Can an Agent Override a Patient’s Wishes? A Difficult Case of a Pregnant Jehovah’s Witness

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Ruth Fischbach, Director, Center for Bioethics, Introduction

“Before we begin our program today, I would like to devote a moment to honor all those in the Philippines who were in the path of Haiyan, one of the most powerful typhoons ever recorded. We send condolences to the survivors of the thousands who perished, were injured, or who lost family, friends, livelihoods, as well as their homes.

We have a large audience today, representing a broad swath of disciplines, institutions, and ranks. I am happy to see old friends as well as many new faces. I would especially like to recognize the School of Nursing for joining us today. Welcome!

For those attending an Ethics for Lunch event for the first time, you should know that this long-running series has been made possible over nine years thanks to the generosity of the Arnold P. Gold Foundation. Drs. Arnold and Sandra Gold are renowned for their promotion of humanism in medicine. I consider these Ethics for Lunch events extremely influential in demonstrating how providing care to patients can be careful, caring, and compassionate. I love to hear Arnold Gold talk about how the head bone is connected to the heart bone.

The Gold Foundation believes that Humanistic practice can be learned by emulating the humanism shown by compassionate physicians. I also like to think of these sessions as potentially preparatory learning for it is likely that at some point in our lives, many of us will find ourselves in challenging medical situations. Learning in advance how to navigate in extreme conditions can be useful and even lifesaving.

I also like to remind the audience that the Golds are strong believers that learning takes place best when you are well nourished. So, this series has always offered you both food for thought -- AND a free lunch. Arnold and Sandra Gold are in Boston today but we can still show our appreciation for their generosity.
The *Ethics for Lunch* series is designed to bring to life humanism in clinical care by presenting challenging cases that have been grappled with by the Ethics Committees at our two Columbia Medical Center hospitals. **Educating our community is a core mission of the Center for Bioethics and we do not hold back from presenting important cases even if controversial.**

Living in this great country, we celebrate our diversity. Yet in the medical setting, this diversity in beliefs, practices, and gender orientation can lead to tension and conflict when particular beliefs and practices may not coincide with what is considered the currently “accepted medical practice.” The state of New York makes accommodations to allow for the exercise of religious traditions but in certain situations, our ability to make those accommodations is sorely tested.

Today’s case is just such a situation. A pregnant woman, who is a Jehovah’s Witness, has repeatedly made clear that she refuses a blood transfusion, even at risk of death. According to their tradition, **blood transfusions violate God’s law against “eating” blood so transfusions must be avoided.** Many believe that an adult Jehovah’s Witness who willingly accepts a blood transfusion is considered to be committing a sin and might forfeit his or her eternal life. And even if the transfusion is given against their will or at an age or situation when they cannot give informed consent, they can lose their promise of eternal life and may be shunned by all other Jehovah's Witnesses. So this is a serious issue to consider.

The woman in question has delivered a healthy baby but begins to have massive post-partum bleeding. She is taken to the OR for a hysterectomy as the only way to stop her bleeding. Given this dire situation, should the doctors call her mother – who serves as her proxy or agent – to ask permission to override the daughter’s wishes in order to save her life? That is the question we will debate today – the dilemma of whether to ask the mother, as the agent, to make the choice of whether to administer blood against her daughter’s expressed wishes in order to save her daughter’s life despite the religious implications.”

In closing her introduction, Dr. Fischbach announced that that several Jehovah’s Witnesses were in the audience to share today’s discussion. She welcomed them and hoped that they would contribute to the discussion.

**Dr. Meghan Prin began describing the case:**

The patient is a 40 year old, recent immigrant from the Dominican Republic completing her first pregnancy. She does not speak English and has only a 9th grade level of education. She is supported entirely by her mother, both financially and as her Health Care agent. In multiple counseling sessions (conducted in Spanish), the patient stated her 100% refusal of all blood products, even at extremis, in accordance with Jehovah’s Witness beliefs.

Jehovah’s Witnesses are at increased risk for death and morbidity compared to the general population. In New York City, the setting of this case, Jehovah’s Witnesses are at 44 times the risk for death compared to the general population.
This patient had multiple risk factors going into labor and delivery. She was of advanced maternal age, had shortness of breath caused by cardiac issues, and had large fibroids in her uterus which put her at increased risk for post-partum hemorrhage. She was briefed on the risks and benefits of blood transfusions, specifically given her health conditions. When referred to the anesthesia doctors, the patient stated that she would only accept cell savers and non-blood volume plasma expanders.

The patient was induced overnight and received a uterine relaxant to facilitate delivery when it was discovered the baby was at risk. Fortunately, the baby was delivered safely through a vacuum assisted vaginal delivery. The patient received masked oxygen for hypotension and uterine contractants to stop her bleeding. At this point, the patient had lost one liter of blood in the labor room and physicians wanted to insert a uterine balloon to prevent further blood loss. The patient's hematocrit dropped to 30 and blood pressure was 70 over 30. She was placed in a tilted position to preserve blood flow.

When the patient began to complain of dizziness, she was moved immediately to the OR for exploration and possible hysterectomy. The patient was again asked if she would receive a blood transfusion, but could only reply, “I don’t feel well.” Life of the baby was not at risk at this time; only the life of the mother was at risk.

Would you transfuse this patient in an emergency?

Dr. Kenneth Prager continued with the discussion of the Case:

Can a healthcare agent override the wishes of a patient?

Jehovah’s Witness Christian movement was founded in the US in the 1870s. Prohibition of ‘consumption’ of blood prevents them from accepting transfusion of whole blood or its primary components. Respect for patient autonomy requires informed consent before any medical procedure.

