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MANAGEMENT OF PATIENTS WHO REFUSE BLOOD TRANSFUSION (including Jehovah's Witnesses)

Please Note: There is a Separate Trust guideline for Treatment of Obstetric Haemorrhage in women who refuse blood transfusion including blood products WAHT-OBS-035

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance

There are patients who refuse blood transfusion on religious or other grounds. The most common and well known group of such patients are Jehovah's witnesses (JW).

This policy applies to all patients who refuse a blood transfusion.

LEAD CLINICIANS

Dr. T.Skibbe — Consultant Haematologist

Gill Godding — Lead Transfusion Practitioner

Approved by Clinical Management Committee on: 20th February 2013

Hospital Transfusion Committee on: 20 December 2012

This guideline should not be used after end of: 20th February 2015

Key amendments to this guideline

Date	Amendment	By:
18.06.2010	This Guideline has been uploaded on the intranet and extended whilst being reviewed	Administrator
01.11.2010	Lead clinicians names amended	Lisa Rowberry / Dr Skibbe
01.11.2010	This Guideline has been amended to manage all Patients that refuse blood including Jehovah's witnesses	Lisa Rowberry / Dr Skibbe
01.11.2010	The circulation list has been amended to reflect the changes in the management structure	Lisa Rowberry
01.11.2010	"Gillick" Competence may also now be referred to as "Fraser" competence	Lisa Rowberry
01.11.2010	Hospital liaison committee network for Jehovah's witnesses local contact numbers checked and amended	Lisa Rowberry
01.11.2010	Example of Advance decision to refuse specified Medical Treatment Documentation added in appendix A and guidance how to record this information in the patients notes	Lisa Rowberry
01.11.2010	Guidance on the procedure for contacting the trusts legal team out of hours	Lisa Rowberry
01.11.2010	Notification of the Obstetric guideline	Lisa Rowberry
14.12.2010	Views of the relative to be taken into account in deciding the patient's best interests	Dr.Charles Ashton
Dec 2012	Expiry date extended whilst guideline is under review	E Maughan
20.12.2012	Document reviewed by the transfusion committee	Dr Thomas Skibbe

MANAGEMENT OF PATIENTS WHO REFUSE BLOOD TRANSFUSION (including "Jehovah's Witnesses")

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MANAGEMENT OF PATIENTS WHO REFUSE BLOOD TRANSFUSION (including "Jehovah's Witnesses")

1. INTRODUCTION

It is the right of every patient to refuse any specific form of treatment including transfusion of blood and blood components. The patient has the right to change his/her mind at any time. It is the duty of the physician to accept that decision and to give the patient the best available alternative treatment which is accepted by the patient. Patients may refuse some blood products but accept others and may refuse blood transfusion in certain clinical circumstances but accept in other situations e.g a life threatening situation. Some patients will have an advance directive document stating that they will refuse blood transfusion even if doing so results in fatality. "Jehovah's Witnesses" are the most common and well known group of patients who may refuse blood products. The patients' reasons for refusal are not relevant for clinical decisions and the patient does not need to specify their reasoning.
It is important to decipher exactly what treatment the patient would refuse and which alternatives will be accepted. It is also important to establish under which circumstances if any the patients' decision would change.

2. THE JEHOVAH'S WITNESS POINT OF VIEW

But flesh with the life thereof, which is the blood thereof, shall ye not eat

(Genesis, Ch. 9 v. 4.)

Jehovah's Witnesses are members of the Watch Tower Bible and Tract Society, a religious denomination founded in the United States in 1872. There are 6 million JW worldwide, of whom 145,000 live in the UK. JW do not accept transfusion of blood or its major components. They are prepared to die rather than compromise this refusal, which is based on the belief that to be transfused with blood is equivalent to eating it and therefore prohibited by scriptures (Genesis 9, 4: Leviticus 17, 12: Acts 15, 29). With the exception of blood transfusion JW accept and expect the highest standards of modern medical care and full use of appropriate modern medical technology.

