Hairmyres Hospital
Monklands Hospital
Wishaw General Hospital

Protocol for the Treatment
of
Jehovah’s Witnesses

Authors

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Based upon:

'Code of Practice for the Surgical Management of Jehovah’s Witnesses'
Royal College of Surgeons of England (2002)

'Management of Anaesthesia for Jehovah’s Witnesses'
Association of Anaesthetists of Great Britain & Ireland (2nd edition 2005)

Review Date

December 2009
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### Appendices:

A. Advance Decision to Refuse Specified Medical Treatment document

B. General Consent Form Excluding Blood Transfusion

C. Consent Form for Specific Blood Components and Procedures for Jehovah’s Witnesses

D. Care Plan for Women in Labour Refusing a Blood Transfusion
NHS Lanarkshire aims to respect the wishes of Jehovah’s Witnesses and their families, and to provide high quality health care acceptable to them. All patients have the right to be treated with respect and staff must be sensitive to the individual needs of the patient, acknowledging their values and beliefs.

This document will be available in clinical areas in each of the three hospitals (including Accident & Emergency, Anaesthetic, Haematology and Obstetric departments, theatre suites and intensive care units), as well as on the NHS Lanarkshire Intranet ‘FirstPort’ site. Copies will also be available on request from the Hospital Liaison Committee of Jehovah’s Witnesses (contact details - see section 13).

1. AIM OF THE GUIDELINE

1.1. To protect the rights of patients, adults and children, in respect of their refusal to be treated with blood or blood products.

1.2. To enable clinicians to feel confident in their approach to treating patients as is clinically necessary, unless there is a specific and clear refusal of consent.

1.3. To protect clinical practitioners and the hospital from unnecessary confrontation and perhaps costly litigation by outlining the procedure to be followed.

2. ETHICAL CONSIDERATIONS

2.1. There are approximately 7,000,000 Jehovah’s Witnesses worldwide. Of these 150,000 reside in the UK. Jehovah’s Witnesses have absolutely refused the transfusion of allogeneic blood and the primary components (red cells, white cells, platelets and plasma/FFP) ever since they have become universally available. This is a deeply held core value and they regard a non-consensual transfusion as a gross physical violation.

2.2. Jehovah’s Witnesses are generally well informed both doctrinally and with regard to their right to determine their own treatment.

2.3. It is not the clinician’s responsibility to question these principles, but they should discuss with each Jehovah’s Witness patient the medical consequences of non-transfusion in the management of their specific condition.

3. LEGAL AND CONSENT ISSUES

3.1. To administer blood in the face of refusal by a patient is unlawful and could lead to criminal and/or civil proceedings.

3.2. In the management of trauma, the Jehovah’s Witness status of the patient may be unknown. Nevertheless, the majority of Jehovah’s Witnesses carry on their person a signed and
witnessed ‘Advance Decision to Refuse Specified Medical Treatment’ document (Appendix A), absolutely refusing blood and releasing clinicians from liability arising from this refusal. This document is renewed regularly. A copy of this document will have been lodged with their GP as well as with friends and fellow worshipers.

3.3. If the patient is able to give an informed, rational opinion, or if an advance directive exists, this should be acted upon. If the patient is unable to give their opinion, or there is no advance directive, the clinical judgement of the doctor should take precedence over the opinion of relatives or associates. Such friends and relatives may be invited to produce evidence of the patient's Jehovah's Witness status in the form of an applicable ‘Advance Decision’ document.

3.4. Informed Consent Form. ‘The General Consent Form Excluding Blood Transfusion’ (Appendix B), has been agreed by the Royal College of Surgeons and is incorporated in their Code of Practice – The Surgical Management of Jehovah’s Witnesses (2002).

3.5. Although all Jehovah’s Witnesses share many common beliefs in relation to the medical use of blood, there are some areas that are considered a matter of patient choice. In brief this means a clinician is not dealing with 'a Jehovah's Witness patient' with a stereotypical medical belief package, but rather with 'a patient who is one of Jehovah's Witnesses'. Hence, a clinician must establish what is acceptable or not acceptable to each individual. Recognising this makes for a richly enhanced relationship, and encourages co-operation rather than confrontation. An NHS Lanarkshire ‘Consent Form for Specific Blood Components and Procedures for Jehovah’s Witnesses’ (Appendix C) should be completed for each patient and a copy filed in the patient’s case notes. This details which products/procedures are acceptable for that individual patient.