Certain situations can challenge patient’s religious beliefs versus a physician’s mandate to preserve a life. This tension binds the doctor, who may feel helpless when not being allowed to save a life.

Legal protection exists for a Jehovah’s Witness who requests not to be transfused, even at risk of dying. Patients may bring signed forms to the hospital declaring their refusal to accept some or all types of blood products; which blood products are acceptable varies by person. “Bloodless surgery centers” are becoming popular and can better meet the needs of Jehovah Witness patients.

The New York State Health Care Proxy Law allows individuals to appoint a trusted person, known as the agent, to make healthcare decisions for them if they lose the ability to do so for themselves. The agent has a duty to follow the individuals’ wishes unless he or she strongly believes that the individuals’ wishes would have changed or do not apply to the circumstances.
**Individual Conscience Exception**

If the healthcare professional object to carrying out the patient’s wishes, the healthcare professional must transfer responsibility to another healthcare professional who would be willing to honor the patient’s decision. When the doctors agreed to care for this patient, they accepted her wishes that she would rather die than receive a blood transfusion.

**Resolution:**

An emergency hysterectomy had to be performed. Most of the blood landed outside the surgical field so the cell saver did not work. The patient was given more than six liters of fluids and required multiple medications and epinephrine. But at this point, she was in grave danger of dying.

Physicians are aware that patients sometimes change their minds about medical decisions they make when they are well. For example, women early in their pregnancy may not wish to receive an epidural yet as labor becomes very painful, they may request to receive the epidural and no one questions their decision. When facing death, patients may certainly reconsider prior decisions. Patients have the right to change their mind.

When the patient was asked in the OR one last time whether she would accept transfusions she replied: “I feel sick.” The physicians felt her response was ambivalent enough to justify calling her mother who was her health care agent. She provided telephone consent to transfuse her daughter, and the patient received the necessary blood transfusion that saved her life. Later, the mother signed forms that confirmed her consent.

The Ethics Committee was called after the transfusion because the family now asked the doctors not to tell the patient that she received blood.

It is standard procedure to inform patients that they received a transfusion because of any future complications that might develop. So, if the patient does not request the information, does “don’t ask, don’t tell” apply in this situation? Would withholding the information that she was transfused be unethical? Many felt that since receiving a transfusion might have implications for the patient’s future care, the patient should be told how the healthcare agent acted on her behalf.

The question posed to the ethics committee proved to be moot as the patient was told she received transfusions by the obstetricians who operated on her, immediately after she recovered consciousness following surgery. Her response was: God is good.” Nevertheless, the hypothetical question of whether the patient family’s request that the patient not be told remained, with arguments presented on both sides of the issue.

Dr. Prager engaged the audience (the Virtual Ethics Committee) in responding to several difficult questions he raised:
• Can we assume that the patient would change her mind about transfusions were she to possess decisional capacity at the critical moment?

An audience member asked whether the patient was asked prior to delivery whether she would allow life-saving transfusions if the baby were already born. A physician responded that such questions are standard procedure. The patient was explicitly asked, “Are you comfortable leaving your child an orphan?” She continued to reject the possibility of transfusions.

• Was it correct legally to call the healthcare agent and ask about a transfusion when the patient had repeatedly stated her refusal to be transfused? Ethically?

A physician familiar with the case responded that up to this point, the case was handled in a respectful manner. The patient was VERY explicit about her choice. She was competent; it was not the doctor’s position to judge whether or not her decision was appropriate. By law, a health care agent cannot override the clear wishes of a patient. An agent is approached for a decision when it is unclear what the patient would want in the condition at hand. In this case it appeared that the patient’s wishes were clear cut. Ethically, the principle of autonomy would also require that the patient’s wishes be carried out and should not be overridden by the agent. Perhaps a weak case could be made in this patient that her equivocal response to the question posed to her as she was hemorrhaging in the OR might allow the doctors, ethically and legally, to go to the health care agent for a final decision. A member of the Jehovah’s Witness community commented that the mother should be called, because she would best know the intentions of her daughter. Dr. Prager added that in this situation the mother may act more like a mother to protect her daughter, rather than as an impartial agent.

• Should we allow more leeway for an agent to override a pregnant Jehovah Witness patient when her life is at risk, than in non-obstetrical cases? Should we allow a double standard for overriding? Should doctors be allowed to look for a way out of allowing a young mother who has just delivered to die for want of blood?

• Should we assume that when a patient appoints a health care agent she is giving permission to the agent to override her wishes when she lacks decisional capacity? If that is so, what good are Advance Directives if the agent can override a patient’s clear cut wishes? A Healthcare agent may be necessary for unanticipated situations; however, this seemed like a very straightforward case.

Dr. Prager polled the audience to see who would call the mother. Most people would not call the mother. Of those who would not call the mother, most would not abide by the mother’s wishes to provide a transfusion if the doctors were forced to make the phone call. Additionally, only one audience member responded that they would excuse themselves from accepting the patient.

As a result of this case, the Ethics Committee recommended that in future similar scenarios, the patient should be asked before delivery whether her healthcare agent
should be consulted if she loses capacity. This gives the patient a way to opt out of her previous decision. If a woman did not wish to appoint a health care agent or did not wish for her agent to be called, her wishes would be respected and her advance directives followed.

This provocative case challenged our attitudes surrounding life, death, birth, religion, and the role of family in decision making. Medical professionals must constantly balance their professional duties with their personal moral convictions. No matter how difficult, the ultimate duty of a clinician is to respect the needs and wishes of a patient, and to provide the highest quality and most compassionate care possible.