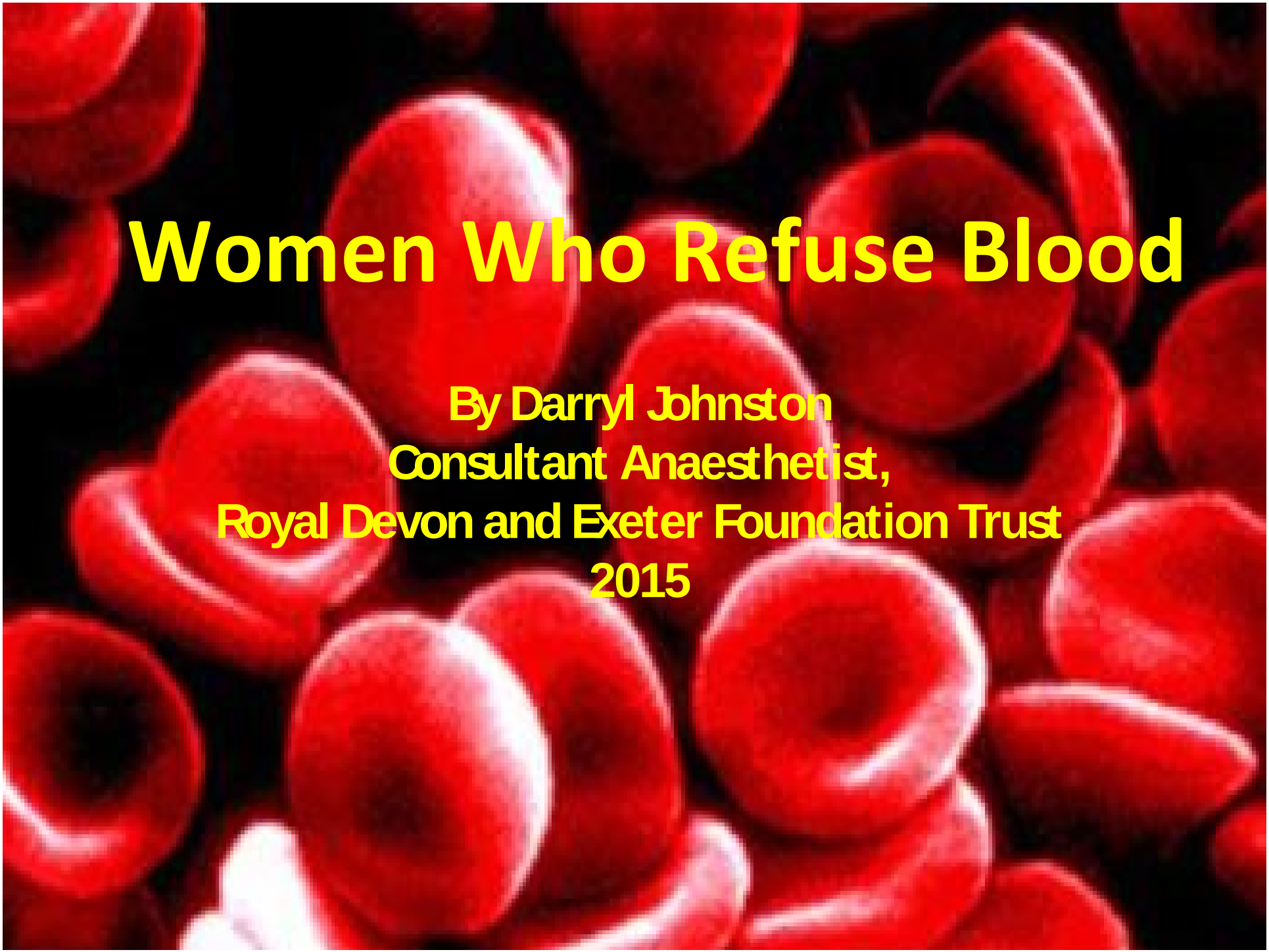

Women Who Refuse Blood

By Darryl Johnston
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2015

In British law the fully informed competent adult patient has an absolute right to accept or refuse medical treatment.