4. TREATMENT NOT ACCEPTABLE TO JEHOVAH'S WITNESSES

4.1. All Jehovah’s Witnesses refuse the transfusion of the four primary blood components; red cells, white cells, platelets and plasma (FFP).

4.2. Pre-deposited autologous blood (PAD) is not acceptable.

5. TREATMENT ACCEPTABLE TO JEHOVAH'S WITNESSES

5.1. Jehovah’s Witnesses will accept medical management to build up or conserve their own blood, to avoid or minimise blood loss and to replace lost circulatory volume. This would include sodium chloride (saline) solution, Hartmann’s (Ringer-Lactate) solution, dextrans, modified gelatins, (e.g. gelofusin, haemacel) and starches (e.g. hemohes, voluven, tetraspan).
6. TREATMENT THAT JEHOVAH’S WITNESSES CONSIDER TO BE A MATTER OF PATIENT CHOICE (see Appendix C)

6.1. Blood products derived from plasma including albumin, intravenous immunoglobulins, cryoprecipitate, anti-D immunoglobulin, other specific immunoglobulins e.g. anti-tetanus, etc.

6.2. Treatment and procedures involving their own (autologous) blood. This would include normovolaemic haemodilution, cell salvage (both intra-operative and post-operative), renal dialysis, plasmapheresis, blood radio-labelling, etc.

6.3. Human recombinant products such as erythropoietin (r-HuEPO) and clotting factors VIIa, VIII and IX.

7. MANAGEMENT OF JEHOVAH’S WITNESS PATIENTS UNDERGOING ELECTIVE SURGERY

7.1. General Peri-operative Non-blood Management Principles

These guidelines are drawn from general principles of peri-operative management applicable to all patients.
- Thoroughly plan the management of the patient so as to avoid allogeneic blood transfusion by using an appropriate combination of blood conservation strategies.
- Anticipate potential risks of blood loss and be prepared to address them.
- Employ a multi-speciality team approach.
- Maintain frequent, close observation for haemorrhage.
- Early recognition and prompt intervention to prevent/control abnormal bleeding is the cornerstone of effective care of patients who will not accept allogeneic blood. Avoid a “watch and wait” approach to a bleeding patient.
- Exercise clinical judgement and be prepared to modify routine practice when appropriate.
- Consult promptly with senior specialists experienced in non-blood management if complications arise.
- Contact Hospital Liaison committee (see section 13) for advice if necessary.
- Discuss with the patient/family the risks (short and long-term), benefits and alternatives to proposed interventions.

7.2. General Therapeutic Principles

- Control or avoid haemorrhagic and iatrogenic blood loss
- Optimise cardiac and respiratory support by maximising oxygen delivery (volume replacement, oxygenation, vasoactive agents) and minimising oxygen consumption (analgesia, mechanical ventilation).
- Restore/improve blood count by stimulating haematopoiesis.
8. PRE-OPERATIVE PLANNING

Whilst thorough assessment of a patient is always desirable, it is absolutely essential when dealing with one who is refusing allogeneic blood. A comprehensive care plan should be drawn up taking into consideration the risk factors and then employing an optimal combination of available alternative strategies.

8.1. At time of referral

8.1.1 Medical history and physical examination

- Congenital/acquired bleeding disorders (suspected by reviewing obstetric history, circumcision, frequent nose bleeds, easy bruising without trauma, tonsillectomy, dental extraction, menorrhagia, prolonged bleeding after minor skin lesion, surgery, pregnancy, etc).
- Personal history and family history.
- End organ disease/injury (especially renal or hepatic).
- Previous surgery (blood loss may be increased with repeat surgery).
- Identify medications that may adversely affect haemostasis (e.g. aspirin, NSAIDs, anticoagulants, platelet aggregation inhibitors, antibiotics, etc). Ensure non-prescription drugs not inadvertently taken by patient.
- Physical examination (e.g. purpuric lesions, petechiae, ecchymosis, hepatomegaly, splenomegaly).

8.1.2 Laboratory Assessment/screening

- Establish baseline parameters:
  - Full blood count
  - Serum ferritin
  - Serum folate
  - Serum vitamin B₁₂
  - PT, PTT, fibrinogen
  - Liver function
  - Renal function (urea & creatinine)
- Additional investigation as indicated by the history of the patient and the degree of haemostatic challenge
  - Further coagulation tests if personal or family history of bleeding – contact Haematology department for advice.

Note: Minimise iatrogenic blood loss – consider using paediatric blood tubes.

