Responses by Pregnant Jehovah's Witnesses on Health Care Proxies

To the Editor:

We read with interest the review work by Gyamfi and Berkowitz,[1] in which the majority of the pregnant women in the Health Care Proxy were willing to accept some forms of blood or blood products. Obstetricians will be pleased with Gyamfi's conclusion because they will be able to gain more opportunities for treatment without religious pressure. We previously reported a case in which informed consent to blood transfusion in patients under 19 years of age had been discussed.[2] In that report, both the patient and her mother, who were Jehovah's Witnesses, refused blood transfusion. Nevertheless, her father, who was not a Jehovah's Witness, agreed to the blood transfusion if it was medically necessary. Since disagreement existed among the patient's family members, it was decided not to perform the blood transfusion even if medically necessary, in accordance with the patient's wishes. She, even if under 18, would have been able to give her own informed consent as to whether or not she would consent to blood transfusion in lieu of her parents' wishes. That determination is justified under the American and British legal environments. In contrast, it remains unclear under Japanese law.

Dr. Gyamfi and colleagues did not mention the age of the pregnant women or describe the husbands' opinions. However, not only the parents' but also the husband's opinions are important, even if the pregnant women's opinions are given the most weight. More importantly, the husband's opinion should be considered for a pregnant woman under 20 years of age, as well as for those where there is parental disagreement.

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In Reply:

We appreciate the comments by Dr. Thomas and Dr. Shukunami and colleagues. Our paper reviewed 61 health care proxies filled out by pregnant women who identified themselves as Jehovah's Witnesses over a 5-year period. The report is purely descriptive. We do not editorialize about the results, other than to make the point that each patient should be approached as an individual and allowed to make her own choices when given information on blood and blood products.

The 44-fold increased risk of mortality for Jehovah's Witnesses compared to the general obstetric population cited in our paper reflects the data from our institution. Singla et al[1] reviewed 391 pregnancies in 332 Jehovah's Witnesses over a 12-year period and found 2 maternal deaths (odds ratio 44, 95% confidence interval 9–211). Although Friedman et al (Friedman AJ, Shander A, Volpe L. Are women who are Jehovah's Witnesses at risk of maternal death [letter]? Am J Obstet Gynecol 2002;187:1729–30) commented that the results of this series might not be confirmed in a controlled trial, Saphier et al (Saphier CJ, Singla AK, Berkowitz RL. Are women who are Jehovah's Witnesses at risk of maternal death [letter of reply]? Am J Obstet Gynecol 2002;187:1730) responded by saying that withholding blood products in a randomized, controlled trial would not be ethical. The authors acknowledged the wide confidence interval based on only 2 deaths, but pointed out that the results did reach statistical significance. They also emphasized that a strict Jehovah's Witness protocol is employed at The Mount Sinai Medical Center and that both of the women who died used intraoperative cell salvage.

It is naïve to assume that all people in any religious group share the exact same beliefs, regardless of doctrine. It is well known that Muslims, Jews, and Christians have significant individual variations in their beliefs. Why should that not also be true for Jehovah's Witnesses? Dr. Shukunami and colleagues raise a very interesting issue regarding consent for pregnant women. Although not mentioned in our report, the mean age was 26.5 ± 7.3 years. In New York State, a pregnant woman who is under the age of 18 years can provide informed consent. New York State Public Health Law §2504(3) provides that "Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care." The New York State Health Care Proxy allows any patient to identify a health care proxy to make decisions for her in cases where she cannot act on her own behalf.[2] Most patients have identified family members. When a patient becomes incapacitated and the family members disagree on how to proceed, a court order should be obtained to make a decision, but the plan of the proxy should be carried out

until otherwise notified. A husband's opinion is not taken into account when the patient is under 20, or at any other age, as long as the patient has the ability to make her own informed consent.

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Repeat Measurement of Cervical Length After Successful Tocolysis

To the Editor:

We read with great interest the article by Rozenberg et al.[1] They concluded that repeating ultrasonographic cervical length measurements after successful tocolysis for preterm labor was ineffective. Most studies that have compared manual and ultrasonographic examination of the cervix in their ability to predict premature delivery have supported the use of ultrasonography. However, those studies included low- or middle-risk populations. Volumenie et al,[2] who compared digital and ultrasonographic cervical examination for prediction of preterm delivery in patients hospitalized for preterm labor, reported that digital examination using a Bishop score was better than ultrasonography in a high-risk population requiring hospitalization. In Rozenberg's study, subjects were also inferred to be of the high-risk population because the patients were admitted and treated for uterine contractions at 24^{+0} to 33^{+6} weeks of gestation and had a cervical length of 26 mm or less by transvaginal ultrasonography. That inference is supported by similar preterm delivery rates found in the Rozenberg and the Volumenie studies. They were 41.3% and 39.0%, respectively.

Volumenie's results imply that systematic ultrasonography after digital examination adds no relevant information to the accurate assessment of threatened preterm labor. Accordingly, in Rozenberg's study, digital examination using the Bishop score should be done before asserting the ineffectiveness of repeat ultrasonographic cervical length measurement, even if it is performed after successful tocolysis for preterm labor.

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In Reply:

We appreciate the opportunity to answer Dr Shukunami's concern. One of the first studies demonstrating that ultrasonographic examination of the cervix performs better than digital examination as a predictor of premature delivery was conducted in high-risk patients,[1] with a preterm delivery rate of 37.3%, which was similar to ours and that of Volumenie.[2]

In a previous study, we compared the predictive values for preterm delivery of fetal fibronectin and ultrasonographic cervical length.[3] Inclusion criteria were clinical signs of premature labor, including 2 uterine contractions per 10 minutes, with shortening or dilation of the cervix detected by cervical digital examination and requiring hospitalization between 24 and 34 weeks of gestation. The preterm delivery rate was only 26.3%. In the current study, performed in the same institution, the preterm delivery rate has increased up to 41.3%, using cervical length of 26 mm or less by transvaginal ultrasound instead of digital examination to consider admission. We, therefore, strongly believe that this is a mere reflection of a better selection of high-risk patients by routine use of transvaginal ultrasound.