Considerations in the management of pregnant women who refuse blood and blood products

Queensland Maternal and Perinatal Quality Council

Introduction

Some patients, including pregnant women, refuse blood and blood products. In particular, Jehovah's Witnesses have specific religious beliefs regarding transfusion, although when it comes to minor blood fractions or procedures involving the use of their own blood, their acceptance of particular products or procedures may vary subject to their conscience views. The issues involved in the provision of medical treatment to pregnant women who refuse blood and blood products are complex and it is therefore difficult to develop a formal protocol that can be applied with certainty to every individual circumstance. Pregnancy, unlike many other situations where acute blood loss may occur, offers a significant window of opportunity during antenatal care to ascertain the woman's exact wishes in a non-acute setting and to make sure she is as unlikely as possible to need blood products.

The primary thrust of this document is to encourage senior medical officer involvement in:

- discussion of, and documentation of, specific issues of consent early in the pregnancy
- optimisation of the woman's cardiovascular status early in the pregnancy
- planning of pregnancy care to minimise risks associated with unexpected need for intervention
- prompt attendance in the event of required surgical intervention or unexpected serious blood loss

Consent to treatment with blood products

A fully informed, competent adult is entitled to decide to accept medical treatment or not. Medical and nursing/midwifery staff have an obligation to provide any patient with all the information necessary to enable that patient to make an informed decision and to answer any relevant questions the patient may have. Further, healthcare staff have an obligation to satisfy themselves that a patient is fully informed before that patient makes a decision to accept or refuse treatment.

Staff in a maternity service have an obligation to become aware of a women's preferences regarding the acceptability (or otherwise) of receiving blood products. In the event that a pregnant woman has specific views regarding treatment with blood and blood products which that woman identifies as unacceptable staff of that service should seek to clarify such wishes as early as possible in the pregnancy. The service is obligated to provide detailed information, in a non-judgmental manner, regarding the pros and cons of such treatment, and such conversations should be undertaken by senior and experienced medical officers.

The decision to accept or decline a specific treatment (including blood components and its alternatives), remains the individual choice of competent adults. 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. Conversations relating to consent to accept or decline a specific treatment should be had in private with the woman only, in order to ensure the confidentiality of her decision.

Subsequently it is important that an individualised plan of care is developed which identifies the blood components / products and the alternatives the woman will accept in the event of haemorrhage, well in advance of birth. Specifically, all such women should have a plan of care established which

identifies what is acceptable in the event of haemorrhage. It is wise to encourage the woman to codify her wishes in an Advance Health Directive (if she has not already done so - see below). Appropriate notation of the agreed plan of care should be clearly included on patient's hospital records, and a copy of the Advance Health Directive, if one is available, should be attached to those records.

Advance Health Directive

There are different documents which can be called Advance Health Directives, and healthcare staff need to be very aware of the differences.

In Queensland, the Powers of Attorney Act 1998 and the Guardianship and Administration Act 2000 operate together to provide a mechanism by which a person can make an Advance Health Directive (AHD) or "living will", which is a written expression of the person's wishes in relation to medical treatment but which only comes into effect if the person loses his or her capacity. Insofar as they relate to health care matters, they are intended to codify the law in relation to substitute decision making for adults who, either temporarily or permanently, have lost their capacity to make decisions for themselves.

Jehovah's Witnesses generally carry with them a card titled 'Advance Health Directive' which is signed and dated by the patient, a medical practitioner and an independent witness. Such a card is an Advance Health Directive as defined in the *Powers of Attorney Act 1998, sections 35 and 36*.

In defining capacity, the *Guardianship and Administration Act 2000* states that, in order to have capacity, the person must:

- understand the nature and effect of decisions;
- be able to make the decision freely and voluntarily; and
- be capable of communicating the decision in some way.

A person has impaired capacity if any of the 3 elements are not present.

Women who are conscious and competent can provide or withhold consent for treatment (of any type). An Advance Health Directive **only** becomes operational if the woman becomes incompetent due to unconsciousness or other circumstances. A substitute decision maker can provide or withhold consent for treatment if named as a Health Power of Attorney in the Advance Health Directive, and if the decision to be made is not articulated in the Advance Health Directive. It is wise to ensure that a copy of such a document is available in the medical record in case the woman becomes incompetent due to unconsciousness or other circumstances. If there is doubt, the Office of the Adult Guardian should be consulted.