Therefore, to administer blood in the face of an informed refusal by the patient may invoke criminal and/or civil proceedings

Jehovah's Witnesses decisions are not related to the perceived risk of transfusion but are a deeply held core belief based on biblical scriptures.

Furthermore they regard a non-consensual transfusion as a gross physical violation

Jehovah's Witnesses still expect the highest standard of modern medical care.

They take full legal responsibility for any adverse consequences directly arising from their decision to refuse certain blood products.

Management of Women Who Refuse Blood

- You have the right to refuse to care for Jehovah's Witnesses in the elective situation
- In an emergency the you are obliged to provide care and must respect the patient's wishes
- They have the right to change their mind at any time, this must be clearly documented.
- To administer blood in the face of an informed refusal by the patient may invoke criminal and/or civil proceedings

ADVANCE MEDICAL DIRECTIVE

1. I, _____ , make this advance directive as a formal statement of my wishes. These instructions reflect my resolute and informed decision.

2. I direct that ***no blood transfusions*** (whole blood, red cells, white cells, platelets, or blood plasma) be given to me under any circumstances, even if deemed necessary to preserve my life or health. I accept *nonblood* expanders, *nonblood* drugs that control hemorrhage and stimulate the production of blood cells, and other *nonblood* management.

3. This directive is an exercise of my right to decide medical treatment in accord with my deeply held values and convictions. I am one of Jehovah's Witnesses, and I make this directive out of obedience to commands in the Bible, such as: "Keep abstaining . . . from blood."—Acts 15:28, 29.

4. **Regarding minor fractions of blood, my instructions are:** [initial those that apply]

   (a) _____ I REFUSE ALL (b) _____ I REFUSE ALL EXCEPT:

   _____

   _____

   (c) _____ I may be willing to accept some minor blood fractions, but the details will have to be discussed with me if I am conscious.

5. **Regarding medical procedures involving the use of my own blood:** I *refuse* to predonate and store my blood for later infusion. I *accept* diagnostic procedures such as blood testing.

   My other instructions regarding use of my blood are: [initial those that apply]

   (a) _____ I REFUSE ALL (b) _____ I REFUSE ALL EXCEPT:

   _____

   (c) _____ I may be willing to accept certain medical procedures involving my blood, but the details will have to be discussed with me if I am conscious.

6. **Additional Instructions:** [this may be left blank]

   _____

   _____

   _____

md-E 1/07 Printed in Canada

Requirements of an Advanced Decision

- Must be in writing
- Must be signed by the individual
- Must be witnessed
- Must contain a statement that it is to apply even if the person's life is at risk

They have the right to change their mind at any time, this must be clearly documented.

Women needing emergency treatment and unable to consent: advanced decision…

- **Available**
- Consult document for guidance and respect its contents
- Ensure there is no evidence that the patient has altered their view.

- **Not available but obtainable**
- Try to avoid blood until available
- In life threatening situations act in the 'best interests' of the patient

- **Not Available**
- Act in the 'best interest' of patient.
- If time permits get a second consultant
- Keep family informed
- Under UK law competent adult is the only person able to refuse treatment.
- Lasting Power of Attorney exception.

Children of Jehovah's Witnesses

Young people aged 16 and 17

- Presumed to have the competence to give consent.
- Their refusal to consent can be overridden by a person with parental responsibility or by a court
- The doctor only needs the consent of one person with parental responsibility.

Children under 16

- May have sufficient understanding to have the capacity to consent.
- Gillick competence
- They can't refuse treatment
- If both they and parents refuse this could be over-ruled by a court.
- Apply for a legal "Specific Issue Order" via the High Court.

Specific Issue Order

- Two Consultants make signed entry in the clinical record.
- The following should be addressed:
  - Non-blood options been fully explored
  - Is another Hospital willing to treat without blood?
  - Is there a consensus that a true emergency exists?
  - Has the hospital liaison committee been approached for assistance?
- Statement faxed to the court proving the child's need for treatment is so overwhelming that the parents' wishes must be overridden.

Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

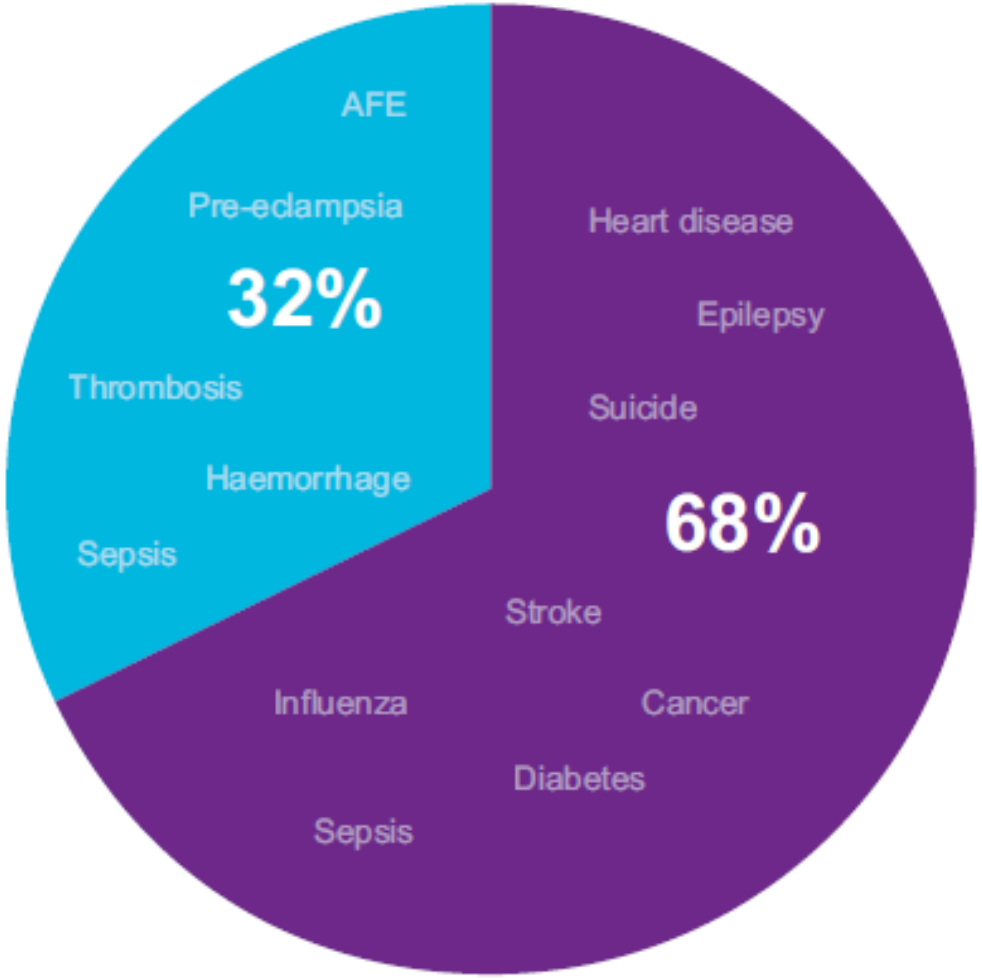
Saving Lives, Improving Mothers' Care

Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012

December 2014

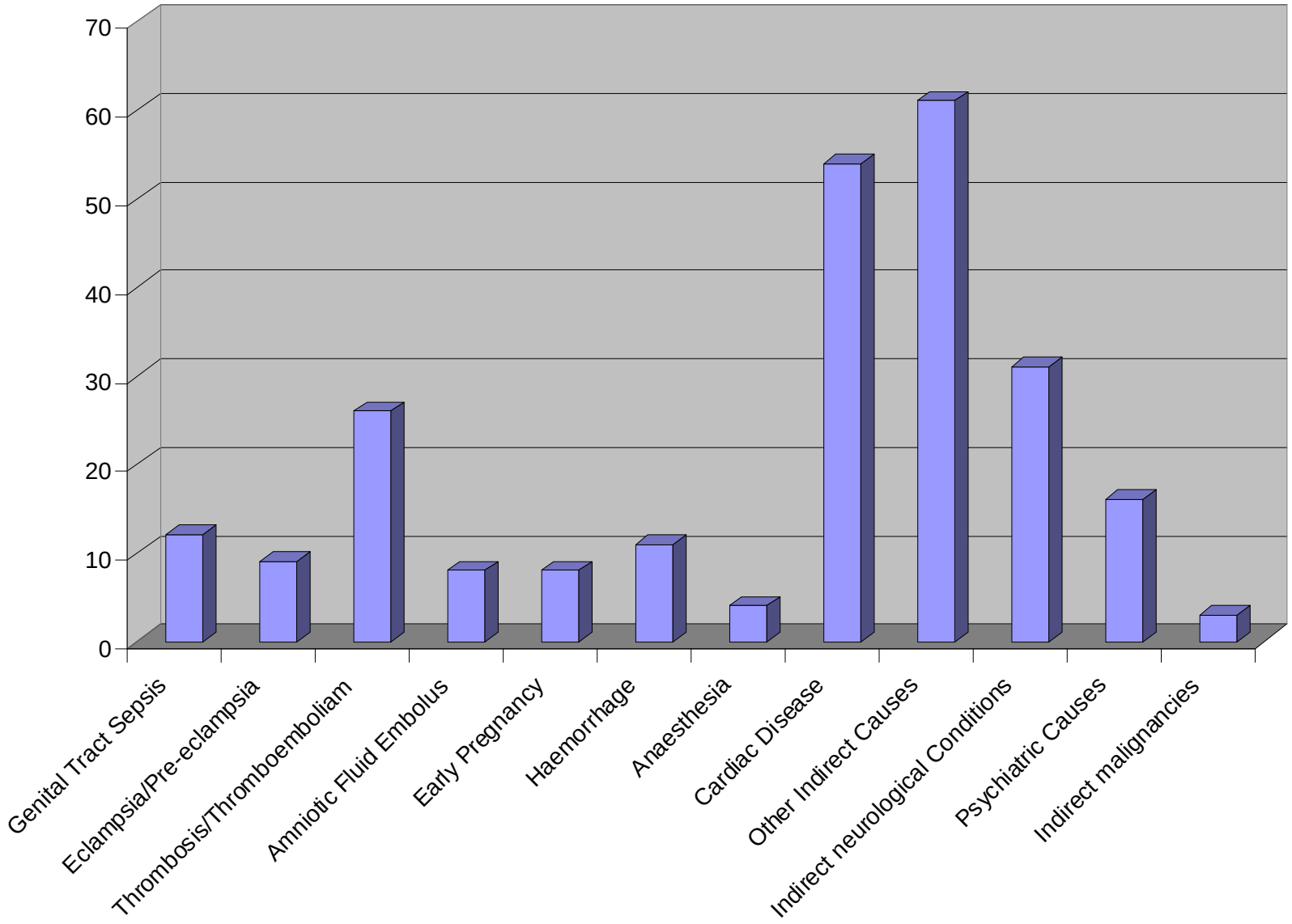
Maternal deaths have decreased

from **11** 2006-08 to **10** 2010-12 per 100,000 women giving birth



Reduction in mortality statistically significant but ***predominantly due to reduction in direct deaths*.**

Maternal Mortality Rates 2010-12



Obstetric Haemorrhage

- 17 deaths
- 10% direct maternal deaths
- PPH (>500ml) affected 13% maternities
- Incidence increasing, doubled from 2004/5 7%

Prevention of PPH: WHO Recomendations

- Active management of 3rd stage of labour with uterotonics
- Skilled midwife
- Tranexamic acid
- Uterine massage

DEFINITION:

Minor: 500-1000ml **Moderate: 1000-2000ml** **Severe: >2000ml**

BLOOD LOSS IS FREQUENTLY UNDERESTIMATED.

