractions of the primary components (ie, cryoprecipitate, albumin) to the individual Jehovah’s Witness, while forbidding the acceptance of the “primary components” of blood, defined as red blood cells, white blood cells, platelets, and plasma [6]. Some would argue that the Jehovah’s Witness refusal to accept blood products represents a form of irrational religious zealotry. However, unlike many other arguably less than scientifically rational religious beliefs, the most recent data suggest overwhelmingly that blood transfusions are associated with an increase in mortality and morbidity that is a direct consequence of the transfusions themselves and not due to uncorrected confounding issues. This point is best illustrated by the observation that there is a direct relationship between the age of the blood transfused and its negative impact on mortality and other complications, hence implicating the blood rather than the condition of the patient receiving it [7]. Thus, rather than representing irrational religious zeal, it is perhaps more appropriate to describe the Jehovah’s Witness’s aversion to blood transfusions as emblematic of divine scientific insight!

Informed Consent to Surgery

In 1914, Judge Benjamin Cardozo wrote a landmark opinion in the case Schloendorf v The Society of New York Hospital, which legally defined simple consent and changed the history of American medical ethics. Cardozo wrote: “Every human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages … except in cases of emergency, where the patient is unconscious, and where it is necessary to operate before consent can be obtained” [8].

Clearly, in this case, although the patient is indeed unconscious, it was the surgeon’s duty to discuss the precise scenario presented, namely, intraoperative life-threatening hemorrhage, with the patient and the patient’s family before the procedure. One might argue that, for a minor surgical procedure, it would not be necessary to discuss life-threatening bleeding but for a cardiac surgical case, it should always be discussed as a possibility.

Furthermore, it is the surgeon’s duty to provide sufficient information to the patient and the patient’s family in advance of the case so that the patient can anticipate how he or she would be expected to react to situations that are likely to occur. Thus, although ventricular perforation is itself a rare complication of mitral valve replacement, potentially life-threatening bleeding is not an uncommon occurrence during cardiac surgery. Failure to discuss this scenario is a failure to provide adequate information for true informed consent. Moreover, it is the surgeon’s duty to accept the patient’s religious beliefs, values, and morals, independent of whether the surgeon finds these beliefs to be rational.

Cognitive Understanding

The surgeon’s duty is to help the patient to develop “cognitive understanding” of the procedure. Cognitive understanding requires that patients appreciate their present condition, the procedure proposed, and that their decisions will have consequences. These consequences are best understood as a series of probabilities attached to a group of potential outcomes, each of which may be associated with either an improvement or a worsening of the patient’s condition and possibly even in the patient’s demise. Only when fully apprised of these probabilities and outcomes, each a function of the patient’s decision, can the patient make an informed decision. It is the surgeon’s charge to correct any misunderstanding the patient may have, to improve their fund of knowledge, and to help them to understand both the nature and the consequences of the options available to them. Throughout this process, the surgeon must respect the patient’s autonomy [8].

Preventive Ethics

This case represents a failure of “preventive ethics.” Here, it is the surgeon’s responsibility to ascertain that the patient fully understands her condition and the probable impact of her refusal to accept blood products on the expected outcome. Because some Jehovah’s Witnesses fear that they will be shunned by their community if they were to accept blood products [1], the surgeon must explore whether the patient’s understanding has been clouded by emotional factors, anxiety, financial obligations, and the like. Only if such factors can be excluded or managed through counseling can informed consent be obtained. Having established true evaluative understanding, the surgeon should acknowledge value conflicts that exist and develop a management plan (including all likely eventualities) and make sure the plan is in accord with the patient’s values and beliefs. These are the tenets of preventive ethics [8]. Adequate preventive ethics in this case would have obviated the need to address this issue of life-threatening hemorrhage after the surgery had commenced. It arguably should have been discussed before the procedure to prevent the
ethical dilemma. The surgeon’s first response to refusal of blood transfusion should have been to review with the patient her understanding of the condition, and its benefits and risks.

Summary

In the case presented, the surrogate decision makers for Josephine Rutherford (the patient’s husband and two daughters) have been asked to provide “substituted judgment” for the patient since she is unconscious. In this case, the surrogates believe that the patient would want to be transfused if she knew that she would otherwise die. However, Dr Thomas has every right and want to be transfused if she knew that she would otherwise die. Therefore, in keeping with her written expressed wishes, the patient must be allowed to die without a transfusion.