There are specific legal requirements for children (under 18 years of age) requiring emergency blood transfusion. Anyone over 18 years of age is legally recognised as an adult. Under 18 years of age a "mature minor principle" may apply. Individuals may be capable of giving consent if, in the view of the care-giver, they are fully aware of the circumstances and implications. In the event of conflict between the parent and a mature child over proposed transfusion, the Family Court has a general supervisory power to intervene to protect the best interests of the child. Although there is not any legally recognised age at which the mature minor principle applies, as a guide, young people between the ages of 14 -18 years are more likely to have a sufficient understanding of decisions affecting their health and are therefore more likely to be considered competent.

Jehovah's Witnesses' position on Allogenic and Autologous Blood		
Unacceptable	**Potentially acceptable (Personal decision)**	
• Whole blood • Red cells • White cells • Platelets • Plasma • Preoperative autologous blood collection and storage for later reinfusion	• Fractions from red cells white cells, platelets, plasma • Albumin • Immunoglobulins • Clotting factors • Haemoglobin • Haemin • Interferons • Cell salavage • Hemodilution • Cardiopulmonary bypass (heart-lung machine)	• Dialysis • Epidural blood patch • Recombinant erythropoietin • Recombinant factor VIIa • Labelling or tagging • Platelet gel autologous • Plasmapharesis (when plasma substitute is used eg. Artificial colloid. Allogenic plasma is not acceptable)

Antenatal optimisation of the woman's cardiovascular status

A multidisciplinary team approach is important, with oversight by a senior member of staff who is familiar with the available alternatives to transfusion.

It is essential that anaemia is prevented in pregnancy, as the presence of anaemia amplifies the impact of blood loss. 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. Treatment aim should be to reach a haemoglobin level of at least 12 g/dL. The threshold for intervention in the treatment of anaemia should be lower in women who refuse blood and blood products than in other patients.

At the initial antenatal visit the following blood tests should be ordered:

- Full blood examination
- Iron studies
- Vitamin 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)

Haematological parameters should be optimised during pregnancy by:

- treatment of any haematinic deficiency (iron, folate, B12) including Vitamin D deficiency
- encourage the woman to have a diet containing high levels of iron, folates and vitamin B12
- 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 relevant physicians. Non-prescription drugs and supplements which may affect coagulation status should be avoided
- repeat full blood examination and iron studies may be required more frequently than is usual, depending on the booking haemoglobin level and must be followed up at 28 and 36 weeks
- iron infusions and/or erythropoietin therapy may be considered for a woman with a low haematocrit not responding within an appropriate timeframe to haematinic supplementation

Planning of pregnancy care to minimise risks associated with unexpected need for intervention

Integrated team management is crucial to minimising the risks of unexpected poor outcomes in any pregnancy, but particularly important when some of the usual treatment safeguards are not available. Central to such integrated team management is a clearly articulated and recorded management plan which has been agreed to by the woman and her carers. It is critical that such a management plan be agreed to and recorded in the medical record well before term. In general, it is appropriate to plan care in a facility where specialists are available in obstetrics, anaesthetics, intensive care and haematology. The management plan must include a specific agreed plan for management of the third stage of labour.

It is wise to ensure that a senior obstetric specialist is aware that the woman is in labour. If intervention is likely to be necessary (eg caesarean section) consideration should be given to ensuring that this process is undertaken electively in the presence of senior specialist staff. Consultation with an anaesthetic specialist prior to the time that such intervention may be necessary is wise, and discussion of pre-surgery haemodilution may be appropriate in some circumstances.

Care should be taken to deliver any blood products that the woman accepts in a private manner, with the assurance of confidentiality.

Prompt senior medical officer attendance in the event of required surgical intervention or unexpected serious blood loss

The need to achieve prompt haemostasis in any situation is magnified by the inability to transfuse if necessary. Prompt and effective haemostasis is most efficiently achieved by a surgeon who is aware of and experienced with the need to use the entire range of available options. The recorded management plan should make it clear that senior specialists (obstetric and anaesthetic) should be involved early in any surgical procedure in women who refuse blood and blood products. Where haemostasis difficulties are anticipated consideration should be given to the need for consultation with other disciplines, including interventional radiology and specialist haematology.