8.1.3 Blood sparing options

If the procedure and the patient’s condition is such that the clinician would normally request 2 or more units of cross matched blood, discuss with the patient which of the blood sparing options and alternatives would be acceptable, if available (Refer to the NHSL Maximum Surgical Blood Ordering Schedule for cross match details).

- Cell salvage – both intra-operative and post-operative.
• Acute normovolaemic haemodilution.
• Human recombinant blood products (e.g. r-HuEPO).
• Blood products derived from plasma e.g. albumin, fibrin sealants, cryoprecipitate, clotting factors, etc.

This should be clearly documented on the ‘Consent Form for Specific Blood Components and Procedures for Jehovah’s Witnesses’ (Appendix C) (if appropriate).

8.2. From 6 weeks pre operatively

• Oral iron unless contra-indicated.
• Consider stopping aspirin, NSAIDs and other anti-platelet agents, at least 7 days pre operatively.
• Consider stopping warfarin and other anticoagulants if possible.
• If the expected blood loss is high – consider recombinant Erythropoietin subcutaneously daily for 10 to 14 days pre operatively to elevate haemoglobin level.
• Ensure acceptability with patients and discuss further with Haematologists.

8.3. At Operation

• Surgical procedure(s) to specifically avoid and prevent blood loss:
  o Minimally invasive techniques (endoscopic/laparoscopic surgery)
  o Enlarged surgical team to reduce time
  o Surgical positioning to minimise bleeding
  o Staged surgery for complex procedures

There are a range of measures which may or may not be available:

• Meticulous haemostasis
• Mechanical occlusion of blood vessels
• Electrocautery
• Ultrasonic scalpel
• Argon beam coagulator
• Tissue adhesives
• Appropriate volume replacement
• Haemodilution
• Hypotensive anaesthesia
• Consider use of antifibrinolytics: aprotonin, tranexamic acid, desmopressin
• Arterial embolisation
• Interventional radiology in the form of prophylactic iliac artery balloons before an anticipated bloody caesarean section
• Intraoperative cell salvage
• Medical antishock trousers (MAST)

8.4. Post-operative Care

• Consider cell salvage via wound drainage, collection and re-infusion, if available.
• Minimise blood sampling
  o Consider use of pulse oximetry
Paediatric sample tubes
Plan multiple tests per sample
- Tranexamic acid
- Continue iron and erythropoeitin therapy as indicated by haemoglobin level

9. TREATING CHILDREN OF JEHOVAH'S WITNESSES

9.1. In Scotland, young persons aged sixteen or over have the exclusive right to determine their own medical treatment. The parent has no right to consent or interfere.

9.2. Children below the age of sixteen may cause some difficult situations for the patient, parents and clinicians. Jehovah’s Witnesses are usually well informed about the legal situation. They are generally aware of the provisions of the Children (Scotland) Act 1995 and the possibility of a Specific Issue Order under section 11. Such a Specific Issue Order should rarely be necessary but if this serious step is considered it is of the utmost importance to keep parents fully informed and given the opportunity to be represented at any hearing. Parents need to be assured that every possible step is being taken to avoid the use of allogeneic blood.

9.3. Children younger than sixteen may be competent to make their own decisions if they demonstrate a clear grasp of the proposed treatment and the issues involved. This is referred to as ‘Gillick Competence’.

If the clinician is persuaded that a child’s refusal to accept blood transfusion is a genuinely held personal belief, and not just a reflection of their parents’ belief, then a clinician should give very serious consideration to the child’s feeling. The ‘Gillick’ principle is unlikely to apply to a child below the age of twelve.

9.4. Trauma situations involving young children and unexpected neonatal emergencies can be particularly difficult. In such a situation where the parents feel unable to give permission to transfuse blood it may be felt that application for a Specific Issue Order would be too time consuming. If two doctors of Consultant status make a clear, unambiguous, signed entry into the clinical record that a blood transfusion is essential, or is likely to become so, to save life or prevent serious harm, then they should act upon the basis of their own clinical judgement. The courts are likely to uphold the decision of the doctors who administered the transfusion in such circumstances.

