

## Case Report

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## Determining a Blood Transfusion Treatment Plan in a Jehovah's Witness with Coronavirus: Navigating Religious Choice vs Medical Philosophy

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### ABSTRACT

**Introduction:** The refusal of blood products by Jehovah's Witnesses (JW) is one of the most frequent cases of refusal of medical treatment. Blood consents enable patients to express their preferences but critically ill patients often do not have the capacity to make these decisions. The general practice is for JWs to carry a specific wallet-sized advanced directive (AD) blood refusal card on their person which lists specific fractionated blood products that are, or are not, acceptable to them. We review the medical, ethical, and legal considerations for transfusing these patients and also discuss some of the challenges in treating a patient without the blood AD for both emergent and routine transfusions that may save his or her life.

**Case Presentation:** An unconscious 60-year-old COVID-19 positive patient was transferred from an outside hospital. On hospital day 30, his hemoglobin dropped to 6.9. Although he previously identified as a JW and indicated no blood transfusions in a note from 15 years ago, he is now intubated and sedated. There was also no blood AD, nor was the medicine team able to contact his family in rural Mexico for confirmation. He required a total of three blood transfusions over his hospital course before he died.

**Discussion:** In a JW patient without capacity and a blood refusal AD, blood transfusion to preserve life is justified. Case law has conflicting decisions but most recently affirmed that the physician should default to the preservation and prolongation of life. Ultimately, the physician has the responsibility to prove the patient's informed refusal when withholding life-saving treatment. However, if an AD blood refusal or documented history of blood transfusion refusal, then the physician should respect the autonomy and religious values of the patient to decline treatment. Although the 15-year-old documentation is not as ideal as an AD, the JW AD should be respected to the same degree as non-JW AD and Provider Orders for Life Sustaining Treatment (POLST). Finally, the clinical team also has a duty to inform patients who identify as JWs of any blood transfusions that were administered over the hospital course.

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### Abbreviations

**AD:** Advanced directive

**ARDS:** Acute Respiratory Distress Syndrome

**COVID-19:** Coronavirus-19

**JW:** Jehovah's Witness

**OSH:** Outside Hospital

**POLST:** Provider Orders for Life Sustaining Treatments

### Introduction/Background

According to the JW.org website, there are 8.4 million Jehovah's Witnesses worldwide, including 1.2 million in the U.S [1]. The refusal of blood products by Jehovah's Witnesses is one of the most frequently encountered cases of refusal of medical treatment. General practice since the 1970s is for Jehovah's Witnesses to carry a wallet-sized advanced directive (AD) card which lists blood products that are, or are not, acceptable to them on their person and sign a new card every year (Supplemental File 1) [2-4].

The standard of care for all patients is that the healthcare provider is expected to discuss the benefits and risks along with possible alternatives to blood transfusions, but ultimately, respect the decision of the patient to accept or decline them. If the patient decides to refuse blood products, a copy of the blood refusal card should be uploaded to the patient record. In these more straightforward cases when the patient can communicate their treatment decisions, the physicians must balance the duty to preserve life with the respect for patient's autonomy.

Instead, we present a more complex case of an incapacitated patient, previously identified as a Jehovah's Witness (JW). He required a blood transfusion due to steadily worsening anemia, but had a documented treatment instruction from 15 years ago stating not to accept blood transfusions. At presentation, he could not communicate current treatment decisions nor did he have a JW AD, general AD, POLST, or family or surrogate decision maker to provide further clarification regarding blood transfusions. We review the medical, ethical, and legal considerations for transfusing

these patients specifically in instances where the patient is unable to communicate a choice.

### Case Presentation

A 60-year-old Spanish speaking patient presented to an outside hospital (OSH) with a three week history of shortness of breath, cough, and diarrhea. He initially presented tachycardia to the 140s, an oxygen saturation of 40% on room air, and a positive COVID-19 result. Oxygen requirements continued to increase and the patient was ultimately intubated and sedated on day 4. There was no clarification at the OSH regarding blood transfusions while the patient was able to talk but his JW religion was noted. He was transferred to our institution for a higher level of care on day 5. On transfer, his initial physical exam while intubated and sedated was otherwise unremarkable. Labs showed acidosis with PaO<sub>2</sub> of 86 and oxygen saturation of 96%. His creatinine continued to rise despite diuretics and leukocytosis of 19, also up trending. On hospital day 30, his hemoglobin dropped to 6.9. An attempt was made to contact the patient's ex-wife in rural Mexico but the phone number listed was no longer in service. A previous discharge summary from 2005 identified the patient as a Jehovah's Witness and stated that he would not want to receive any blood products. The patient did not have a blood refusal card among his belongings. The decision was made to proceed with emergent blood transfusion. On day 32, his hemoglobin fell to 6.6 and another blood transfusion was given.

On hospital day 37, the palliative care team was consulted to help facilitate Advance Care Planning regarding code status and goals of care. On day 45 of hospitalization, hemoglobin fell again to 6.7 and the patient received a third blood transfusion. The patient ultimately died of COVID-19 pneumonia and acute respiratory distress syndrome (ARDS).

