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# A Patient's Right to Refuse Medical Treatment

## Introduction

The right to refuse medical treatment is generally based on the common law right of self-determination of one's body, the ethical principle of respect for autonomy[1], and the doctrine of informed consent.[2] Further, the right to refuse treatment has also derived from a federal and state constitutional right to privacy.[3] The United States Supreme Court has also held that a competent person has a liberty interest in the Due Process Clause in refusing any unwanted medical treatment.[4] The right to refuse medical treatment may also be based upon the freedom of religion.[5] Competent patients have the right to refuse any medical treatment, including blood and blood product transfusions, for themselves.[6] Accordingly, a competent adult patient who does not want to receive blood or blood products should be required to sign a release that explains the risks inherent in refusing treatment and holds harmless any health care providers, hospital, facility, and any of their employees and agents from all liability arising out of the refusal of treatment. However, as the following two case studies highlight, even when competent adult patients or their legal representatives are provided with comprehensive informed consent discussions of the risks of refusing blood and blood products and those communications are documented in the medical record, that does not necessarily prevent litigation from being filed against those health care providers in the event of patient injury or death.

## In This Issue

Competent adult patients have the right to refuse any medical treatment for themselves, even involving life-threatening situations. This concept is supported by the ethical principle of respect for autonomy as well as state and federal law. In this issue, we examine two case studies involving adult patients who refused blood and blood product transfusions based on religious grounds and the medicolegal implications that can arise from those situations. We also offer risk management strategies to consider when a patient or legal representative refuses medical treatment for themselves or others.

Thanks for reading,

Brian J. Thomas, Editor

## Case Study One

A 56-year-old female presented electively for a vaginal hysterectomy. Preoperative hemoglobin and hematocrit (H/H) were 12.4/36.6 three weeks before the procedure. The patient was a known Jehovah's Witness who refused blood products. There were no known bleeding or clotting problems. The patient was assessed as an ASA PS 1.

The nurse who performed the initial review of the past medical history documented her religious preference and that the patient refused blood. The surgeon's orders also noted her religious preference and refusal of blood and blood products. The surgical consent and the preoperative notes included the risk of bleeding. Her anesthesia consent noted the patient stated, "she would rather die than receive blood products." A subsequent consent stated, "no blood products." The patient also had a durable power of attorney (POA) who was aware of the patient's refusal of blood and blood products.

The anesthetic and surgery were uneventful. The surgeon's operative note documented "excellent hemostasis." The anesthetic lasted from 0857-1044. The patient was transferred to PACU in

stable condition. The PPM insured anesthesiologist went to perform another surgical case. He finished that case and returned to the PACU to check on the patient. The PACU nurse reported that the patient had experienced low blood pressure, for which she administered ephedrine and fluid boluses per the anesthesiologist's standing PACU orders. The patient responded to the medication and fluids. However, the patient complained of pain during her PACU stay. She was administered narcotics that caused her blood pressure to dip again. At approximately 1224, the anesthesiologist spoke with the patient about her pain level. He palpated her abdomen for pain, and her complaints were negligible at that point. The anesthesiologist then left the hospital and was not contacted again about the patient's condition.

The PACU nurse subsequently contacted the surgeon because she began to suspect that, given the patient's totality of complaints, she might be experiencing a bleed. The surgeon examined the patient and ordered an ultrasound at 1244 due to continuing hypotension. At 1313, the surgeon was at the patient's bedside examining her. The ultrasound demonstrated no frank evidence of bleeding. No tachycardia was noted, and a second IV was started.

At 1453, the PACU nurse paged the surgeon again due to the patient's continuing hypotension. He examined the patient and decided that abdominal exploration was indicated due to decreased hemoglobin (approximately three and a half hours after the anesthesiologist last saw the patient). The H/H was now 7.2/21.7. Consents for surgery and anesthesia were obtained once again, and the patient continued to refuse blood products. Continuous pressors were necessary to maintain sufficient blood pressure (BP) levels.

The take-back surgery lasted from 1534-1753. A different anesthesiologist administered general anesthesia for the second case. Dark, clotted blood was found in the peritoneal cavity. The surgeon noted a "pumping vessel" on the left pelvic sidewall that was resutured. The H/H in the PACU was 3.2/11. The surgeon documented the extremely low hemoglobin but noted in the medical record that he would respect her declining any blood products. He prescribed iron infusion, erythropoietin, vitamin B12, and fluids to treat the anemia. The second anesthetic was without complication with minor hypotension controlled by continuous neosynephrine. The patient was extubated after the second surgery and taken to the ICU.

The patient required tracheal intubation and mechanical ventilation on the first post-op day. The ICU nurse documented that the patient declined blood products or transfusion. The patient was still lucid the first night and making her own decisions. Three different vasopressors were necessary to maintain an acceptable BP. The H/H was 2.6/7.5. Blood gas analysis was consistent with a metabolic acidosis.

***Her anesthesia consent noted the patient stated, "she would rather die than receive blood products."***

The family wished to transfer the severely anemic patient to another facility on the second post-op day. The H/H was 2.4/8.0. After multiple family members, the POA, church elders, and physicians discussed her grave condition, the decision was made to transfer the patient.