10. OBSTETRICS

10.1 Child birth is a process where the issue of blood transfusion can arise. Pregnant Jehovah’s Witnesses are encouraged to make use of the document, ‘Care Plan for Women in Labour Refusing a Blood Transfusion’ (see Appendix D). They are encouraged to leave a copy with their consulting obstetrician and also request that a copy be placed in their medical file.
10.2 General Principles of Non-blood Obs/Gyn Management

- Prepare an individualised management plan to facilitate rapid decision-making. Be prepared to utilise a combination of interventions to minimise blood loss.
- Ensure the availability of experienced personnel, appropriate drugs and equipment to prevent and promptly manage haemorrhage without blood transfusion.
- Communicate the care plan to involved medical and nursing personnel to avoid treatment delay.
- Maintain frequent close observation for postpartum or postoperative haemorrhage. Prompt intervention to prevent/control blood loss can be life saving. The clinical urgency of low-level persistent bleeding may not be recognised until compensatory mechanisms fail and blood pressure falls. Early recognition and prompt intervention to prevent/control abnormal bleeding is the cornerstone of effective care for patients who refuse allogeneic blood. In general, avoid a watch and wait approach to the bleeding patient.
- Adopt a multidisciplinary team approach to patient care, involving other specialists in planning if necessary.
- Obtain informed consent for non-blood management strategies. Discuss the options, and the risk/benefits (both short-term and long term) of the proposed interventions with the patient/family.

10.3 General Therapeutic Principles

Most Obstetric units have clear protocols for obstetric haemorrhage and a copy should be kept in the patient’s casenotes.
- Thorough patient history, physical examination and judicious laboratory investigation improve the estimation of risks and facilitate planning and preparation to prevent/control blood loss.
- Optimise red cell mass preoperatively and during pregnancy.
- In the face of severe haemorrhage, early recourse to definitive surgical measures to control blood loss is required.
- Use appropriate intraoperative blood conservation techniques.
- In the haemorrhaging patient, avoid aggressive fluid resuscitation to restore blood pressure to a normal range until the bleeding is controlled.
- Prevent or treat coagulation disorders promptly.
- Minimise the volume of blood drawn for laboratory analysis during the perinatal or perioperative period.
- Normovolaemic anaemia can be well tolerated in haemodynamically stable patients.

11 THE MANAGEMENT OF WOMEN IN LABOUR REFUSING BLOOD TRANSFUSION

11.1 Booking in

- When a patient books in it is customary to ask their religion. If they are one of Jehovah’s Witnesses it is likely that they will have with them a copy of their ‘Advance Decision to Refuse Specified Medical Treatment’ (Appendix A) document. This will
indicate what products and/or treatments they accept or reject. This document should become part of their medical file.

- They may well bring with them a ‘General Consent Form Excluding Blood Transfusion’ (Appendix B) the patient and the attending physician should complete this. If they do not bring such a form, one supplied by the hospital should be used, and it should clearly show what is excluded from consent.

- An NHS Lanarkshire ‘Consent Form for Specific Blood Components and Procedures for Jehovah’s Witnesses’ should be completed for each patient (Appendix C).

- The risks associated with the refusal of blood transfusion should be discussed in a non-confrontational manner. She should be advised that if a massive haemorrhage occurs then there is an increased risk that hysterectomy would be required.

- A patient refusing blood transfusion should be booked for delivery in a unit which has all facilities for prompt management of haemorrhage, including hysterectomy.

**Labour**

- The consultant obstetrician should be informed when a patient refusing blood transfusion is admitted in labour.
- Staff experienced in the care of high-risk women should manage the labour routinely.
- Oxytocics should be given when the baby is delivered. The woman should not be left alone for at least an hour after delivery.
- If a caesarean section is necessary it should be carried out by a Consultant Obstetrician.
- The majority of pregnancies will end without serious haemorrhage. On discharge, the patient should be advised to report promptly if she has any concerns about bleeding during the postpartum period.

**Haemorrhage**

- See Figure 1: ‘Management of Obstetric Haemorrhage in Woman refusing Blood or Blood Products’.
- The primary principle in the management of haemorrhage in a patient refusing blood transfusion is to avoid delay. Rapid decision making may be necessary, particularly with regard to surgical intervention.
- If unusual bleeding occurs at any time during pregnancy, labour or the puerperium the Consultant Obstetrician should be informed and the standard management should be commenced promptly. Extra vigilance should be exercised to detect and quantify any haemorrhage.
- Consultants in other specialities, particularly anaesthetics and haematology, should be informed immediately after abnormal bleeding has been detected.
- Management should follow the same principles as the general Major Obstetric Haemorrhage Guideline, avoiding the administration of blood and products as per the individuals consent. This will include administration of oxygen, establishing IV access and commencing infusion of crystalloid and/or colloid. Oxytocic drugs should be administered and the cause of haemorrhage ascertained, including retained products of conception and trauma.
- Dextran should be avoided for fluid replacement because of its possible effect on haemostasis.
• In cases of severe bleeding, medical treatments to be considered are Ergometrine, Haemabate, Misoprostol/Gemeprost, Tranexamic acid (Cyclokapron), Aprotinin (Trasylol) and recombinant factor VII (if acceptable to the patient).