There are strong ethical reasons to accede and adapt to the wishes and beliefs of our patients, as far as consistent with acceptable medical practice, which depends upon informed, freely given, valid consent. The paternalistic assumption that medical priorities outweigh patients' expressed wishes is no longer tenable. To overtly discriminate against JW and others who refuse a blood transfusion (e.g. by denying them needed surgery when it could be safely carried out without transfusion) would clearly be unacceptable.

3. CHANGED CONSEQUENCES FOR JW RECEIVING BLOOD TRANSFUSIONS

Rejection is no longer carried out by JW congregations, but self-inflicted: any JW who 'wilfully and without regret' accepts blood transfusion 'revokes his own membership by his own actions'. This policy shift is clearly a matter for each individual JW rather than doctors: the UK JW Transfusion Committee takes the view that nothing essential has changed, as no JW would wish to dissociate them self.

Doctors, however, should consider the possibility that individual JW patients have interpreted this change as allowing them to accept transfusion under certain circumstances. This possibility could only emerge (and be realized) in absolute confidentiality. JW patients should (unless they decline the offer) at some point be asked about their personal interpretation in a one-to-one consultation.

In British Law, the competent adult patient has an absolute right to refuse medical treatment, or choose an alternative treatment, 'not withstanding that the reasons for making the choice are rational, irrational, unknown or even nonexistent' (Re T, 1992; quoted in Mason & McCall Smith, 1994).

4. THE BASIC LEGAL POSITION IN RELATION TO AN ADULT PATIENT WHO REFUSES BLOOD PRODUCTS

This policy applies to all patients who refuse a blood transfusion.

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical examination, or providing personal care, for a patient. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. A health professional who does not respect this principle may be liable both to legal action by their patient and action by their professional body.

If a competent adult patient refuses the administration of blood products failure to respect that refusal could constitute an assault.

A health professional who does not respect this principle may be liable both to legal action by their patient and action by their professional body.

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Persons who lack capacity

A person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Inability to make decisions
a person is unable to make a decision for himself if he is unable—

(a) To understand the information relevant to the decision,

(b) To retain that information,

(c) To use or weigh that information as part of the process of making the decision, or

(d) To communicate his decision (whether by talking, using sign language or any other means).

(Mental Capacity Act 2005)

Advance Decisions

An advance refusal of treatment, made by a competent adult patient, is just as valid as a contemporaneous one. Such a refusal is known as an Advance Decision and remains valid (until revoked) even if a patient subsequently loses capacity.- this must be in writing and state that 'THIS IS TO APPLY EVEN IF MY LIFE IS AT RISK'
If a patient holds an advance directive it should be highlighted to the multidisciplinary team. The advance directive should be photocopied and filed inside the front of the patients' notes. The alert box located on the front of the notes should be ticked and alert card inside patient notes should be completed. This Alert should also be highlighted in the Nursing handover.

Advance decisions to refuse treatment: general

(1) "Advance decision" means a decision made by a person ("P"), after he has reached the age of 18 and when he/she has capacity to do so, that if—

(**a**) At a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and

(**b**) At that time he lacks capacity to consent to the carrying out or continuation of the treatment,

the specified treatment is not to be carried out or continued.

(2) For the purposes of subsection (1)(a),(above) a decision may be regarded as specifying a treatment or circumstances even though expressed in layman's terms.

(3) P may withdraw or alter an advance decision at any time when he has capacity to do so.

(4) A withdrawal (including a partial withdrawal) need not be in writing.

(5) An alteration of an advance decision need not be in writing (unless section 25(5) applies in relation to the decision resulting from the alteration).

(Mental Capacity Act 2005)

"JW carry on their person an Advance Medical Decision Document to refuse Specified Medical Treatment (Jan 07)/ Release that directs no blood transfusions be given under any circumstances, while releasing medical practitioners/ hospitals of responsibility for any damages that might be caused by their refusal of blood." (Suffolk Inter- Faith Resource 2001)
See example of Jehovah's Witness Advance Directive- Appendix A Page 20-21
An Advance Decision may be revoked at any time while a patient retains capacity to do so.