Appendices

Suggested further reading

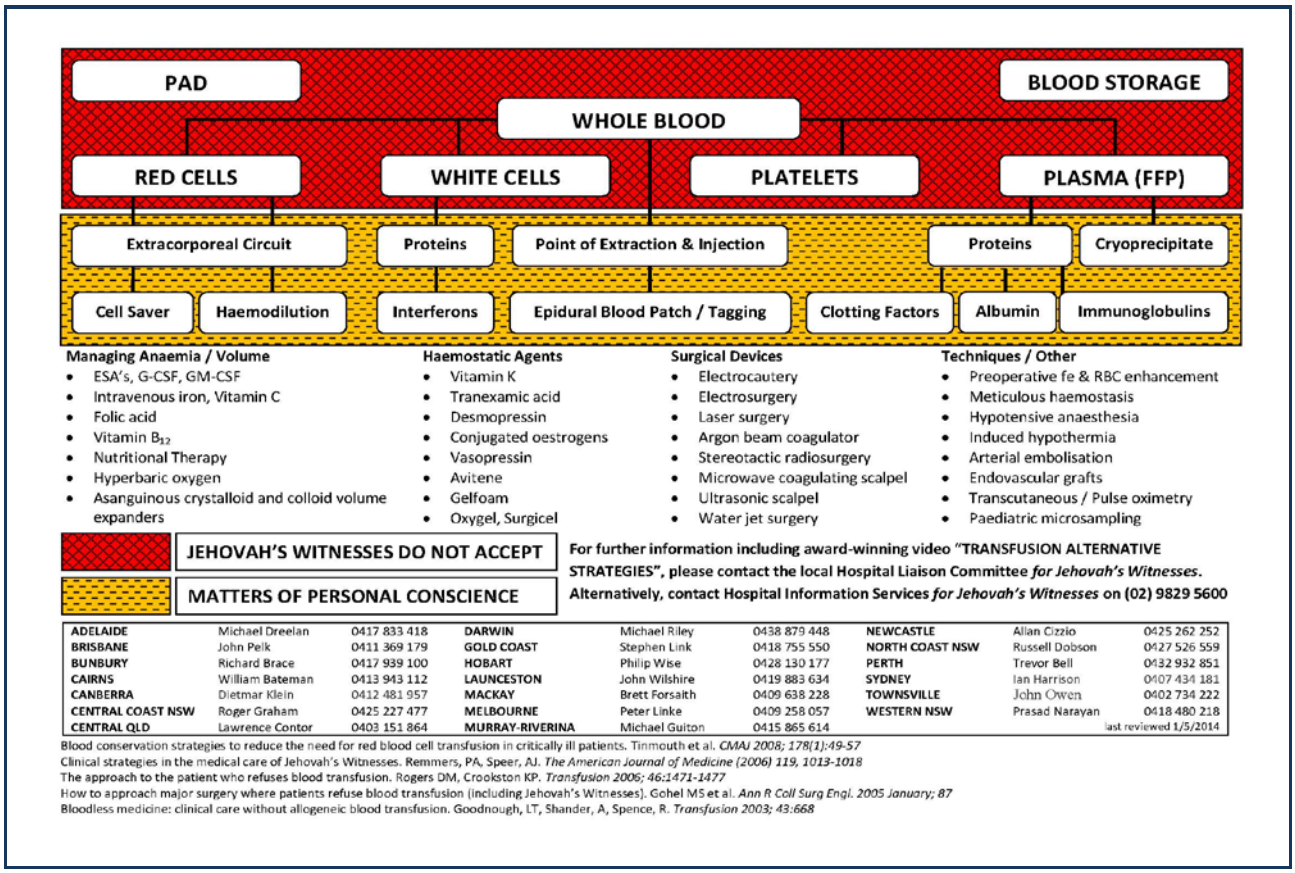
Brydon C. Jehovah's Witnesses. Anaesthesia and Intensive Care Medicine, 2013; 14(2): 79-81

Berend K and Levi M. Management of Adult Jehovah's Witness Patients with Acute Bleeding, Am J Med, 2009; 122(12): 1071-1076

Gupta S, Onwude J, Stasi R and Manyonda I. Refusal of blood transfusion by Jehovah's Witness women: a survey of current management in obstetric and gynaecological practice in the UK. Blood Transfus, 2012; 10: 462-470

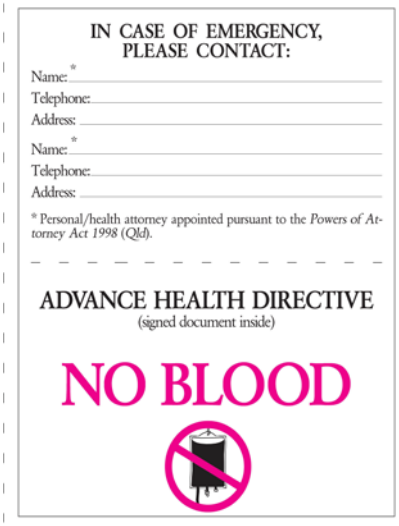
National Blood Authority's Patient Blood Management Guideline: Module 1 – Critical Bleeding/Massive Transfusion www.blood.gov.au/pbm-module-1

Jehovah's Witness "Conscience Chart"