• The patient should be kept fully informed about what is happening. Information should be given in a professional way, preferably by someone she knows and trusts.

• If she maintains her refusal to accept blood transfusion, her wishes should be respected. The legal position is that any adult patient (i.e. 16 years old or over in Scotland) who has the necessary mental capacity to do so is entitled to refuse treatment, whatever the consequences. No other person is legally able to give consent or refuse treatment on her behalf.

• Staff must maintain a professional attitude. They must not lose the trust of the patient as further decisions – for example, about hysterectomy – may have to be made.

• Massive obstetric haemorrhage usually occurs postpartum. In the case of life threatening antepartum haemorrhage in which the baby is still alive, the baby should be delivered promptly by Caesarean section if necessary (following consent).

• For postpartum haemorrhage, prior to hysterectomy, conservative surgical techniques such as uterine packing, intra-uterine balloon catheter, B-Lynch suture, uterine artery ligations or embolisation should be attempted and may be effective.

• Hysterectomy is normally a last resort in the treatment of obstetric haemorrhage.

• The timing of the hysterectomy is the decision of the Consultant Obstetrician on the spot.

• When hysterectomy is performed the uterine arteries should be clamped as early as possible in the procedure. Subtotal hysterectomy can be as effective as total hysterectomy, as well as being quicker and safer.

• If the patient survives the acute episode and is transferred to the ICU, the management there should include erythropoietin (R-HuEPO), parenteral iron and adequate protein for haemoglobin synthesis.

• If, in spite of all care, the woman dies, her relatives require support like any other bereaved family.
**Figure 1: Management of Obstetric Haemorrhage in Woman refusing Blood or Blood Products**

- If antepartum consider need for and mode of delivery and commence CTG. Ante and postpartum, check the details of the advance directive refusing blood and blood products.

- Blood loss > 500mls for vaginal delivery or >1000mls for caesarean section and ongoing haemorrhage. Fast page the Obstetric Registrar. Insert a large bore IV cannula. Take FBC, coagulation screen, group & save. Commence IV Hartmann’s. Monitor. Look for cause and treat. Phone labs: 5pm-9am ext 6446, 9am – 5pm ext 7262 (G&S) / ext 7260 (FBC & coag).

- Blood loss > 1500mls or any signs of shock, this is ‘Major Obstetric Haemorrhage’ Telephone 2222, state obstetric emergency and place and follow full guideline as below.