The following should be considered from a legal perspective:-

- **Competent Adult Patient – No Valid Advance Decision Refusing Blood Products.**

  Patient is free to consent to/refuse treatment and his/her decision must be respected. The explanation given to the patient and his/her response must be fully documented.

- **Competent Adult Patient – Valid Advance Decision Refusing Blood Products**

  A competent adult patient can revoke an Advance Decision at any time whilst he/she retains competence. Accordingly, such a patient should be given the opportunity to consent to/refuse the administration of blood products notwithstanding the existence of a valid Advance Decision.
  The explanation given to the patient and his/her response must be fully documented.
  If the patient does not revoke the Advance Decision, its contents must be respected.

- **Incompetent Adult Patient – Valid Advance Decision Refusing Blood Products Produced**

  Where an incompetent adult patient has previously made an Advance Decision (when competent) refusing the administration of blood products, that refusal should be respected.
  In the event of doubt as to the validity of an Advance Decision or its extent, the Legal Services Department should be contacted urgently. The Legal Services Department has access to 24-hour legal advice.

- **Incompetent Adult Patient – No Valid Advance Decision Refusing Blood Products Produced**

  In such a situation, the Trust is technically entitled to treat the patient in accordance with his/her best interests. However, in all such cases, the lead Clinicians must urgently contact the Trust's Legal Department. Where there appears likely to be any dispute as to that patient's best interests (e.g. patient known to be JW; family object to administration) it may be necessary to make an urgent Application to the Court.
  Where the patient is incompetent, no valid Advance Decision has been produced and there is not sufficient time to obtain legal advice, the Clinician may administer blood products if this is necessary to avoid the patient suffering death or serious harm.

Invoking the assistance of the Court

In relation to incompetent patients and children, the Courts will sometimes make an order stating it is in the patient's best interests to be administered with blood products. Whilst the assistance of the Court is always available in emergency situations, the Court does not make such Orders lightly and, in non-emergency situations, will only do so after careful enquiry and extensive examination of all the evidence. Accordingly, it is vital that Clinicians are quick to identify situations (e.g., where a JW patient is referred for elective surgery) where the Court's assistance may be needed and that Legal Services are contacted immediately.
In this instance please contact the hospital switchboard who can then put you in touch with the Trusts Legal Services Team **24hrs** a day.

Children + Parental Responsibility

Competent children can consent to medical treatment if they understand the implications involved (see below in relation to "**Gillick Competence**" also maybe be referred to as "**Fraser Competence**").

Parental Responsibility ("PR") is an important concept when looking at legal aspects of treating children.

PR is a legal concept that consists of the rights, duties, powers, responsibilities and authority that most parents have in respect of their children. PR is afforded not only to parents, however, not all parents have PR.

Who Possesses PR?

- Both legal parents if married at the time of birth;
- If parents unmarried (child born pre-01-12-2003) Mother will have PR but Father will only have PR if he has entered into a PR Agreement with the Mother or has obtained a PR Order from the Court;
- If Parents unmarried (child born post-01-12-2003) Mother has PR. Father will also have PR if parents have registered or re-registered the birth jointly, or if PR Agreement entered into, or if confirmed by Court Order.
- Any other person (e.g., Local Authority) granted PR by virtue of a Court Order.

A child's legal parents are the child's biological parents, unless the child has been adopted or was born as the result of some method of assisted reproduction (Human Fertilisation and Embryology Act 1990). Where the child has been formally adopted, the adoptive parent(s) is/are the child's legal parent(s) and automatically acquire(s) PR.

If both parents have PR neither loses it if they divorce or if the child is in care or custody. It is lost, however, if the child is adopted.

In the event of doubt about the status of somebody claiming to have PR the Legal Services Department should be contacted.

In the absence of anyone with PR, any person who has care of a child may do "what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare" Children Act 1989 s3(5).

When Will a Child be Competent?

A child under 16 will have "Gillick" competence if he/she has:-

- An understanding of what his/her condition means and what treatment is needed.

- An appreciation of what the proposed treatment involves and what the intended outcomes would be.
- An understanding of the implications of both treatment and non-treatment and the consequences.

It must be remembered that unwillingness to participate in treatment is not the same as incompetence.