Blood conservation strategies to reduce the need for red blood cell transfusion in critically ill patients. Tinmouth et al. *CMAJ 2003; 178(1):49-57*
Clinical strategies in the medical care of Jehovah's Witnesses. Remmers, PA, Speer, AJ. *The American Journal of Medicine (2006) 119, 1013-1018*
The approach to the patient who refuses blood transfusion. Rogers DM, Crookston KP. *Transfusion 2006; 46:1471-1477*
How to approach major surgery where patients refuse blood transfusion (including Jehovah's Witnesses). Gohel MS et al. *Ann R Coll Surg Engl. 2005 January; 87*
Bloodless medicine: clinical care without allogeneic blood transfusion. Goodnough, LT, Shander, A, Spence, R. *Transfusion 2003; 43:668*

Jehovah's Witness "Advance Health Directive" ("No Blood Card")



IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: *
Telephone:
Address:
Name: *
Telephone:
Address:

* Personal/health attorney appointed pursuant to the *Powers of Attorney Act 1998 (Qld)*.

ADVANCE HEALTH DIRECTIVE
(signed document inside)

NO BLOOD

ADVANCE HEALTH DIRECTIVE

To my family, friends, and health-care providers:

I, _____ (Full Name), of _____ (Full Address), _____ (State), being over 18 years of age, make this directive as a formal statement of my instructions, the nature and likely effects of which I fully understand, after careful consideration and of my own free will. If at any time I am unable, for any reason, to take part in decisions about my medical care, let this document stand as evidence of my views, wishes, beliefs, and directions about the medical treatment I require. I sign this document with full knowledge that my health care may be limited as a result, but only as specified below. I request that all who are responsible for my care respect the directions given in this document.

I am one of Jehovah's Witnesses and, out of obedience to commands in the Bible, such as "Keep abstaining . . . from blood" (Acts 15:28, 29), 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 physicians deem such necessary to preserve my life or health. I will accept non-blood volume expanders (such as dextran, saline or Ringer's solution, or Haemaccel) and other non-blood medical management. This directive is an exercise of my statutory and common-law right to accept or to refuse medical treatment in accord with my deeply held values and convictions. I also know that there are various dangers associated with blood transfusions. I have decided to avoid such dangers and, instead, to accept whatever risks may seem to be involved in my choice of alternative non-blood medical management.

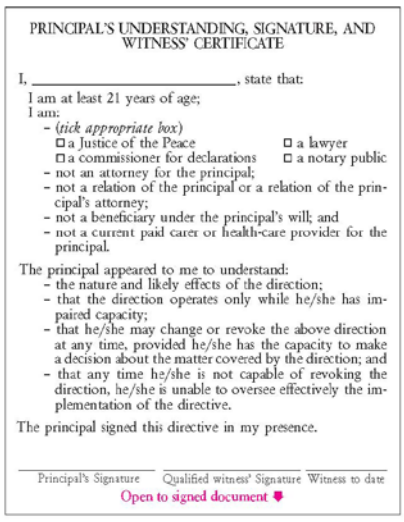
I, Doctor _____ (Name), of _____ (Address), _____ (State), _____ (Phone), have discussed this document with the principal and, in my opinion, he/she is not suffering from any condition that would affect his/her capacity to understand the things necessary to make this directive, and he/she understands the nature and likely effect of the directive to refuse to accept a blood transfusion under any circumstances given herein. The principal signed this document in my presence. I am not:

- the person witnessing this Advance Health Directive
- an attorney of the principal
- a relation of the principal or an attorney of the principal
- a beneficiary under the principal's will

Principal's Signature | Doctor's Signature | Doctor to date

I, _____ affirm that I have reviewed this document and there is nothing I would like to change. Signature _____ Date _____ Signature _____ Date _____ Signature _____ Date _____

ed48 Au (Q) 11/03



PRINCIPAL'S UNDERSTANDING, SIGNATURE, AND WITNESS' CERTIFICATE

I, _____, state that:

I am at least 21 years of age;
I am:
- (*tick appropriate box*)
  - ☐ a Justice of the Peace
  - ☐ a commissioner for declarations
  - ☐ a lawyer
  - ☐ a notary public
- not an attorney for the principal;
- not a relation of the principal or a relation of the principal's attorney;
- not a beneficiary under the principal's will; and
- not a current paid carer or health-care provider for the principal.

The principal appeared to me to understand:
- the nature and likely effects of the direction;
- that the direction operates only while he/she has impaired capacity;
- that he/she may change or revoke the above direction at any time, provided he/she has the capacity to make a decision about the matter covered by the direction; and
- that any time he/she is not capable of revoking the direction, he/she is unable to oversee effectively the implementation of the directive.

The principal signed this directive in my presence.

Principal's Signature | Qualified witness' Signature | Witness to date

Open to signed document ⬇