<table>
<thead>
<tr>
<th>Clinical staff</th>
<th>Investigation / Assessment / Monitoring</th>
<th>Resuscitate</th>
<th>Arrest the Bleeding (For PPH but not APH)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact Key Personnel</strong></td>
<td><strong>Airway -</strong></td>
<td><strong>Ensure not obstructed</strong></td>
<td><strong>Atony</strong></td>
</tr>
<tr>
<td><strong>Clinical staff</strong></td>
<td><strong>Breathing -</strong></td>
<td><strong>Oxygen 15 l/min</strong></td>
<td><strong>Massage fundus</strong></td>
</tr>
<tr>
<td>• If not already done, telephone 2222, including when in theatre</td>
<td><strong>Circulation -</strong></td>
<td><strong>Assist if required</strong></td>
<td><strong>Bimanual uterine compression</strong></td>
</tr>
<tr>
<td>• State ‘obstetric emergency’ and place.</td>
<td>• FBC</td>
<td>• Insert 2 large bore IV cannulae.</td>
<td><strong>IV 5 iu slowly</strong></td>
</tr>
<tr>
<td>This will alert;</td>
<td>• Group and save</td>
<td>• Use mixture of Hartmann’s solution and gelotusin</td>
<td><strong>IV or IM ergometrine 500mcg</strong></td>
</tr>
<tr>
<td>At all times</td>
<td>• Coagulation screen</td>
<td>• Fluid warmer</td>
<td><strong>IV or IM ergometrine 500mcg</strong></td>
</tr>
<tr>
<td>• Midwife coordinator</td>
<td>• U&amp;Es</td>
<td>• Infusion pressure bags</td>
<td><strong>Consider misoprostol, maximum of 1,000 micrograms (5 tablets), rectally</strong></td>
</tr>
<tr>
<td>• Obstetric registrar and SHO</td>
<td>• ABGs</td>
<td>• ‘Level 1’ infusion warming device</td>
<td><strong>Consider IM hemabate (PGF2α) 250mcg into thigh muscle</strong></td>
</tr>
<tr>
<td>• Anaesthetic resident</td>
<td></td>
<td>• Jehovah’s Witness’s will NOT accept red cells, platelets or FFP</td>
<td><strong>o can be repeated every 15 minutes to maximum 8 doses</strong></td>
</tr>
<tr>
<td>• Anaesthetic assistant</td>
<td></td>
<td>• Jehovah’s Witness’s MAY accept cryoprecipitate** and/or recombinant factor VIII</td>
<td><strong>Exclude other causes</strong></td>
</tr>
<tr>
<td><strong>Monday – Friday 0900-1700</strong></td>
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<td><strong>Ensure placenta complete</strong></td>
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<tr>
<td>• Consultant obstetrician</td>
<td></td>
<td></td>
<td><strong>Suture any obvious lacerations of vagina and cervix</strong></td>
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<tr>
<td>• Consultant anaesthetist</td>
<td></td>
<td></td>
<td><strong>Transfer to theatre</strong></td>
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<td><strong>‘Out-of-hours’</strong></td>
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<td><strong>Consider;</strong></td>
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<td>• Contact the consultant obstetrician and consultant anaesthetist via the switchboard</td>
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<td>• Examination under anaesthesia</td>
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<tr>
<td><strong>Haematology</strong></td>
<td></td>
<td><strong>Airway -</strong></td>
<td><strong>Atony</strong></td>
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<tr>
<td>• Maternity Unit Coordinator to Page 062 (haematology BMS)</td>
<td><strong>Breathing -</strong></td>
<td></td>
<td><strong>Massage fundus</strong></td>
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<tr>
<td>• State ‘Major Obstetric Haemorrhage in Jehovah’s Witness’ and patient details and type of bleed</td>
<td><strong>Circulation -</strong></td>
<td></td>
<td><strong>Bimanual uterine compression</strong></td>
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<tr>
<td>• BMS will contact portering staff and haematology consultant</td>
<td><strong>Resuscitate</strong></td>
<td></td>
<td><strong>IV 5 iu slowly</strong></td>
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<td><strong>Maternity Unit Co-ordinator will act as ‘major haemorrhage coordinator’</strong></td>
<td></td>
<td><strong>Ensure not obstructed</strong></td>
<td><strong>IV or IM ergometrine 500mcg</strong></td>
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<td>Coordinator will inform ‘062’ when haemorrhage is under control</td>
<td></td>
<td><strong>Oxygen 15 l/min</strong></td>
<td><strong>Consider misoprostol, maximum of 1,000 micrograms (5 tablets), rectally</strong></td>
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<td><strong>Assist if required</strong></td>
<td><strong>Consider IM hemabate (PGF2α) 250mcg into thigh muscle</strong></td>
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<td><strong>Insert 2 large bore IV cannulae.</strong></td>
<td><strong>o can be repeated every 15 minutes to maximum 8 doses</strong></td>
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<td></td>
<td></td>
<td><strong>Use mixture of Hartmann’s solution and gelotusin</strong></td>
<td><strong>Exclude other causes</strong></td>
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<td><strong>Airway -</strong></td>
<td><strong>Ensure placenta complete</strong></td>
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<td></td>
<td></td>
<td><strong>Breathing -</strong></td>
<td><strong>Suture any obvious lacerations of vagina and cervix</strong></td>
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<td><strong>Circulation -</strong></td>
<td><strong>Transfer to theatre</strong></td>
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<td><strong>Resuscitate</strong></td>
<td><strong>Consider;</strong></td>
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<td><strong>Assist if required</strong></td>
<td>• Examination under anaesthesia</td>
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<td><strong>Insert 2 large bore IV cannulae.</strong></td>
<td><strong>Intrauterine balloon</strong></td>
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<td></td>
<td><strong>Use mixture of Hartmann’s solution and gelotusin</strong></td>
<td><strong>Interventional radiology</strong></td>
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<td></td>
<td></td>
<td><strong>Airway -</strong></td>
<td><strong>Laparotomy</strong></td>
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<td><strong>Breathing -</strong></td>
<td><strong>Consider;</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Circulation -</strong></td>
<td><strong>B-Lynch suture</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Resuscitate</strong></td>
<td><strong>Hysterectomy</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Ensure not obstructed</strong></td>
<td><strong>Ligation internal iliacs</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Oxygen 15 l/min</strong></td>
<td><strong>Consider help from vascular surgeon and other specialists</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Assist if required</strong></td>
<td><strong>Antepartum</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Insert 2 large bore IV cannulae.</strong></td>
<td><strong>Left lateral position</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Use mixture of Hartmann’s solution and gelotusin</strong></td>
<td><strong>Blood loss is usually underestimated.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Airway -</strong></td>
<td><strong>Possible concealed haemorrhage</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Breathing -</strong></td>
<td><strong>Consider ITU care</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Circulation -</strong></td>
<td><strong>Exclude other causes</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Resuscitate</strong></td>
<td><strong>Ensure placenta complete</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Ensure not obstructed</strong></td>
<td><strong>Suture any obvious lacerations of vagina and cervix</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Oxygen 15 l/min</strong></td>
<td><strong>Transfer to theatre</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Assist if required</strong></td>
<td><strong>Consider;</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Insert 2 large bore IV cannulae.</strong></td>
<td>• Examination under anaesthesia</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Use mixture of Hartmann’s solution and gelotusin</strong></td>
<td><strong>Intrauterine balloon</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Airway -</strong></td>
<td><strong>Interventional radiology</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Breathing -</strong></td>
<td><strong>Laparotomy</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Circulation -</strong></td>
<td><strong>Consider;</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Resuscitate</strong></td>
<td><strong>B-Lynch suture</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Ensure not obstructed</strong></td>
<td><strong>Hysterectomy</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Oxygen 15 l/min</strong></td>
<td><strong>Ligation internal iliacs</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Assist if required</strong></td>
<td><strong>Consider help from vascular surgeon and other specialists</strong></td>
</tr>
</tbody>
</table>