As with all capacity assessments the test for "Gillick" competence should be fully documented in a well-reasoned fashion. In the event of difficulty assessing whether or not a child is "Gillick" competent, a second opinion should be sought from a (different) Consultant Child-Psychiatrist.
The following should be considered from a legal perspective:

- **"Gillick Competent" Child – Child consents to administration of blood products despite objections of person with PR**

  In cases where a child is "Gillick" competent, that child can consent to treatment irrespective of views of the person(s) with PR.

- **"Gillick" competent child refuses the administration of blood products but person(s) with PR agree(s) to the administration**

  In these circumstances, the acceptance of the person(s) with PR overrides the child's refusal, and the administration is lawful.

- **"Gillick" competent child refuses the administration of blood products and person(s) with PR echo refusal**

  In such a situation, the lead Clinician should obtain urgent advice from Legal Services as an Application to the Court will in all probability, be necessary.

  Where there is not sufficient time to obtain legal advice, the Clinician may administer blood products if this is necessary to avoid the patient suffering death or severe harm.

- **Non "Gillick" competent child – Person(s) with PR agree to administration of blood products**

  In these circumstances, the administration of blood products will be lawful.

- **Non "Gillick" competent child – person(s) with PR object to administration of blood products**

  In such a situation, the lead Clinician should obtain urgent advice from Legal Services, as an Application to the Court will, in all probability, be necessary.

  WHERE THERE IS NOT SUFFICIENT TIME TO OBTAIN LEGAL ADVICE, THE CLINICIAN MAY ADMINISTER BLOOD PRODUCTS IF THIS IS NECESSARY TO AVOID THE PATIENT SUFFERING DEATH OR SERIOUS HARM.

5. PRACTICAL ALTERNATIVES TO REDUCE OR AVOID BLOOD TRANSFUSION

Blood Products That Are, May Be, or Are Not Acceptable To Jehovah's Witnesses.

The Watch Tower directive that ended 'disfellowship' also stated that although 'primary components' of blood must be refused (red cells, white cells, platelets and plasma) 'when it comes to fractions of any primary components, each Christian…must conscientiously decide for himself' (Muramoto, 2001).

Every JW patient should be asked to decide which blood products are acceptable to him or her during the consent process (see below). Individual JW patients may have made decisions about the acceptability of 'fractions of…primary components' that may differ from the current mainstream view summarised in Table 1.

Crystalloids and synthetic colloids:
JW patients accept the above including dextrans, hydroxyethylstarch (Hetastarch) and gelatins (Volpex) for circulatory support. Some JW patients requiring plasma exchange refuse human albumin solution.

All available blood products should be discussed with all patients. Interpretations of a 'fraction of the primary component' might, hypothetically include leucocyte-depleted red cells and platelets, haemoglobin solutions and solvent detergent treated fresh-frozen plasma (FFP).

Recombinant blood products:

The above are acceptable to many JW patients. Erythropoietin (Epo) is acceptable to aid correction of anaemia and Granulocyte colony-stimulating factor (G-CSF) is also widely accepted by JW patients in the treatment of neutropenia. Recombinant haemopoietic growth factors for platelets are not currently available for clinical use in this country.

Recombinant activated Factor VII (rFVIIa, NovoSeven) is licensed for the treatment of bleeding episodes in haemophilia patients with inhibitors. It has also been used successfully to treat bleeding in platelet function disorders. In platelet disorders rFVIIa may activate FIX and FX on platelet surfaces to prevent bleeding, effective haemostatic responses to rFVIIa in severe thrombocytopenia without concurrent platelet transfusion seems very unlikely.

In the context of inherited bleeding disorders, the availability of recombinant Factor VIII and Factor IX therapeutic products (particularly second generation products containing no albumin in the final vial) allows therapy of haemophilia A and B. Recombinant FVIIa is used in patients with inhibitors. Desmopressin (DDAVP), a synthetic product, can be used in mild haemophilia A and type 1 Willebrand Disease (VWD). For rare haemorrhagic disorders that currently require plasma-derived therapeutic product (e.g. type 2 or 3 VWD), some patients and their families will accept purified fractionation products as permissible after discussion.

