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### Clinical Ethics Committee Case 16:

## A request from an accident and emergency department – should we give our patient a blood transfusion?

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### Biographical Information

Dr Ainsley Newson is Senior Lecturer in Biomedical Ethics at the Centre for Ethics in Medicine, School of Social and Community Medicine, University of Bristol. She has a PhD in Medical Ethics and Bachelors degrees in Science and Law. Her research interests include clinical and reproductive decision-making in genetics and synthetic biology. Ainsley is a member of the European Clinical Ethics Network, the Board of Trustees of the UK Clinical Ethics Network, The BMA Medical Ethics Committee and the Editorial Committee of this journal. She has been a member of Clinical Ethics Committees for 9 years; and is currently a member of the CEC at Royal United Hospital Bath.

### Introduction

This is the sixteenth in a series of cases provided and discussed by UK clinical ethics committees. All clinical ethics committees registered with the UK Clinical Ethics Network may submit a case, which is then discussed by another committee. In this issue, a case has been provided by the University of Southampton, based on a scenario used in medical student exams. To publish case discussions for this section of the journal, a member of the *Clinical Ethics* editorial committee attends the discussion of the case and writes a summary of the discussion. This is then published once the discussing committee and the journal editors have approved it.

**Cardiff and Vale University Health Board Clinical Ethics Committee** agreed to discuss the following case. The CEC was officially launched in May 2005 and was the first CEC in Wales. There are currently 25 members, including medical, nursing and other professionals from within the Trust, augmented by two professional ethicists, a chaplain, a non-executive member of the Trust Board, a member of the corporate management team and patient representatives. The CEC meets monthly and discusses individual cases as well as reviewing various policies and procedures. The CEC has organised annual conferences and tries to raise the profile of clinical ethics by contributing to The Grand Round. A report is presented to the Trust Board and to the Clinical Governance Committee annually.

## **A referral to the Clinical Ethics Committee from a junior doctor in the Accident and Emergency Department<sup>1</sup>**

It is 9.30pm on a busy Tuesday night in the Emergency Department. Louise is a 29 year-old woman who has been admitted following a road traffic accident. She was driving her car on a single carriageway when her vehicle left the road and hit a tree. Her vehicle was extensively damaged and Louise had to be cut out of the wreckage. The accident has caused Louise to sustain severe injuries, which on initial assessment appear to include chest fracture, head injuries, cuts that have given rise to significant blood loss and two badly broken legs. Louise is currently unconscious.

It is anticipated that Louise will require surgery early the following morning. During the course of this surgery it is anticipated that Louise will require at least four units of blood to be transfused. A senior member of the treatment team asks Rachel, a junior doctor, to begin making arrangements for the availability of blood for transfusion.

However on her way from the area where Louise is being treated, Rachel is approached by the staff nurse. He asks her to stop and talk with a group of people who have arrived in the Department. They identify themselves as Louise's friends and state that they are Jehovah's Witnesses. They also tell Rachel that Louise is a Jehovah's Witness and that they all worship together regularly.

Louise's friends state, adamantly, that Louise takes her faith very seriously and that she would certainly refuse a blood transfusion. They also state that Louise would still refuse a transfusion even if the result would be that she would die. Rachel is unsure whether to go ahead and organize the units of blood or whether she should further explore the information she has been given by Louise's friends.

While Rachel is talking with her friends, Louise regains consciousness and on assessment the team feel that even though she is very unwell, she is able to understand and retain information about what has happened to her and to use this information to consider the offer of a transfusion.

Louise initially agrees to a transfusion, so Rachel quickly leaves the Department to go and get this organized. While she is away, Paul, one of Louise's friends, spends some time talking with her. When Rachel returns, she is told that Louise has now changed her mind and is refusing a transfusion. It has also emerged that even though she is a committed Jehovah's Witness, Louise has joined the faith only in the last year and has lost contact with her family.

