



CLINICAL PRACTICE GUIDELINE

Refusal of Blood Components and / or Products; management of

This document should be read in conjunction with the [Disclaimer](#)

Contents

Aim	2
Background.....	2
Key Points.....	2
Antenatal Care	3
Intrapartum Care.....	4
Caesarean Birth	5
Postpartum Haemorrhage.....	5
References	6

Aim

To identify and initiate a management plan in the antenatal period for women who decline the use of blood components or blood products as part of their treatment at KEMH.

Background

In some circumstances, a competent adult may refuse transfusion of blood or its major components, or indeed fractionated blood products. This refusal may be based on religious or personal beliefs. The management of such women continues to present a challenge within obstetric practice, due to the potential for catastrophic haemorrhage. This is particularly so in obstetric women whose mortality and morbidity is higher than the general population^{1,2}. It is important that an individualised plan of care is developed which identifies the components, products and the alternatives the woman will accept in the event of haemorrhage, well in advance of birth. Furthermore it is essential that anaemia is prevented in these women, as the presence of anaemia amplifies the impact of blood loss.

The majority of fully baptised pregnant Jehovah's Witnesses in Australia will:

- be well versed with the issues
- have high expectations re standards of care
- carry a completed Advanced Health Directive which identifies their individual treatment decisions surrounding the use of blood components, products and the acceptable alternatives to transfusion

The decision to accept or decline a specific treatment (including blood components and its alternatives), remains the individual choice of a competent adult. Not all women adhere to the same beliefs, and healthcare professionals should not make assumptions on what the woman may accept, must respect the wishes of the woman and bear in mind that she has the right to change her mind at any time^{4,5}.

Key Points

1. All women should be counselled to ascertain the individual components, products and treatments which are acceptable or not acceptable. The discussion should be recorded clearly in the medical notes. A "Checklist for discussion for patients declining blood / blood product support" (MR 295.95) has been designed to support this process and should be retained in the medical records if used
2. All such women shall have a plan of care established which identifies what is acceptable in the event of haemorrhage^{5,6}.
3. A copy of the woman's Advance Health Directive produced by the patient (including the acceptance of death before receiving blood components), must form part of the discussion and should be secured in her medical notes (Non baptised Jehovah's Witnesses may not have one).
4. All women should be counselled about their increased risk of maternal mortality due to obstetric haemorrhage.

5. All women should be advised that hysterectomy may be required to control bleeding, but that the limitations related to inability to transfuse, places her at a significant risk of death / disability if she has a major haemorrhage.
6. Effective treatment of anaemia in the antenatal period is essential to optimise good fetal and maternal outcomes, and ameliorate as far as possible, the consequences of haemorrhage, should it occur^{5,6}.
7. Management differs from that of the routine patient because haemostasis must be obtained as rapidly as possible, given that other avenues of treatment are limited. The threshold for intervention may differ to that of other patients..
8. Active management of the third stage of labour should be strongly advocated, discussed and documented well in advance.
9. Ultimately the woman's decision is final, and to provide treatment directly against her expressed wish would be considered to be assault. In the severely ill, incompetent patient this still stands if her wishes were made known to the treating team prior to her becoming incompetent.
10. Where the woman has not been seen antenatally and there is no Advance Health Directive, or common law directive that is known immediately available and applicable in the circumstances, the Medical Officer may give life saving blood transfusion even in the event the relatives indicate the woman is a Jehovah's Witness.

Antenatal Care

Women should be managed by a multidisciplinary team including a member of staff who is familiar with the available alternatives to transfusion, and includes:

- Obstetrician
 - Anaesthetist
 - Haematologist
 - Midwife
1. At initial visit arrange for the woman to have blood tests for:
 - Full blood picture
 - Iron studies
 - B12
 - Folate studies
 - Urea and electrolyte
 - Coagulation screen, if clinically indicated
 - Blood group and antibody screen
 - Consider obtaining Vitamin D level (if at high risk of Vitamin D deficiency)
 2. For women booked at KEMH arrange a prompt referral to the CNC Patient Blood Management to discuss the available alternatives to transfusion.
 3. Arrange prompt referrals to other specialities if required i.e.
 - Consultant Anaesthetist – if caesarean section planned
 - Consultant Haematologist – if coagulation disorders are identified, has a history of haemoglobinopathy or presents with severe anaemia
 - Physician – in the event of pre-existing medical disease