Platelet substitutes:

There has been considerable interest in the development of platelet substitutes, but to date, all involved using either modified platelets (lyophilised platelets), infusible platelets membranes, fibrinogen-coated albumin microspheres or semiartificial platelets substitutes using autologous erythrocytes or liposomes (as carriers or molecules which regulate platelet function). None are currently available for clinical use.

Red cell substitutes:

The above **are** currently undergoing Phase III studies. Haemoglobin solutions from human red cells, bovine red cells or recombinant haemoglobin may eventually be acceptable alternatives to blood transfusion for JW in some situations: they are not yet available for clinical use.

Table 1: Acceptability of blood products to Jehovah's Witnesses.

NOT ACCEPTABLE ('PRIMARY COMPONENTS OF BLOOD')	IS ACCEPTABLE	MAY OR MAY NOT BE ACCEPTABLE ('MATTERS OF CONSCIENCE')
Whole blood (an autologous predonation)	Crystalloids	Albumin
Red cells	Synthetic colloids, e.g.dextrans	Immunoglobulin
Platelets	Hydroxyethyl starch (Hexastarch)	Vaccines
White cells	Gelatines (Haemacel, Gelofusine)	Coagulation factors (non-recombinant)
Plasma (FFP)	Recombinant products e.g. G-CSF,† Epo, Coagulation Factors	Haemodilution
		Intraoperative cell salvage
		Organ transplantation

6. THERAPEUTIC MANOEUVRES TO REDUCE OPERATIVE USE OF ALLOGENEIC BLOOD

Pre-operative clinical assessment:

The patient should be assessed preoperatively and should be asked about a history of bleeding episodes, anaemia, hypertension and evidence for chronic inflammation, infection or malignancy sought, as these may predict a poor response to Epo. A drug history should be taken to identify any that increase bleeding risk (e.g. aspirin, non-steroid anti-inflammatory drugs (NSAID's), coumarins). A clinical examination should also include measurement of blood pressure. If there is anaemia this should be investigated and treated. The following blood tests are indicated: full blood count, serum ferritin, B_{12} and folate, urea, creatinine and electrolytes and a coagulation screen.**Pre-operative erythropoietin administration.**

Erythropoietin (EPO) can be given preoperatively to increase red cell production, which may be particularly useful in the context of intraoperative haemodilution (below). In the absence of renal failure, high doses of Epo are needed to elevate Hb concentration. Epo should be given subcutaneously, with concurrent iron supplementation. Oral iron is standard (e.g. ferrous sulphate 200 mg (65mg elemental iron) t.d.s). The use of intravenous iron is not proven in this situation, although the advantage in efficacy emerged in one study. It is important to try to guarantee the date of surgery (even during winter in the NHS). If surgery is cancelled, preoperative treatment with Epo will need to be continued until the new date to avoid a fall in Hb level preoperatively. A consultant Haematologist should be contacted for advice re dosage and length of time for administration of erythropoietin.

A critical approach to preoperative Hb concentration

An alternative to Epo is to accept lower Hb threshold prior to surgery as well as in critically ill patients, as studies have shown no benefit in actively maintaining the Hb above 10 g/dl compared with a lower level. There has been much debate on how far the Hb concentration can be safely allowed to fall to before blood transfusion is required, and studies in JW patients have provided useful information in this situation. A review of published literature on the tolerability of a Hb level of <8 g/dl among 61 JW patients treated for various medical and surgical conditions [Vile & Weiskopf, 1993] found that all patients whose deaths were attributed to anaemia died with Hb levels of <5 g/dl. In Europe and North America there is now general acceptance of a threshold for Hb of around 8 g/dl in surgical and critically ill patients with no risk factor for ischaemia and a threshold of 10 g/dl for patients with a history of pulmonary disease, cardiac or cerebral ischaemia [Goodnough et al, 2001].