At this point, Rachel suggests to the medical team that she contact a member of the Hospital's Clinical Ethics Committee via the Switchboard.

*We are approaching the ethics committee with the following questions in mind:*

1. If Louise had not regained consciousness, to help us make a decision about transfusion, what additional information should we seek, from whom and how?
2. Again, if Louise hadn't regained consciousness (and given her need for surgery), how should have we handled the friends' claims about Louise's faith? What should we have done and why?

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<sup>1</sup> This case study has been developed from an exam question in medical ethics and law that was set for final-year medical students at the University of Southampton. Many thanks to Dr Anneke Lucassen for making this case available for discussion as a case study in *Clinical Ethics*.

3. What if Louise had suffered an acute deterioration in her health that evening? What should we have done? What if the care team couldn't agree about what to do?
4. The fact that Louise has changed her mind about a transfusion after speaking with a friend worries us. What should we do about this? How can we adequately explore the possibility of coercion or undue influence in the consent process, particularly in an Emergency Department?
5. What would constitute a valid advanced decision for this sort of situation?

**Response from the Cardiff and Vale University Health Board Clinical Ethics Committee:**

Thank you for your referral, which we considered at our meeting on 9 August 2011. The case prompted significant discussion around the concept of coercion and whether it is possible to ever be truly neutral when talking with patients. We also discussed the relationship between law and ethics and the dilemma of what to do when they may not suggest consistent courses of action. Ordinarily on our committee, a referrer of a case would attend a committee meeting in person to present their problem. Our committee then asks the referrer what he or she perceives to be the ethical issue to focus on. However the urgent nature of this case, together with the way it has been presented to us means that the issues are clearly set out.

Background

This case contains a mix of legal and ethical issues. On our committee, we tend to begin a discussion of a case by asking our legal member (who was not present at this meeting) whether there are any pressing matters of law that would need to be addressed before an ethical discussion can proceed. Although such an eventuality has never happened, we undertake this procedure to ensure that no case comes before us that should instead be taken straight to court for a determination. We also discuss with our legal representative whether there are any issues arising that are specific to the Mental Capacity Act 2005 (MCA). In this case there clearly are issues arising from the MCA, and we return to these throughout the discussion.

The predominant ethical and legal issue in this case is that of consent. More specifically, can or should a patient's self-identified 'friends' have a role (either moral or legal) in the consent process? We determined that although we can listen to them as a courtesy, their moral role beyond this is unclear and they seem to have little or no legal role at all. Our hospital is currently developing a policy on consent which, once completed, we would also refer to in conjunction with our consideration of legal and ethical issues.

Another strategy in cases similar to this one is to ask whether there is any scope to delay treatment in order to seek further advice (perhaps including that of a court) if there is no input from the patient other than the knowledge that she followed the Jehovah's Witness faith. This might happen, for example, if Louise was still unconscious. However we appreciate that the emergency nature of this particular case means that any delay is unlikely, although the Hospital's Liaison Committee for Jehovah's Witnesses (discussed below) may be able to respond quickly.

We have also assumed throughout this discussion that Louise had no evidence on her person regarding her faith or her wishes regarding transfusion, although there are other possibilities such as the fact that Louise may have a written advanced decision in a bag that has been left at the scene due to the substantial damage to her vehicle. Some patients do carry a card stipulating their wishes should they become involved in an emergency situation.

### Addressing the questions posed by the committee

1. *If Louise had not regained consciousness, to help us make a decision about transfusion, what additional information should we seek, from whom and how?*

We would first try to establish who Louise's next of kin were. These individuals won't have the legal power to make decisions for Louise (see below) but we would still like to try to talk to them. Louise's friends are in the emergency department, but who else might we wish to talk to? It has 'emerged' that she has lost contact with her family, but on whose authority has this statement been made? We would be mindful of vested interests in the outcome and whether this might or should influence how information is used by the care team or indeed by us as the CEC. This also raises the question of the definition of 'family', which can mean different things to different people.