**Repeat ALL bloods regularly**

- HR < 100
- BP SBP > 90
- SpO₂ > 94%
- Capillary refill < 2 secs
- Conscious level alert
- Urinary catheter 0.5ml/kg/hr

**Consider arterial and central lines**

**Remember:**
- Left lateral position
- Blood loss is usually underestimated.
- Possible concealed haemorrhage
- Consider ITU care

**Cryoprecipitate is a group specific product**

**Anticipate need for blood components**
- cryoprecipitate – 20mins

**Exclude other causes**

- Ensure placenta complete
- Suture any obvious lacerations of vagina and cervix
- Transfer to theatre

**Consider:**
- Examination under anaesthesia
- Intrauterine balloon
- Interventional radiology
- Laparotomy

**Consider:**
- B-Lynch suture
- Hysterectomy
- Ligation internal iliacs

**Consider help from vascular surgeon and other specialists**
GUIDANCE ON THE LAW OF CONSENT

See the Department of Health publication ‘Reference guide to consent for examination or treatment’ and ‘Seeking consent: working with children’ for a comprehensive summary of the law on consent. Also available at www.doh.gov.uk/consent.

HELP AND ADVICE

Further help and advice on the non-blood management of Jehovah’s Witnesses may be obtained from the Hospital Liaison Committee of Jehovah’s Witnesses. They operate a 24/7 assistance arrangement. Contacts are as shown below:

John Allum
110 Brownside Road
Cambuslang
GLASGOW
G72 8AF
Tel 0141.641.6206
Mobile 07836.704774
johnallum@hlcglasgow.co.uk

John Flack
17 Croft Road
Balmore
TORRANCE
G64 4AL
Tel 01360.621865
Mobile 07775.837513
Johnflack080238@aol.com

Further advice is also available from the following two documents, copies of which are available from the Transfusion Practitioners, the Hospital Transfusion laboratories and the chair of the NHS Lanarkshire Hospital Transfusion Committee.

“Code of Practice for the Surgical Management of Jehovah Witnesses”
Royal College of Surgeons of England (2002)

“Management of Anaesthesia for Jehovah’s Witnesses”
Association of Anaesthetists of Great Britain & Ireland, (2nd edition 2005)
Appendix A

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 even if those medically responsible for my welfare and/or any other persons believe that such treatments are necessary to sustain my life.

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, intra-operative and post-operative 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 accept only the following procedures:

   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):

   ____________________________
   ____________________________
   ____________________________
   ____________________________

   ____________________________
   ____________________________
   ____________________________
   ____________________________
6. I consent to my 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  
   Telephone  
   Mobile  
   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)  

Advance Decision to Refuse Specified Medical Treatment (signed document inside)
## Appendix B

### General Consent Form Excluding Blood Transfusion

<table>
<thead>
<tr>
<th>Trust or Authority</th>
<th>Patient’s Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Other Name(s)</td>
</tr>
</tbody>
</table>
| Unit Number        | Date of Birth     | Male ☐ Female ☐

**DOCTOR—Please See Overleaf (this part to be completed by Registered Medical Practitioner)**

**Type of Operation, Investigation or Treatment**

I confirm that I have explained the operation investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/regional/sedation) proposed, to the patient or family to which my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient. I further confirm that I have emphasised my clinical judgement of the potential risks to the patient and/or person who none-the-less understood and imposed the limitation of consent expressed below.