The patient was admitted to the trauma service at the other facility. The patient's family and her POA denied repeated offers for blood transfusions. She underwent multiple procedures for her worsening medical condition. Diagnoses included ARDS, anoxic brain injury, vegetative state, DVT, and severe anemia. Procedures included tracheostomy, CVP placements, abdominal exploration, bronchoscopy, wound closure, and echocardiogram. The neurologic changes caused the family to withhold treatment, and the patient died three weeks post-op.

The patient's husband and three adult children sued the PPM insured anesthesiologist, two attending OB/GYN physicians and their practice group, and the hospital. The plaintiffs alleged that before this procedure the decedent had informed the defendants that due to her religious beliefs as a Jehovah's Witness, she would refuse blood products for this surgery. They also alleged that the two OB/GYN physicians told her a bloodless vaginal hysterectomy could safely be performed at the hospital.

The plaintiffs further alleged the defendants failed to diagnose the post-operative bleeding timely and negligently delayed bringing the decedent back to the OR to stop the bleeding.

The plaintiffs' anesthesia expert, Aalok Agarwala, M.D., Boston, Massachusetts, testified in his deposition that a team consisting of the anesthesiologist and the surgeon should confer about whether to take the patient back to the OR. He also testified that the anesthesiologist caused or contributed to the patient's delay to return to surgery. On cross-examination, however, he conceded that the anesthesiologist's role would be to determine whether there were any anesthetic concerns about taking the patient back to surgery. He also admitted that the surgeon would have been the physician who had to make the ultimate decision whether to return the patient to surgery.

***The anesthesiologist noted in the preanesthesia evaluation that he informed the POA that without blood transfusion, the patient would probably not survive the surgery.***

The plaintiffs claimed damages for past medical expenses for approximately $400,000, lost earnings, conscious pain and suffering, and loss of consortium. Defense counsel evaluated the overall value of the damages in the case, assuming liability, at over $2 million.

After over ten years of litigation and an upcoming trial date, the co-defendants settled their cases for a confidential amount estimated to be in the high six figures. The PPM insured anesthesiologist, the sole remaining defendant, consented to and requested that PPM settle his case. PPM settled the case on behalf of the PPM insured for $25,000.

## Case Study Two

A 54-year-old male patient with a history of nausea, fatigue, and multiple syncopal episodes arrived via ambulance at the hospital emergency department at approximately 0245. The patient was a Jehovah's Witness and advised his providers he did not want to receive blood or blood products. His hemoglobin (Hgb) was 9.5.

After the patient was observed for approximately six hours, the clinical decision unit (CDU) determined the patient should undergo esophagogastroduodenoscopy (EGD). While preparing for that procedure, the patient experienced hypotension and an increased heart rate upon attempting to stand. Because of this episode and his decreasing Hgb, an intensive care unit (ICU) consult was ordered.

The ICU staff evaluated the patient and noted that he was more hemodynamically stable while he was lying down. A progress note entered by the ICU attending indicated the gastroenterologist discussed the endoscopy with anesthesia but stated that "anesthesia determined the patient is currently too unstable to undergo the procedure at this time." An ICU resident documented that he called the anesthesiologist and discussed the case, but the anesthesiologist was unwilling to take the patient for the endoscopy. The ICU staff then administered IV fluids to stabilize the patient for EGD, but his condition worsened over the next few hours.

An emergent EGD was ultimately performed bedside at 1855 on the day of admission. The EGD revealed clotted blood in the gastric fundus and a bleeding ulcer in the intestine, which were cauterized by the endoscopist.

The following day the patient's condition deteriorated, and he became more hemodynamically unstable; his Hgb dropped to 3.5, and he was intubated and sedated. An exploratory laparotomy was performed, and a 2 cm oozing ulcer was found on the medial wall of the duodenum. The ulcer was sutured and over-sewn by the surgeon. Another PPM insured anesthesiologist administered the general anesthetic for the second procedure. He noted that the patient's power of attorney (POA) consented to the surgery and again refused blood products. The anesthesiologist noted in the preanesthesia evaluation that he informed the POA that without blood transfusion, the patient would probably not survive the surgery. The patient was assessed as an ASA PS 5E.

On the following day, the patient was administered 5 units of Hemopure®, a blood alternative, which increased his Hgb to 4.5. The patient survived the procedure and was returned to ICU. However, the patient went into cardiac arrest later that morning;

resuscitation efforts were aborted following a discussion with the patient's mother, and he expired.

The patient’s mother sued the emergency room physician, ICU resident, ICU physician, anesthesiologist, and the hospital. The plaintiff alleged the defendants breached the standard of care by failing to treat the patient's internal bleeding in a timely manner. Plaintiff alleged the defendants should have performed the EGD and laparotomy sooner. Plaintiff retained three experts to support her theory: an internal medicine expert, a gastroenterology expert, and an anesthesiology expert. All three experts opined that the defendants breached the standard of care by failing to treat the patient before his blood count dropped so low.