So in terms of what information we would seek, we would seek to confirm Louise's identify, to find any evidence that we can about Louise's prior wishes, including any evidence of an advance statement about her wishes for care in this type of situation. We'd also be interested to receive any other potentially relevant information.

As to whom to seek this information from, we would ideally seek to talk with her next of kin, but they may not be readily available. The police would also be relevant here (perhaps via their family liaison service) given that Louise was involved in a road traffic accident. They may therefore be able to assist with identifying Louise's family and putting the care team in touch with them. We would also receive information from her friends, although we did discuss whether any of this information could be taken beyond mere 'face value' without additional evidence.

A valuable possible course of information in cases such as this one is likely to be the local Hospital Liaison Committee for Jehovah's witnesses, which can be contacted via the hospital switchboard.<sup>2</sup> Through its contacts, this committee would be able to put the care team in touch with Louise's Congregation Elders. One of these Elders could then attend the hospital to provide information including:

- Whether Louise has made an advanced decision; as each January all baptised members<sup>3</sup> of the Jehovah's Witness faith who ask for one are given a printed legal advanced decision, with most completing this immediately. This is then counter-signed by two witnesses, who may also be able to attend the emergency department if asked to do so.
- Whether Louise also had a more detailed Advanced Decision specific to health care. These are also offered to all baptised members of the Jehovah's Witness faith each January and are again signed and witnessed. These cover a variety of scenarios such as emergency blood transfusions, resuscitation and use of life support. Often these are logged with GPs (and so Louise's GP could be contacted first thing the next morning, before surgery) or requested to be placed into patient notes. The Congregation Elder will also have a copy of this document.

The 'how' of obtaining this information could also be difficult, particularly if it will involve having to approach a person who was previously unaware that Louise had been involved in an accident. The police family liaison unit or Hospital Liaison Committee for Jehovah's Witnesses may be able to assist with this.

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<sup>2</sup> There are over 30 such committees throughout the United Kingdom. They were established in part to assist with incidents like this one and have a network of contacts, both members of the JW faith and doctors.

<sup>3</sup> We don't know if Louise is baptised, but are told by her friends she "takes her faith very seriously" and is "committed" which suggests she may have been baptised.

It is also worth noting that in law, unless Louise was under the age of 16, none of these people would have the legal authority to make decisions on her behalf unless Louise had designated them a Lasting Power of Attorney under the MCA. However in making a 'best interests' determination as to her treatment, medical staff would in general consider the opinions of others who know Louise.

*2. Again, if Louise hadn't regained consciousness (and given her need for surgery), how should have we handled the friends' claims about Louise's faith? What should we have done and why?*

Before any treatment goes ahead that may be contrary to Louise's wishes (based on her friends' statements) and assuming we have not been able to obtain any further information, there may be a role here for the hospital solicitor. We would want to know whether it would be wise to go ahead and treat (using a best interests assessment, given that the claims of her friends' statements cannot be corroborated), whether a court determination should first be obtained or in fact whether we should not give Louise a transfusion. Even if going to court is not deemed necessary, it would be wise to have a legal opinion at this point.

In addition to seeking a legal opinion (being mindful that we want to focus on the ethical and practical issues arising), as we have already stated above it would be pertinent to consult the Hospital Liaison Committee for Jehovah's Witnesses as this may help obtain valuable information that we currently lack. This will complement any legal opinion together with our own discussions.

As to the claims by Louise's friends, we would only take these comments at 'face value'; they should not of themselves dictate the course of action. This is because these claims (assuming none of her friends is acting as a lasting power of attorney for Louise) have no legal weight and their ethical status may be subject to vested interests. We would also want to try to find out a bit more about the nature of the friendship between Louise and this group, such as the length, depth and nature of the friendship. This of itself should not determine how their statements are handled; but it would be helpful information in terms of how wary we might be in using this information.

