Blood Relations

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My patient was a small, elderly woman lying in bed, looking gray. She was weak and not able to say much, but she confirmed "*dolor del pecho*" and gestured feebly toward her chest.

Several days earlier, she had undergone knee-replacement surgery and had lost some blood. After the surgery, her surgical site had continued to ooze a little, and her hematocrit had dropped steadily until it reached the 20s. She began to have chest pain, and the orthopedists taking care of her ordered an ECG, which showed ischemia. That's when her orthopedics team called a medical consult, and I, an intern at the time, was sent over to see the patient.

After examining her and looking at her ECG, I told the orthopedists that she had demand-related ischemia and they needed to transfuse her aggressively. They told me they knew that, but the patient was refusing transfusion because she was a Jehovah's Witness. Perhaps because of the language barrier, this fact had not been clearly communicated to them before the patient's operation. Then the surgeons explained that from a knee standpoint, there was nothing more to be done, and we arranged the patient's transfer off the surgery service and onto my medical service.

It took a few hours to get her moved from one floor of the hospital to another. During that time, some type of communication must have taken place, because when I went to check on the patient later that day, there were four strapping young men in three-piece suits standing at the four corners of her bed, staring straight ahead. They looked like living columns of a four-poster bed. One of them, evidently the leader, stepped forward to tell me that they were members of the patient's church and had come to support her in her hour of need. He gave me a pamphlet outlining all the substances that one could use in place of blood that were acceptable in the Jehovah's Witness religion.

Unfortunately, none of these substances, which basically consisted of intravenous fluids, could possibly address her problem. I explained to the young men that without a transfusion, we believed the patient would die. In the bed, the patient shook her head. She didn't want a transfusion — it was against her religion.

When I left her room, I found her son waiting for me. He was wearing a hospital uniform because he worked as part of the environmental services staff. I knew him by sight and remembered that he was always smiling and friendly, encouraging to the residents. Now he had many members of his family with him, and they were frantic, his daughters crying. They had learned that their grandmother was refusing transfusion, putting her life in danger, and they begged me to do anything I could to save her. They explained that she had converted to the Jehovah's Witness religion after coming to the United States from Central America, but that she was the only member of her family to do so. Her son and his siblings remained Catholic, they told me, and did not share their mother's beliefs.

We gave her all the treatments we could: nitrates and beta-blockers, morphine and oxygen, but the next day, the cardiologist came by to reiterate that the patient would die without a transfusion. The young men guarding her bed were replaced at regular intervals by new young men, so that she was surrounded by fresh-faced teenagers in three-piece suits at all times. I spent a lot of time trying to make sure that the patient understood the consequences of her choice and trying to persuade her to accept transfusion, both in my own inelegant Spanish and through a hospital interpreter. The patient was adamant. Her son and his family beseeched our team repeatedly for help.

I don't remember how long this went on. I don't remember the conversations I must have had with my attending and the other members of my team. I do remember that, finally, I wrote an order that I've never written before or since. I wrote in the chart that no one who was not a hospital employee or a blood relation of the patient was permitted to enter her room. Within minutes, the nurses were on the phone to hospital security.

After that, her room was filled with family members arguing and gesticulating in Spanish from morning until night. The patient seemed to grow ever smaller and grayer in her bed. Finally, I got the call: the patient had consented to transfusion.

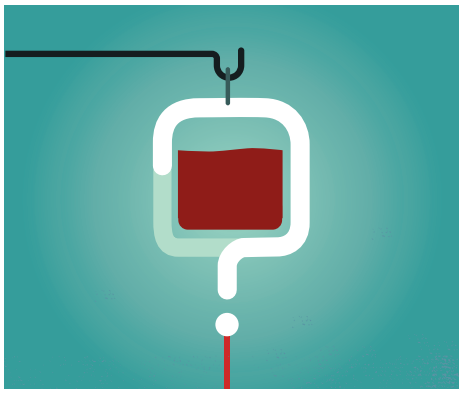
I ran all the way to the blood bank to get the blood and bring it to her room myself, where her nurse was waiting with a transfusion pump. We hung the bag of blood and connected all the tubes, then watched, with all her family members gathered round, as the blood began to flow into her arm. I felt a rush of triumph and relief: I knew we were saving her life.

When I turned to look at her face, however, I saw a mask of despair and inconsolable grief. She looked like a person suffering unspeakable loss.

For the rest of my residency, whenever I encountered her son in the hospital, I got a warm greeting and vigorous thanks. It made me uncomfortable for more than one reason. I knew full well that I had been powerless to persuade his mother. Truly, he and the other members of his family had made the difference. But I also never forgot the look on his mother's face when we transfused her. It seemed possible to me that in "saving" his mother's life, we were actually trampling all over her spirit.

I believe that patient autonomy is the foundation of all medical care. When patients express their wishes, doctors — and the enormous institutional edifice of modern medicine — should listen. On other occasions when patients have refused care and shortened their lives, I have defended their right to this choice.

Why did this case go differently? Certainly, this patient had many characteristics that made it less likely that we would listen to her. She wasn't a powerful, important, authoritative person. She was elderly, female, physically tiny, and frail. She came from another



country, she was nonwhite, and she didn't speak English. She was poor and poorly educated. She had a son opposing her wishes who had a preexisting personal connection to her doctors and the hospital.

She didn't want to die. But she also didn't want a transfusion. She was stuck between medical necessity and her religious ideals. Did my behavior respect her autonomy? I didn't transfuse her against her will. But with my position of relative power in the hospital, I cast my vote for the body over the spirit, for physical necessity, for transfusion, and for more life.

I'm haunted by my decision to this day. Even after many years of medical practice, I'm not sure what the right course of action would have been. My patient, suffering in her bed, seemed so small, and the people arguing over her loomed so large. I don't know how we could have created a protective space around her in which she could have freely exercised her will, except by banning everyone from her room, thereby leaving her to face death alone.

I do remember how clear it was that she was in pain. It can't feel good to feel your heart die, day after day, despite all our morphine. In the end, I imagined that this was the factor that tipped the balance, that she literally followed her heart.

I never spoke with her son in detail about how his mother was doing after she went home. I wanted to preserve my hope that she was happy with the way her care went, content at the heart of the family that had fought so hard to save her life. I never knew whether she chose to stay within her church by repenting of her transfusion. I hoped the ties of blood had proven strong enough to sustain her through the years she had remaining.

Disclosure forms provided by the author are available at NEJM.org.

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