The defendants moved for summary judgment disposition under state law.[1] The defendants argued that, even if defendants were negligent, the doctrine of avoidable consequences precluded the plaintiff from recovering an award. Defendants noted that, under the doctrine of avoidable consequences, a party could not recover for losses that they could have avoided through reasonable effort or expenditure. The defendants argued that the patient could have avoided death had he accepted a blood transfusion – a minimally invasive treatment with little risk.

Plaintiff responded that the doctrine of avoidable consequences did not preclude a plaintiff from recovering if a reasonable alternative to the forgone treatment existed. Plaintiff argued that there was an alternative treatment available: defendants could have performed surgery earlier in lieu of a blood transfusion.

***The defendants argued that the patient could have avoided death had he accepted a blood transfusion – a minimally invasive treatment with little risk.***

The trial court granted the defendants' motion for summary judgment. The trial court ruled that by rejecting a blood transfusion, the patient had failed to take advantage of objectively reasonable means to avoid the consequences of the defendants’ alleged negligent conduct. The trial court found that the blood transfusion was a minimally invasive procedure and that all three of the plaintiff's expert witnesses agreed that it would likely have saved the patient’s life. Plaintiff appealed the trial court’s decision to grant summary judgment in favor of the defendants to the state’s court of appeals. The court of appeals affirmed the lower court’s ruling resulting in the final dismissal of this litigation.

## Risk Management Analysis

The two case studies underscore that even though our insured anesthesiologists provided multiple informed consent discussions that were properly documented, the patients’ families still sued them. However, if the anesthesiologists had not adhered to the patients’ and their representatives’ refusal of blood products, they would have likely been sued for civil assault and battery, intentional infliction of emotional distress, negligent infliction of emotional distress and significant damages for emotional distress. “In PPM’s experience, when our anesthesiologists provide ethical, culturally competent, and medically appropriate care under the circumstances, as they did in these cases, juries will understand and accept our insureds’ duty to respect patients’ rights and beliefs and not find them liable even if the patient dies,” according to Tracey Dujakovich, PPM Senior Claims Attorney.

[1] Grounds for summary judgment disposition vary pursuant to federal and state law. The grounds for the summary judgment motion being granted in this case were, “the opposing party has failed to state a claim on which relief can be granted,” and “there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law.”

## Risk Management Strategies and Considerations for Patients Who Refuse Medical Treatment[7]

- Consult or review with hospital Ethics Committee if available
- Educate the patient or their legal representative as much as possible about the treatment recommendations and the risks of refusing treatment
- Attempt to discover the patient's reasons for refusing care and discuss these with the patient to determine if there are ways to compromise so the patient can receive care that is in their best interests
- With the patient's permission, speak with family, legal representatives, or clergy to determine if that might help the patient reconsider their refusal of treatment
- Consider a mental health referral if the patient has overwhelming anxieties about receiving care or shows psychiatric comorbidities and is willing to be evaluated
- Document your efforts to educate the patient, the rationale for your recommended treatment, and the patient's refusal of care
- Have the patient sign a release that explains the risks inherent in refusing treatment and holds harmless the health care providers and facility from all liability arising out of the refusal of treatment

The right to refuse medical treatment generally is a very complex area of the law. Due to conflicting legal precedents, the validity of the refusal of treatment depends on the patient's situation. For example, if the patient is a minor, courts have generally ordered that blood transfusions be administered in life-threatening cases over the objections of parents who based their decision on religious grounds. State laws vary and are less clear for a minor in a less than life-threatening situation. If the minor is a teenager, joint refusal of the patient and the parents would likely be valid.

For these reasons, PPM strongly recommends seeking the advice and assistance of legal counsel when caring for a patient who refuses medical treatment. Also, hospitals and facilities need to develop a response in advance of a medical emergency because of these same complexities. If procedures are not already in place, it may be impossible to marshal the necessary resources within the time required by a medical emergency. PPM's in-house attorneys and claims professionals are available to provide guidance and assistance in reviewing hospital and facility policies for patients who refuse medical treatment, including blood and blood products, based on religious and other grounds.

## References:


1. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 8th ed. New York, NY: McGraw Hill; 2022.
2. *See, e.g., In re Storar,* 52 N.Y.2d 363, 438 N.Y.S. 2d 266, 420 N.E. 64.
3. *See, e.g., Superindendent of Belchertown State School v. Saikewics*, 372 Mass. 728, 370 N.E.2d 417.
4. Cf., *e.g., Jacobson v. Massachusetts*, 197 U.S. 11, 24-30, 25 S.Ct. 358, 360-363 L.Ed. 643.
5. U.S. Const. amend. I.
6. *See Cruzan v. Director Missouri Department of Health*, 110 S.Ct. 2891 (1990).
7. When Patients Refuse Treatment: Medical Ethics Issues for Physicians. *NORCAL GROUP PROASSURANCE Knowledge Library*. July 5, 2017. https://www.norcal-group.com/library/when-patients-refuse-treatment-medical-ethics-issues-for-physicians. Accessed March 8, 2022.

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**Note**: The purpose of this newsletter is to provide information to policyholders and defense counsel regarding professional liability issues. Risk management analysis is offered for general guidance and is not intended to establish a standard of care or to provide legal advice.

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