INITIAL MANAGEMENT:

➢Call for help. Switchboard **2222** " Major obstetric haemorrhage": Summon: Obstetrician, Anaesthetist, ODA, Midwives, Theatre staff
➢**A**irway **B**reathing &**C**irculation
➢High flow oxygen via a facemask
➢Head down tilt, Left lateral if APH
➢IV access: 2 x 14 gauge (orange) cannulae
➢**Request cell salvage**
➢Give fluids via fluid warmer or Level 1 infuser
➢O-negative blood, if bleeding is uncontrolled
➢Inform lab, order blood products: **2466** (blood bank) or Bleep **227**

DIAGNOSIS:

Ante partum haemorrhage (APH)
➢Placenta Praevia & Placental Abruption: If severe - deliver baby ASAP.
Post partum haemorrhage (PPH) (> 500ml blood loss post delivery):
➢**Tone**: Atonic Uterus (70%)
➢**Tissue**: Retained Products (10%)
➢**Trauma:** Genital Trauma (20%)
➢**Thrombin**: DIC (1%)

SPECIFIC MANAGEMENT:

Specific management of PPH:

Pharmacological:
➢Syntocinon:
➢Ergometrine: **Caution in PET**
➢Syntocinon:
➢Carboprost **Caution in asthmatics**
➢Misoprostol:
➢Uterine massage if atony
➢Bimanual uterine compression
➢Ballon tamponade (eg Rusch ballon)
➢B-Lynch suture
➢Ligation of uterine/ internal iliac arteries
➢Hysterectomy
Radiological:
➢Contact radiology consultant via switch: Embolization / arterial balloon occlusion

Blood Loss and Coagulation Management:

➢Identify member of team to coordinate sample delivery and blood product collection
➢Contact consultant haematologist via switch for advice
➢Give packed red blood cells (RBC)
➢1 unit FFP for each further unit blood
➢If INR >1.5 give FFP
➢Platelets if platelets $<50x10^9$
➢Cryoprecipitate 1 unit/5kg, if Fibrinogen < 1g/L
➢If DIC suspected transfuse platelets and cryoprecipitate earlier
➢Consider Recombinant Factor VIIa 90µg/kg and/or Octaplex. D/W haematologist first

Anaesthetic considerations:

➢Call consultant anaesthetist
➢Liaise early with ITU: **2424.** Bleep **484**
➢Avoid hypothermia:
➢Ensure swabs are weighed to aid accurate estimation of blood loss
➢Monitor urine output and temperature
➢Consider arterial line early
➢Take regular blood samples for FBC, coagulation, ABG and Hemocue
➢If surgery is required, avoid regional anaesthesia if cardiovascular instability: GA and RSI
➢Consider CVP line and oesophageal doppler
➢Vasopressors may be required despite fluid resuscitation. Use phenylephrine in first instance; Norad (4mg in 40 ml 5%

Health Service Circular

"Better Blood Transfusion Safe and Appropriate Use of Blood"

November 2007,

detailing the actions required of NHS Trusts, NHS Blood & Transplant (NHSBT) and clinicians to improve transfusion practice.

Risks of blood transfusion

1 : 1300	Wrong blood in tube
1 : 7000	Acute severe transfusion reaction
1 : 13000	Blood transfused to the wrong patient
1 : 1.3 million	Hepatitis B
1 : 6.5 million	HIV/AIDS
1 : 28 million	Hepatitis C
unknown	CJD

3 Pillars of Blood Management

- ***Pre Operative***
- Hb optimisation oral or IV iron, b12 or folate
- Stop drugs that increase bleeding, aspirin, warfarin, novel anticoagulants
- Minimise iatrogenic blood loss

- ***Peri Operative***
- Optimal anaesthetic
- Blood sparing surgical techniques
- Meticulous haemostasis
- Cell salvage
- Haemostatic agents eg tranexamic acid and sealants

- ***Post Operative***
- Monitor for post operative bleeding
- Normothermia
- Treat infections promptly
- Minimise iatrogenic blood loss
- Prophylaxis against GI haemorrhage
- Stim erythropoesis
- Max O2 delivery

Anaemia and transfusion both increase mortality.

When does the risk of anaemia outweigh the risk of transfusion?

Transfusion and PPH

- Restrictive or liberal?
- Patients randomized to:
  - liberal Hb <80g/l
  - Restrictive with symptoms of anaemia
- No difference in morbidity and mortality

What do we do differently?

Do we do anything differently?

Lessons to Learn

- Good communication
- Attention to detail
- High index of suspicion
- *"Effective resuscitation"*
- Prompt "turning off the tap"
- Uterotonics
- Situation awareness


Questions?