### Defining issues

We present the case of an incapacitated Jehovah's Witness (JW) patient without a blood refusal card who required both emergent and non-emergent blood transfusions. In the case of an incompetent or incapacitated Jehovah's Witness patient without existing documentation, emergent blood transfusion to preserve life is justified via implicit consent [5]. In these emergent scenarios, the judgment of the treating physician outweighs the opinions of patient's friends and family [6,7]. However, in this case, documentation that the patient decided not to receive blood products existed in a note from 15 years ago.

### Ethical Analysis

After further consultation with the hospital ethics committee and the Hospital Liaison Committee for Jehovah's Witnesses, the authors believe blood transfusions should not have been administered to this patient. Although the society for Jehovah's Witnesses recommends members carry the card in their wallet, not all Witnesses do. At this time the blood refusal advanced directive is only available in English, meaning that Jehovah's Witnesses of other native languages, such as our patient, may be less likely to have one. Despite a 15 year gap between the documented discharge summary and the patient's presentation, the documented decision to refuse blood transfusions should be respected unless there is reason to suggest the patient has changed his or her mind. In this instance, there was nothing suggesting the patient changed his mind regarding his treatment decisions. Given clear documentation in the electronic medical record stating the patient refuses blood transfusions, withholding transfusion would be ethically and legally justified. The treating physician also has a duty to inform the patient of the use of any blood products,

consistent with existing literature [7].

Next, there was concern that the JW surrogate should also be a practicing JW to ensure they know and understand the patient's religious values. This is not a requirement. The current literature suggests that the religious beliefs of the surrogate should not be the pinnacle consideration when using a proxy decision maker. A surrogate decision maker, as in other proxy decision makers, should be next-of-kin or whoever best knows the patient's values, goals, and wishes. The National Health Act states that a person designated by the patient in writing may consent to or refuse the blood transfusion on behalf of the incompetent Jehovah's Witness patient [8]. If the next-of-kin refuses a blood transfusion, the physician must obtain a court order to proceed with blood transfusion if it is determined to be in the best interest of the patient.

Legal precedent regarding blood transfusions for adult Jehovah's Witness patients has been conflicting [3]. In 1985, the Supreme Court of Pennsylvania sided with the medical establishment and upheld the emergent transfusion of blood to a young, critically ill patient. More recently and conversely in *Malette v. Schulman* (1990), the Supreme Court of Ontario sided against the physician, deciding that giving blood transfusions in spite of the blood refusal card constituted negligence, assault and battery, and religious discrimination. Later, *HE v. a Hospital NHS Trust* (2003) stated the physician should default to the preservation of life and only withhold life-saving treatments when a clear and applicable advanced directive exists.

"There are no formal requirements for a valid advance directive... There are no formal requirements for the revocation of an advanced directive... An advance directive is inherently revocable... The burden of proof is on those who seek to establish the existence and continuing validity and applicability of an advance directive... If there is doubt, that doubt falls to be resolved in favour of the preservation of life"

Even when a clear blood refusal card is present, some authors have questioned the ethics of relying on the card provided by the Jehovah's Witness society because the blood AD explains risks, but not benefits of transfusions [2, 3, 9]. The blood refusal card explains risks but not benefits of blood transfusion [2, 3]. There is not enough information on the card to know if the patient made an informed refusal or was under any undue influence from community members or the threat of disfellowship, which is similar to excommunication [2]. If the physician has any doubt that the card represents an informed refusal and there is not enough time to obtain a court order, blood should be administered immediately [2]. However, contemporary medical ethics and patient-centered care philosophy would not hold the JW AD to a higher standard of informed consent, capacity determination, and health care ethical principles of autonomy, beneficence, no maleficence, and justice than other ADs and POLST documents. These later documents also do not list the risks, benefits, and formal capacity evaluation within their documentation. These expected patient explanation of benefits are presumed and these documents are still valid. Finally, they also do not have an expiration, and are also enforced after 15 years like the case study example.

### Conclusion

Despite the lack of an AD blood refusal card, given the existing prior documentation the authors believe the clinical team should have withheld blood products from this unconscious Jehovah's Witness patient. The medical team should ask JW patients for

their AD card, similar to asking other patients if they have an AD. The card, if available, should be scanned into the electronic medical record. Without an AD, other documentation, or surrogate decision maker, both emergent and non-urgent blood transfusions should be administered as clinically indicated to an incapacitated JW patient. If the JW does have documentation of their medical treatment wishes, it needs to be respected to the same degree as other non-JW patient medical records, history, and Advance Care Planning documents such as advanced directive and POLST. Finally, clinical team also has an ethical duty to inform patients who identify as Jehovah's Witnesses of any transfusions that were administered over the hospital course.

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**Ethics Approval Statement:** This case has been discussed with the hospital ethics committee but did not meet criteria for IRB review.

**Contributions:** Danielle Brazel: Dr. Brazel performed the literature review, drafted and reviewed all versions of the manuscript.

Jeffrey Wong: Dr. Wong conceptualized the study, critically reviewed the manuscript, and approved the final manuscript as submitted.

All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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