Association of Anaesthetists Guidelines

Anaesthesia and peri-operative care for Jehovah's Witnesses and patients who refuse blood

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Jehovah's Witnesses

- about 8.5 million Jehovah's Witnesses
- around 150,000 live in GB and Ireland.
- refuse blood component transfusion (including red cells, plasma and platelets).
- They regard non-consensual transfusion as a physical violation.
- Consent to treatment is at the heart of this guideline.
- Refusal of treatment by an adult with capacity is lawful.

Belief

Jehovah's Witnesses believe that the Bible teaches **that life**, which is **held as sacred**, is represented by the blood of a creature, thus **blood (representing life) acquires a sacred status**. They, therefore, take the view that taking into their bodies (parenterally or enterally) the blood of another creature violates Biblical law [7].

Recommendations

* associated with significant blood loss

- 1. Give pts clear explanation of the blood products that might be required during or after surgery, and risks involved if they refuse. Discussion alternative treatments if available.

- 2. Documented specifically which treatments and/or procedures the patient consents to and which they do not. Written consent/checklist.

- 3. Check Pt Hb at least 6 weeks before elective surgery*, if < 130 g.l1, consider optimising with iron Rx +/- EPO

Recommendations

- 4. Team brief and surgical safety checklist before induction should specifically discuss issues. A checklist recording which components/products/ procedures the patient will or will not accept is important and should be available at these times.

- 5. The majority of Jehovah's Witnesses will accept intraoperative CS – discuss as above, written consent should be obtained.

- 6. Rigorously apply PBM interventions, inc TXA for major surgery.

- 7. Post op comprehensive verbal and written handover of the patient is essential. Staff should be made aware of any adverse intra-operative events and understand and respect the wishes of the patient as discussed before the procedure.

Summary

- 1. Discuss products required, risks of refusal, alternatives.
- 2. Written consent specifying which are accepted and not.
- 3. Pre-op optimisation if Hb <130. Hb 6 weeks, iron/EPO
- 4. Discuss at team brief and WHO blood Mx plan, check documentation
- 5. Most JW accept CS, document consent. Continuous circuit?
- 6. Rigorous peri-op blood Mx, TXA, etc.
- 7. Comprehensive handover of patient wishes and intraop events.

Remember consent issues.

Consent and Capacity

An adult patient with capacity can give consent to a procedure while withholding consent for specific aspects of management, such as the administration of blood components. The bar to the provision of that treatment is absolute.

Treatment in the face of such a bar is unlawful and can give rise to both civil and criminal liability, as well as professional sanctions.

Extra info after this

1 Patients should be given a clear explanation of the blood products that the medical team looking after them consider might be required during or after surgery, and the risks involved if they refuse. Discussion of alternative treatments should be undertaken if available.

- Not all patients are Jehovah's witnesses and not all Jehovah's witnesses refuse blood transfusion.
- Informed consent required for all patients.

2 It should be clearly documented in the medical record which treatments and/or procedures the patient consents to and which they do not.

Jehovah's witness patients who follow the teaching of their church:

- Do not accept whole blood, primary components (red cells, fresh frozen plasma and platelets.)
- are permitted to accept products derived by further processing of the primary blood components – cryoprecipitate, fibrinogen concentrate, prothrombin complex concentrate, fibrin glue, platelet gel and human albumin solution.
- accept recombinant coagulation factor concentrates and drugs such as erythropoietin and iron which are not derived from blood.

- Pre-operative donation, that is, donation of the patient's own blood typically a few weeks before surgery with the blood being given back during or after surgery is not usually acceptable to a Jehovah's Witness patient.
- Acute normovolaemic haemodilution (ANH), in which blood is taken from the patient into a bag containing anticoagulant before or at the start of surgery, kept in the operating room and given back to the patient during or after surgery, is regarded as being a matter of individual choice and may be acceptable.

Other procedures that are usually acceptable to Jehovah's Witness patients but matters of individual choice include:

- 1 Cell salvage, either during surgery or postoperatively
- 2 Renal replacement therapy with haemodialysis or haemofiltration
- 3 Cardiopulmonary bypass
- 4 Extracorporeal membrane oxygenation (ECMO)

5 The majority of Jehovah's Witnesses will accept intraoperative CS – this should be discussed before surgery and if agreed set up from the start of surgery. Consent should be obtained.

- The equipment can usually be set up as for non-Jehovah's Witness patients,
- There is usually no requirement for a continuous connection from the patient to the CS system and back to the patient.
- This is a new recommendation, however, some patients may request, as a matter of personal preference, some form of continuous connectivity.

Consent for children 0-15

Presenting for elective/emergency op, without Gillick competence

'*Duty of the physician is to act in best interests of the child. Usually considered by the courts as requiring clinician to give blood even in the face of parental refusal. This is not an absolute rule'*

MDT discussions should be held with parents/surgeon/anaesthetics to establish risk of clinical situation/alternatives and risk of refusal of blood

It is essential that parents feel their beliefs are being respected and that every effort is being made to avoid transfusion. Avoid resorting to most obvious medical solution (giving blood) or proceeding quickly to court.

If parents refuse and the situation is urgent/dynamic give blood to avoid threat to life/disability, while awaiting the outcome of an application to the court.

Consent for children 0-15

Presenting for elective/emergency op, without Gillick competence

Most often outcomes of such MDT discussions are:

1. Blood is required and consent obtained from parents for Tx.

2. There is a low risk of bleeding and sensible precautions are taken. But team make clear that on rare occasions blood may be required. Consent obtained for Tx on condition that blood is unavoidable. Clear documentation required.

3. Absolute refusal of blood by the parents under all circumstances. (Court application required if threat to life)

4. Nuanced permission for products in certain situations, or use of specific techniques, the conditions for which are clear to both medics and parents. Requires clear documentation.

Consent for children 0-15, **with Gillick competence**

'Understand proposal to use blood, retain, weigh up and communicate'

Three possible outcomes. The competent child..

1. ..accepts blood, parents have no right to refuse. Sensible to involve solicitor but rarely need court decision.
2. ..refuses blood, those with parental responsibility can override child's wishes.
   Court referral sensible as forcing child against wishes goes against human rights.
3. ..refuses blood and parents refuse blood.

Court referral seeking that the requirement for consent is set aside.
Elective setting this done in person, emergency done over the phone.

Consent for 16-17 year olds

England and Wales: Same ability as adults to consent/refuse Rx with 2 exceptions:

1. Cannot make advance decisions
2. A court can override their refusal even with capacity*

Old legal cases suggest parents of 16-17yo with capacity can also override child refusal. However a court application should be made as blood transfusions may fall beyond the legal 'scope of parental responsibility'. The closer to aged 18 the child is the less likely the Court would be to overrule the child*.

Scotland, Northern Ireland and Republic of Ireland:

- Neither courts/parents can override competent refusal of treatment/blood for children 16 and over.
- Children <16 with capacity may consent to treatment. By extension this may include refusal of blood that courts/parents cannot override, but this has never been tested in Court.