Acute normovolaemic haemodilution

This technique involves removing whole blood from the patient in theatre immediately prior to surgery and replacing it with a crystalloid or colloid. The blood is collected into blood bags containing an anticoagulant which remains connected to the patient's venous access line. The resulting haemodilution means that red cell loss at the time of surgery is reduced because the patient's haematocrit will be lower at that time. The collected blood is ready to be re-infused immediately after surgery or earlier if indicated. In a 70kg adult male with a haematocrit of 45%, 4 units of blood can be removed before the haematocrit falls to 30%. Haematocrits of 20-25% are quite safe because normovolaemia is maintained at all times with the simultaneous infusion of crystalloids or colloids. The sudden drop in haematocrit

and consequent fall in arterial oxygen content is well tolerated and accompanied by an increase in cardiac output and reduction in blood viscosity (Goodnough et al. 1999b). Haemodilution may be contraindicated in patients with impaired myocardial function due to coronary artery disease or patients on β-blockers or calcium channel blockers, and in patients with severe obstructive or restrictive lung disease. Goodnough et.al. (1998) have reviewed the importance of acute normovolaemic haemodilution for bloodless surgery, particularly if used with preoperative Epo therapy. This technique may be acceptable to many JWs, but requires the presence of an anaesthetist with relevant expertise.

Intra-operative cell salvage

Intra-operative cell salvage uses 'cell saver' devices, which collect and process blood shed in the operative field. The collected blood is citrated, filtered, washed with saline, concentrated and returned to the patient. Cell savers can provide a large amount of blood immediately in the event of rapid blood loss, and if used regularly can be cost effective. Cell saver systems are increasingly used in operations where transfusion typically exceeds one unit of blood, or the anticipated collection of shed blood is more than one litre. It is of proven benefit in cardiothoracic, vascular, orthopaedic and liver surgery and open prostatectomy. Contamination by bacteria or malignant cells is a relative contraindication: addition of antibiotics to the anticoagulant and leucocyte-depleting filters may be appropriate. Intraoperative cell salvage is a safe cost-effective procedure that may reduce the need for allogeneic blood transfusion (Royal College of Physicians of Edinburgh, 1996). Like normovolaemic haemodilution, intraoperative cell salvage is acceptable to most JWs because the blood has remained in continuity with the body, but this must be discussed with the patient beforehand. Post-operative salvage of blood, involving collection of blood from surgical drains followed by re-infusion may be acceptable to JWs.

Other practical Issues

Minimal access surgery with devices such as ultrasonic, laser, microwave or argon beam scalpels improve surgical haemostasis, if available and appropriate. Systemic pre and peri-operative administration of antifibrinolytic agents (tranexemic acid) or desmopressin (DDAVP) should be freely considered. The use of topical haemostatic agents such as fibrin glue should be discussed with the JW patient as some are plasma fractional products. Postoperative folic acid should be considered when reduced oral intake is anticipated or intravenous folinic acid if oral nutrition is not possible. Iron supplementation should be given if there is postoperative bleeding or if the patient is being maintained on Epo. If the patient is unable to take oral iron then intravenous iron sucrose may be necessary, especially if Epo is continued. The frequency and amount of blood sampling should be kept to a minimum.

7. GUIDELINES FOR LIFE THREATENING BLEEDING IN AN UNCONSCIOUS ADULT JEHOVAH'S WITNESS PATIENT (St Georges Hospital, London, 2002)

A) Any documentary evidence, for example an Advanced Decision (living will), stating that the patient will not accept blood transfusion in the event of a life-threatening bleeding, should be requested from the relatives or associates of the patient and examined, if time permits.

B) A copy should be put in the case notes and its contents respected.

C) The doctor (who should be of consultant status), if time permits, should discuss with the patient's relatives the implications of withholding blood. The view of the patients' relatives should be taken into account in deciding the patients best interests

D) The doctor should act in the best interest of the patient and will be expected to perform to the best of his/her ability, which may involve giving blood if steps a, b and c are impossible.

E) A clear and signed entry of the steps taken must be written in the patient's case notes.