- MFM – in the event of the woman/fetus requiring highly specialised obstetric care
4. Haematological parameters should be optimised during pregnancy by:
 - Treatment of any haematinic deficiency (iron,folate,B12) including Vitamin D deficiency
 - Avoidance of antiplatelet drugs such as aspirin prior to birth where possible. However, in patients with complex medical disease, specific advice regarding the discontinuance of therapy should be discussed with the Obstetric Medical team.
 - Repeat FBP and iron studies may be required more frequently than is usual, depending on the booking Hb, and must be obtained and followed up at 28 and 36 weeks.
 5. A full and frank discussion should take place which identifies and documents the acceptable treatments and associated risks.
 6. The woman must complete a “Refusal to Permit Blood Transfusion” (MR 295.99) form with a Medical Officer which is filed in the woman’s medical record.
 7. Haematological protocols for the treatment of severe anaemia may be appropriate.
 8. Encourage the woman to have a diet containing high levels of iron, folates and B₁₂.⁶
 9. Discuss management of the third stage and provide the leaflet ‘Active management of the third stage of labour’ available in the Antenatal Clinic.
 10. A Non-Standard Management Plan (sticker) is to be signed if the woman elects to have a physiological 3rd stage.

Intrapartum Care

1. Inform the Consultant Obstetrician and Anaesthetist when a woman who refuses blood or blood components is admitted to the Labour and Birth Suite.
2. Check that the “Refusal to Permit Blood Transfusion” form (MR295.99) is in the woman’s medical record and that it has been signed.
3. Consider intravenous access with a 16 gauge cannula, taking into account other risk factors.
4. Ongoing risk assessment for postpartum haemorrhage.
5. The third stage must be actively managed with oxytocic drugs, early cord clamping and controlled cord traction.
6. Any abnormal bleeding during labour must be reported to a Consultant Obstetrician.
7. If the woman has any of the risk factors below, an intravenous infusion of oxytocin should be considered after the birth of the baby
 - Previous history of bleeding, post or antepartum haemorrhage.
 - Prolonged labour (especially when augmented with oxytocin).
 - Increased maternal age > 40 years and / or maternal obesity (BMI > 40).

- Multiple pregnancy and / or ≥ 4 previous births.
- Difficult operative birth.
- Abnormal placentation / retained products.
- Fetal macrosomia > 4kg.
- Polyhydramnios
- Uterine Fibroids
- Uncorrected anaemia
- Gestational diabetes

Caesarean Birth

- A senior Anaesthetist and the Team Obstetrician must be notified in advance of a planned caesarean birth where the patient is declining a transfusion of blood or blood products.
- If a caesarean birth is indicated it must be supervised by a Senior Registrar, and with the knowledge of a Consultant Obstetrician and Anaesthetist.

Postpartum Haemorrhage

- Contact the Obstetric Senior Registrar, Anaesthetic staff, and Midwifery Co-ordinator immediately. They should attend promptly. Notify the Consultant Obstetrician. Consider obtaining specialist advice from the Consultant Haematologist.
- Management as per Clinical guideline Primary Postpartum haemorrhage and Transfusion Medicine Protocols 1.6- Refusal of Blood Products
- Rapid and definitive management of obstetric bleeding should be undertaken according to the cause of the blood loss (oxytocics and other uterotonic agents, EUA, intrauterine haemostatic balloon insertion, embolisation, laparotomy, B-Lynch suture, uterine artery ligation, internal iliac artery ligation, hysterectomy).
- In the presence of haemorrhage, the decision to proceed to laparotomy should be taken earlier than is usual.
- Surgical decisions at laparotomy need to be taken rapidly, before the onset of Disseminated Intravascular Coagulation if possible.
- The woman and her family must be kept fully informed of events in a non-judgmental way. If standard treatment is not controlling the bleeding she must be advised that blood or blood component transfusion is strongly recommended, but this recommendation must not be forced. Any woman is entitled to change her mind about a previously agreed treatment plan.
- Clinicians must be satisfied that the woman is not being subjected to pressure from others. No other person is legally able to consent to or refuse treatment on the woman's behalf.
- Discharge advice should include prompt reporting of any concerns regarding bleeding during the puerperium⁶.

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