Concluding Remarks

Robert M. Sade, MD

For the purpose of this debate, we accept the hospital attorney’s opinion that the UHCDCA provides immunity from civil or criminal liability to the surgeon, whether he chooses to transfuse or not to transfuse. The attorney bases his opinion on Section 9 (a): A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for (1) complying with a health care decision of a person apparently having authority to make a health care decision for a patient, including a decision to withhold or withdraw health care; (2) declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or (3) complying with an advance health care directive and assuming that the directive was valid when made and has not been revoked or terminated [1].

So Dr Thomas’s decision should be made on ethical grounds, that is, what is the right thing to do: transfuse in an attempt to save the patient’s life, or withhold transfusion and allow the patient to die? Both essayists present their cases clearly and logically. Both base their analyses on the principle of respect for autonomy. The nature of autonomy has been understood in many different ways, but generally, most analysts accept the minimal components of an autonomous decision as a choice that is made intentionally, with understanding of the relevant information, and with freedom from controlling influences [9].

Intentionality is generally taken to be binary, whereas understanding and voluntariness can be matters of degree. For example, a professor of biology and an illiterate grade school dropout lie at opposite ends of a spectrum of ability to comprehend medical information. Similarly, a range of influences can have greater or lesser impact on a patient’s decision-making freedom—persuasion, manipulation, and coercion are different kinds of influences [9]. Persuasion is not a controlling influence if a physician’s balanced presentation of facts and honest reasoning moves a patient to a choice recommended by the physician, but could be controlling if the physician’s balanced and honest discussion produces an emotional reaction that drives the patient’s decision. Manipulation impels a patient toward a certain choice when the physician presents information in a biased manner, misrepresents facts, or withholds information; manipulation is always a controlling influence that compromises autonomous decision making. Coercion—the use of force or the threat of force or harm—also undermines autonomy.

Protecting autonomous decision making is the primary purpose of informed consent. The process of informed consent requires the presence of several elements that signal the centrality of respect for autonomy. These elements are generally understood to be competence, disclosure of relevant information, understanding of that information, voluntariness of decision making, and consent that both chooses an option and authorizes the chosen procedure [10].

Bridges believes that all these elements are present in the case of Mrs Rutherford. He asserts that the patient must have known at least that bleeding is common during cardiac surgery and that death was a possible outcome. She has persistently and repeatedly expressed her wish not to have a blood transfusion, and this
autonomously executed directive must be respected. He finds no circumstances that mitigate the surgeon’s responsibility to respect the patient’s autonomy—he must withhold transfusion.

Naunheim argues that, to the contrary, Mrs Rutherford’s directive was not autonomous because it was executed under duress—the threat of expulsion from her community—thus failing the test of freedom from controlling influences. Moreover, she did not truly understand the implications of her choice not to allow blood transfusions—those closest to her insist that she did not fully appreciate the implications of her directive, made when facing a rare complication of her surgery. On the spectra of both voluntariness and understanding, her informed consent lies on the side of insufficient magnitude to support autonomous decision making.

The patient’s husband, who is also her health care agent, asserts that the patient would have changed her mind and accepted transfusions if she had known that death were imminent. The most commonly used standard by which agents make decisions for a patient is substituted judgment: in the absence of a relevant and specific advance directive, the agent must choose the option that the patient would have chosen had she not lacked decision-making capacity. But in this case, Mrs Rutherford has made a first-person decision not to have blood transfusions, a decision that generally cannot be overridden by others. There are situations, however, in which overriding a first-person directive may be justified. In clinical settings, as the severity of risk of harm to the patient increases, there is a parallel increase in justification for overriding an advance directive [11]. The dilemma in this case is the clash between the patient’s clear directive and the most severe of risks, death by exsanguination. To her husband and children, overriding Mrs Rutherford’s directive does not undermine her true beliefs and values, rather, it respects and restores her autonomy, a position that Dr Thomas could find plausible.

Under the circumstances of this case, there seems to be no clearly right or wrong answer. The precise nature of autonomy and of its protector, the process of informed consent, has not been decisively resolved in the biomedical ethics literature, and the courts still find difficult cases at the edges of settled law. Both Naunheim and Bridges have made cogent arguments in support of their positions. Under the UHCDA, they both seem to have made a legally defensible case and, in my view, they both have presented positions that are reasonable and ethically acceptable.

I close with a caveat: the UHCDA was adopted by only a few states, and the statutes and case law governing informed consent in the remaining states display great variation. A surgeon who faces a similar case would be on ethically defensible grounds to choose either to provide or to withhold transfusion, but legally, would be prudent to consult the health care institution’s legal staff before reaching any conclusion about the most appropriate course of action.

References