8. MANAGEMENT OF AN ADULT PATIENT REQUIRING ELECTIVE SURGERY

The concept of 'bloodless surgery' is developing rapidly, and avoiding allogeneic blood transfusion in many types of surgery is becoming an increasingly attractive option. This has led to evaluation and the use of techniques such as acute normovolaemic haemodilution and intraoperative cell salvage, as well as optimisation of preoperative Epo schedules. Nonetheless, the core element of consent in elective surgery is the same as in an emergency: what happens in the case of unexpected overwhelming blood loss?

Elective surgery in JW patients requires careful advanced planning. It is vital that the patient actively confirms their JW status to the surgical team, as soon as the possibility of surgery is mooted. No surgical procedure must be planned, let alone listed, without a preliminary structured discussion between the surgeon anaesthetist and the patient. The aim of this discussion is to achieve the necessary degree of certainty about the limits and extent of the patient's consent.

- If the patient has made an Advance Decision it should be read and a copy placed in the notes.

The Association of Anaesthetists Great Britain & Ireland (AAGBI) guidelines (1999) state that "it is very important to take the opportunity to see the patient without relatives or members of the local community", but the patient may insist on their presence (particularly that of a spouse) throughout the discussion. Accordingly, the patient should be offered single consultation, but, if it is declined, the only logical response is to accept their desire to be accompanied, as well as their written or verbal consent, as a true indication of their will.

9. HOSPITAL LIASION COMMITTEE NETWORK FOR JEHOVAH'S WITNESSESS

The above form an international network of experienced ministers who are trained to liaise with medical personnel at the patient's request. They support the Witness patient and the treating doctor by arranging contact with doctors and medical teams experienced in bloodless medicine and surgery techniques.

Local contacts: - Birmingham Hospital Liaison Committee (24 hour contact)

Mr Neil Farmer	01384 565 308 or mobile 07563785203.
Mr Gerald Taylor	01386 45639 or mobile 07767 640447.
Roy Jackson	0121 605 6613 or mobile 07889 648508
Tom Felton	0121 354 3300 or mobile 07973 669503
Christopher Porter	02476 317526 or mobile 07970 072780
Paul Millard	0121 350 9108 or mobile 07769 667723
Steven Meah	0121 2409159 or mobile 07958 546883
Raphael Waite	0121 605 0567 or mobile 07811 270511

10. MONITORING

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Page 6	The advance directive should be photocopied and filed inside the front of the patients' notes.	Compliance with the guideline will be monitored by auditing 10 sets of case notes	Once a year	Transfusion Practitioner	Trust Transfusion committee	Once a year

1. REFERENCES

Association of Anaesthetists of Great Britain and Ireland (1999). *Management of Anaesthesia for Jehovah's Witnesses*

Department of Health (2001) Reference Guide to Consent for Examination or Treatment

Goodnough et. al. (1998) *British Committee for Standards in Haematology*

Marsh JC and Bevan DH (2002) *Haematological Care of the Jehovah's Witness Patient.* British Journal of Haematology, 119, 25-37

Muramoto, O (2001). *Bioethical Aspects of the Recent Changes in the Policy of Refusal of Blood by Jehovah's Witnesses.* British Medical Journal, 322, 37-39

Office of Public Sector Information – Mental Capacity Act 2005 (Implemented October 2007)

Re T. (1992). *Adult Refusal of Medical Treatment.* 4 All ER 649, 9 BMLR 46, CA

Ridley D. (1999). *Jehovah's witnesses Refusal of Blood: Obedience to Scripture and Religious Conscience.* Journal of Medical Ethics, 25, 469-472

Royal College of Surgeons of England (1996). *Code of Practice for the Surgical Management of Jehovah's Witnesses*

Suffolk Inter- Faith Resource (2001) an Inter- Faith Handbook for Community Use

The Advanced Decision Document to refuse specified medical treatment Jehovah's Witness Society December 2005

Watchtower Bible and Tract Society (1981). *Disfellowship – How to view it.* Watchtower, September 15, 20 – 26.

Watchtower Bible and Tract Society (2000). *Questions from Readers.* Watchtower, June 15, 29 – 31.