Handling the information from Louise's friends would therefore comprise listening to them carefully and being grateful for their input. However ultimately we would treat this information with some scepticism, given that (at least while Louise is still unconscious) we have little else to go on other than the friends' statements. Yet despite the fact that we are concerned about the value of this information from Louise's friends, as an addition we could also try to work with them to try and contact her family.

Ultimately, as health professionals our duty is to do the best we can, based on the knowledge that we have access to. What we need to ensure is that the knowledge we use is based on as sound information as possible. We would give this information from Louise's friends appropriate weight, yet we could not take it to be definitive, particularly given the stakes involved. While Louise is unconscious and in the absence of reliable evidence as to her wishes, we would err towards prioritising life-saving treatment rather than accepting information offered by her friends in the emergency department.

*3. What if Louise had suffered an acute deterioration in her health that evening? What should we have done? What if the care team couldn't agree about what to do?*

Our answer to this question would be very similar to our answer to Question 2 above. We would 'err on the side of caution' and treat Louise in attempt to stabilise her. This is because it would appear that she may not survive without an urgent intervention, which we assume would necessitate a blood

transfusion. If required we could also defer to the legal doctrine of necessity to defend our treatment of Louise in the absence of compelling evidence against treatment.

However, we also noted that if there was indecision or uncertainty about whether a transfusion should go ahead, then surgery should be delayed as long as possible to allow time to try and resolve the issue.

Further, the Hospital Liaison Committee may be able to assist here by putting the care team in touch with either a consultant or other hospital who is experienced in dealing with scenarios such as this one. We know of some medical evidence where emergencies such as this one have been successfully overcome without resorting to a blood transfusion, such as the use of volume expanders and blood recovery equipment. The Liaison Committee may also be able to advise on appropriate surgical techniques.

If the care team were in disagreement about what to do, we would try to encourage some kind of mediated discussion about Louise's best interests, and whether or not treating her would cause harm (and to whom). But even if some members of the team believed there was ethical justification to not treating Louise following Rachel's discussion with Louise's friends, we believe that (if needed) life-saving treatment should be administered in the interim to then allow resolution of the outstanding issues for all parties.

We also discussed the fact that in acute situations like this one, there will often be someone who is required to make a decision even if there is no group consensus on an issue. This is an accepted aspect of working in a well-functioning team. However what everyone would want to avoid would be for Louise to die while the care team was equivocating about her treatment.

There may also be human rights considerations arising in this case, such as the right to life or the right not to be treated inhumanely or in a degrading manner. However these considerations are also difficult to discuss further without more reliable knowledge of Louise's wishes. We also noted at this point in our discussion that, in our experience, the Jehovah's Witness faith does incorporate a degree of flexibility and that it may be possible to all work together to achieve a good outcome for Louise.

*4. The fact that Louise has changed her mind about a transfusion after speaking with a friend worries us. What should we do about this? How can we adequately explore the possibility of coercion or undue influence in the consent process, particularly in an Emergency Department?*

We would approach this question by first asking Rachel what it is that worries the team. Is it the fact that Louise has changed her mind about treatment at all, or the fact that she has changed her mind to a decision that sits less well with the care team?

Given the potentially serious consequences of Louise's decision to change her mind about a transfusion, we would also suggest that a MCA capacity assessment be carried out to make sure that Louise is able to make this kind of decision at this point in time. For the purposes of this discussion, we have assumed that such an assessment has shown that Louise does have capacity to make this decision.

We spent some time discussing the merits and drawbacks of ways to approach patients who have seemingly changed their minds about treatment following a discussion with a relative. An initial suggestion was that the care team should speak with Louise again, without her friends present. This is because if the care team is worried about undue influence, they could probe this further with Louise to

see if she sustains her position on her own. However, this does also open up the possibility that Louise will then be influenced by the care team, as given how unwell she is, she may be very vulnerable or vacillating between positions. This could perhaps be overcome or mitigated by including a member of the Hospital Liaison Committee for Jehovah's Witness in discussions, or another neutral third party (inasmuch as it is possible for anyone to be neutral in these kinds of discussions).

