When I first read the e-mail explaining this assignment to us, I immediately thought of a patient that I had during my second year community medicine visit. I do not remember all the details exactly, but the basics of the case are quite clear in my memory. I was working with an Internal Medicine doctor in his office when we heard that one of his patients had been involved in a serious motor vehicle accident. He had just seen his last patient in the office so we went to the hospital to check on his patient from the wreck. Upon arriving, we learned that she had been an unrestrained front seat passenger in a car that was struck on the passenger’s side by another vehicle. As I was unable to obtain any history from the patient due to her condition, my preceptor explained to me her pertinent medical history. She was a 23 year old African American female with sickle cell disease who regularly received dialysis for her chronic renal failure. From what was explained to me, I gathered that she was as healthy as she could be given her medical problems. My preceptor noted that her hemoglobin normally ranged from around 7-9, and that she was generally asymptomatic.

From what I can remember on physical exam, her GCS score was around 8 or so. She was tachycardic, and her breath sounds were slightly diminished on the right. Her abdomen was moderately distended with some discoloration on the right side. Her extremities were slightly cool to the touch, and her pulse was rapid. Her right humerus appeared to be broken. She had small cuts on the right side of her face, and on her right arm. From what I can remember, her electrolytes were relatively normal, but her
hemoglobin had dropped to around 5. Imaging studies showed no brain or spinal cord injuries, but did show a broken right humerus and a small amount of fluid that had accumulated around the liver. The patient was being treated with fluid boluses of lactated ringers, but her vitals were not responding as the trauma surgeon would have liked. At this point, my preceptor asked me what I would do in this situation. As I was only midway through my second year, I had very little experience on what to do in these situations so I said to give her blood. He noted that the first thing they had to do was surgery to determine the location of the bleeding, and if it was the liver bleeding (there was some free fluid seen around the liver on imaging) they would have to repair it. He noted that normally she would have been given blood in addition to surgery and boluses of fluid to support her hemodynamically. However, in this case the patient was a known Jehovah’s Witness who had expressed to my preceptor at least one time before that she did not want to receive any blood under any circumstance. However, she did not have an advanced directive indicating her wishes and currently was not able to consent or deny blood.

Evidently, before we arrived at the hospital, the patient was still semi-lucid and the trauma team felt that she was trying to tell them that she did not want to receive blood even if was deemed necessary, but that they did not feel comfortable with this. My preceptor and I arrived at the hospital around the same time as the patient’s mother and sister. After our exam and after discussing the case with the trauma team, my preceptor explained the situation to the family. He stressed that it was possible that a blood transfusion could help the patient survive but that there was no guarantee. He told them of her wishes to not receive blood under any circumstance, but asked if they knew if she
had changed her wishes or not. They responded that she had not, and made it quite clear that they knew the consequences of her not receiving blood. Her family made it quite clear that she should not receive blood under any circumstance. With the information from the patient when she arrived at the hospital, in addition to her family’s wishes, and what she had expressed to my preceptor in an earlier discussion, the decision was made to withhold a potentially life saving blood transfusion. Despite surgery to repair a liver laceration, her hemoglobin continued to drop and she passed away early the next day.

Case Analysis

I found this case very interesting because I had no previous experience with treating Jehovah’s Witnesses so I researched it. I found that Jehovah’s Witnesses consider blood sacred. They feel that it must not be eaten or transfused. They feel that blood leaving the body of a human or animal must be disposed of, except for autologous blood transfusions that are considered to be part of a “current therapy” like dialysis. Even in the case of an emergency, they feel it is not permissible to sustain life with transfused blood. If a member conscientiously receives blood, they are subject to organized shunning known as being disfellowshipped or disassociated. It was also interesting to me that while transfusion of allogeneic whole blood or its parts including red blood cells, white blood cells, plasma, platelets, and the transfusion of pre-operatively donated autologous blood are considered illegal, they allow Heart-Lung machines, dialysis, and plasmapherisis. Most interestingly, they allow fractions of blood products including hemoglobin from platelets, interferons from white blood cells, platelet factor 4 from platelets, and albumin from plasma.
Given the information about what treatments Jehovah’s Witnesses can and cannot receive, and given the fact that the leaders of the Jehovah’s Witnesses continue to revise their stance on “blood treatments,” (at first they could receive no blood products at all, but over the years they have gradually increased the number of blood fractions that could be received in addition to allowing treatments like dialysis) I feel that physicians have an obligation to explain these factors to their patients. Physicians must do this away from the patients’ family and friends. They must make sure that the patient is competent to refuse treatment, and are without coercion from family and friends. While I find Jehovah’s Witness doctrines confusing and subject to change at their leaders’ whims, I feel if they are deemed competent that they should be able to refuse any treatment that does not agree with their beliefs. However, what I found to be the ethical issue in our case was whether or not the doctors should have tried all possible treatments including blood transfusions given the fact that our patient was not able to decide for herself at that time whether or not she wanted a potentially life saving treatment.

After the patient died, my preceptor and I discussed the case at length. He noted that this was a very tough decision for him, but ultimately he felt the patient’s wishes were followed. While this patient was clearly not competent to refuse treatment when we examined her, he knew from many previous discussions with the patient that she did not want a blood transfusion under any circumstance. In addition, while her mother did not have Durable Power of Attorney over her, she only echoed what her daughter had previously told my preceptor. Finally, the trauma team indicated that they felt she was trying to tell them she did not want a blood transfusion. Given all this information, I feel the right decision was made even though the patient had no written Advanced Directive
nor did her mother have Durable Power of Attorney over her. This case high-lighted the importance of discussing Advanced Directives with Jehovah’s Witness patients, and the issues of consent to treatment, and determination of competence to deny treatment in emergency situations.