CONTRIBUTION LIST

Circulated to the following CD's/Heads of dept for comments from their directorates / departments

Name	Directorate / Department
Dr. T. Skibbe	Consultant Haematologist- Chair of tru transfusion committee
Dr Andrew Short	Clinical Director Paediatrics
Dr David Aldulaimi	Clinical Director Medicine
Rachel Carter	Maternity matron
Dr S Hellier	Clinical Director Resp/Gastro
Dr S Graystone	Associate Medical Director patient safety
Dr J Berlet	Clinical Director Anaesthetics
Dr Santi Vathenen	Divisional Medical Director Emergency Care
Mr A Thomson	Clinical Director Obs and Gynae
Ms K Kokoska	Risk manager Midwifery
Dr Simon Hellier	Clinical Director medicine
Steve Houston	Clinical Governance
Ms Rabia Imtiaz	Consultant Obstetrician
Dr Baylon Kamalarajan	Consultant Paediatrics
Mr Stephen Lake	Clinical Director Surgery WRH
Dr Shiju Mathew	Consultant anaethetist
Carla Newland-Baker	Transfusion laboratory manager
Mr Nick Purser	Clinical Director Surgery Alex
Dr Alagirisamy Raajkumar	Consultant Anaethetist
Alison Talbot	Midwifery Matron
Dr Lakshmi Thirumalaikumar	Consultant Obstetrics
Karen Young	Matron Pershore Community hospital

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group	
Nick Hubbard	Medicines Safety Committee	
Penny Venables	Clinical Management Committee	
Dr Thomas Skibbe	Trust Transfusion Committee	20th December 2012

2. ADVANCED DECISION DOCUMENTATION

Advance Decision to Refuse Specified Medical Treatment

1. I, ______________________________ (print or type full name), born ______________________ (date) complete this document to set forth my treatment instructions in case of my incapacity. **The refusal of specified treatment(s) contained herein continues to apply to that/those treatment(s) even if those medically responsible for my welfare and/or any other persons believe that my life is at risk.**

2. I am one of Jehovah's Witnesses with firm religious convictions. With full realization of the implications of this position I direct that **NO TRANSFUSIONS OF BLOOD or primary blood components (red cells, white cells, plasma or platelets)** be administered to me in any circumstances. I also refuse to predonate my blood for later infusion.

3. **Regarding minor fractions of blood** (for example: albumin, coagulation factors, immunoglobulins): [Initial **one** of the three choices below.]

   (a) ______ I refuse all

   (b) ______ I accept all

   (c) ______ I want to qualify either (3a) or (3b) above and my treatment choices are as follows:

   ____

   ____

4. **Regarding autologous procedures** (involving my own blood, for example: haemodilution, heart bypass, dialysis, intraoperative and postoperative blood salvage):
   [Initial **one** of the three choices below.]

   (a) ______ I refuse all such procedures or therapies

   (b) ______ I am prepared to accept any such procedure

   (c) ______ I want to qualify either (4a) or (4b) above and my treatment choices are as follows:

   ____

   ____

   I am prepared to accept diagnostic procedures, such as blood samples for testing.

5. **Regarding other welfare instructions** (such as current medications, allergies, and medical problems):

   ____

   ____

   ____

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6. I consent to my relevant medical records and the details of my condition being shared with the Emergency Contact below and/or with member(s) of the Hospital Liaison Committee for Jehovah's Witnesses.

7. ______________________ Signature ______________________ Date

______________________ Address

8. **STATEMENT OF WITNESSES:** The person who signed this document did so in my presence. He or she appears to be of sound mind and free from duress, fraud, or undue influence. I am 18 years of age or older.

Signature of witness	Signature of witness
Name Occupation	Name Occupation
Address	Address
Telephone Mobile	Telephone Mobile

9. **EMERGENCY CONTACT:**

______________________ Name

______________________ Address

______________________ Telephone Mobile

10. **GENERAL PRACTITIONER CONTACT DETAILS:** A copy of this document is lodged with the Registered General Medical Practitioner whose details appear below.

______________________ Name

______________________ Address

______________________ Telephone Number(s)

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Advance Decision to Refuse Specified Medical Treatment
(signed document inside)
NO BLOOD