An alternative to talking with Louise without her friends present would be to have a discussion with everyone who has been involved to date, including her friends. However this could be overwhelming for someone who is acutely unwell and may not be productive to resolving the problem. We should aim to create an environment where Louise is as comfortable as possible; this is something that will need to be guided by her behaviour and demeanour at the time. It would also be best if a physical environment conducive to this type of discussion could be located within the department.

We spent some time discussing the merits and drawbacks of these alternative approaches, including a discussion of the role of stakeholders such as Rachel and her supervising consultant – which then led into a wider discussion of medical professionalism and trust. We wondered whether any health professional could genuinely be neutral when discussing a transfusion with Louise, given that professionals do have an interest in protecting the lives of their patients. However on the other hand, a professional will respect a patient's competent decision so long as the patient has had a full opportunity to articulate and act upon his or her own interests.

In whatever manner a further discussion with Louise is constituted, we would want to discuss with her aspects such as her reasons for changing her mind and anything else that might provide a 'feel' for any influence she might be under. We would also be frank in our discussion with Louise of the likely outcomes of giving or withholding a blood transfusion. The aim of this would be to maximise the chances of Louise making an informed choice about her treatment.

Ultimately, we do need to respect Louise's wishes, having explained to her the options, risks and consequences of her decision. Before acting on her decision, we would want to be confident that she has reached her decision of her own accord and that her refusal of treatment is what she really wants. At the moment, we would be concerned about her vulnerability and apparent vacillation in her decision, but if this then stabilises and the consequences have been clearly explained and documented, Louise's decision may be accepted.

##### *5. What would constitute a valid advanced decision for this sort of situation?*

In our opinion, it would be difficult to construct an advanced decision that is specific enough for this type of situation. We also wondered whether a general advanced decision to refuse all blood transfusions would be acceptable in an emergency situation, particularly given that subsequent statements can invalidate a decision. There are formal criteria for advanced decisions under the Mental Capacity Act, including specific criteria for life-limiting decisions. So to establish the validity of any advanced decision that Louise may have made, we would seek legal advice – most likely from the hospital solicitor.

Of course if Louise was conscious, then her advanced decision would be overridden by her decision made at the time; an advanced decision would only become relevant (assuming Louise had one) if she was unconscious and had not yet regained consciousness.

We noted that in general a lot of Jehovah's Witnesses carry written advanced decisions. However how any advance decision might be interpreted in practice is subject to debate – a problem that has already been documented.<sup>4</sup>

### **Conclusion**

This case has given us an opportunity to discuss many aspects of caring for acutely unwell individuals who have specific wishes about their care. We have raised issues of neutrality, professionalism and the relationship between law and ethics.

In this particular case, if Louise has capacity and has sustained a decision to refuse a blood transfusion and we have been able to establish that this does appear to be her own decision, then if the consequences of her decision have been clearly explained to her, her decision should be respected. However, while this deliberation is ongoing, it would be wise to send some of her blood for cross-matching and to also seek legal advice.

### **Members of Cardiff and value University Health Board Clinical Ethics Committee who discussed this case:**

Dr Angus Clarke, Clinician  
Dr Richard Hain, Clinician, (CEC Chair)  
Mr Douglas Harrett, Lay Member  
Mrs Jane Rowlands-Mellor, Senior Nurse – Bereavement Services  
Mr Steve Sims, Lay Member  
Mr John Viney, Patient Representative  
Mr Keithley Wilkinson, Equality Manager

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<sup>4</sup> Thompson, T., Barbour, R., Schwartz, L. (2003) "Adherence to advance directives in critical care decision making: vignette study" *BMJ* 327: 1011. doi: 10.1136/bmj.327.7422.1011.