I acknowledge that this limited consent will not be over-ridden unless revoked or modified in writing.

Signature

Date

Name of Registered Medical Practitioner

---

**Patient/Parent/Guardian—Please See Overleaf**

**I am**
- ☐ the patient / parent / guardian (delete as necessary).

**I agree (subject to the exclusions below)**
- ☐ to what is proposed, which has been explained to me by the doctor named on this form.
- ☐ to the use of the type of anaesthetic that I have been told about.
- ☐ to the use of non-blood volume expanders; pharmaceuticals that control haemorrhage and/or stimulate the production of red blood cells.

**I have told the doctor**
- ☐ that I am one of Jehovah’s Witnesses with firm religious convictions and that I have decided resolutely to obey the Bible command “keep abstaining from … blood” (Acts 15:28, 29). With full realisation of the implications of this position, and exercising my own choice, free from any external influence, I expressly WITHHOLD MY CONSENT to the transfusion of ALLOGENEIC BLOOD OR PRIMARY BLOOD COMPONENTS (RED CELLS, WHITE CELLS, PLASMA & PLATELETS), and to the use of any sample of my blood for cross-matching.
- ☐ that this limitation of consent shall remain in force and bind all those treating me unless and until I expressly revoke it in writing.
- ☐ about any additional procedures I would not wish to be carried out straightaway without my having the opportunity to consider them first.

**I understand**
- ☐ that the procedure might not be done by the doctor who has been treating me so far.
- ☐ that my express refusal of allogeneic blood or primary blood components will be regarded as absolute and will NOT be over-ridden in ANY circumstance by a purported consent of a relative or other person or body. Such refusal will be regarded as remaining in force even though I may be unconscious and/or affected by medication, stroke, or other condition rendering me incapable of expressing my wishes and consent to treatment options, and the doctor(s) treating me consider that SUCH REFUSAL MAY BE LIFE THREATENING.
- ☐ that any procedure in addition to the investigation or treatment described on this form, but with the exclusion of the transfusion of allogeneic blood or primary blood components, will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.
- ☐ that details of my treatment, and any consequences resulting, will not be disclosed to any source without my express consent or that of my instructor agent(s), unless required by law.

Signature ___________________________ Date ___________________________

Printed in Britain

Jan-02
Appendix C
Consent Form for Specific Blood Components and Procedures for Jehovah’s Witnesses

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Hosp./CHI No.</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(or affix patient label)</td>
</tr>
</tbody>
</table>

Please complete list by ticking appropriate boxes -:

<table>
<thead>
<tr>
<th>Products containing a minor blood fraction</th>
<th>Acceptable</th>
<th>Not acceptable</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cryoprecipitate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albumin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous immunoglobulin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-D immunoglobulin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other immunoglobulins e.g. tetanus</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures involving my own blood</th>
<th>Acceptable</th>
<th>Not acceptable</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell salvage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute normovolaemic haemodilution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasmapheresis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood radio-labelling</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recombinant products – not blood sourced</th>
<th>Acceptable</th>
<th>Not acceptable</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>rFVIIa (Novoseven)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erythropoietin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others e.g. FVIII</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Components/Procedures (please specify)</th>
<th>Acceptable</th>
<th>Not acceptable</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

**Patient**

I confirm that I do/do not accept the blood components & procedures as detailed above.

Signature:    Print name:    Date:

**Doctor**

Signature:    Print name:    Date:
Appendix D

CARE PLAN FOR WOMEN IN LABOUR REFUSING A BLOOD TRANSFUSION*

As referred to in the ACCO News (October 2000) and the NOCT course annual 2000 of the Royal College of Obstetricians & Gynaecologists

This document has been prepared as an aid to medical staff and midwives who are managing a Jehovah’s Witness or other patient who refuse a blood transfusion and is a tool for use in the event of, or experienced, postpartum haemorrhage. We urge clinicians to plan in advance of blood loss, which includes correction of anaemia in advance. Management of postpartum anaemia, second patient blood, initiated now. This should be discussed with the patient in keeping with her wishes to avoid blood or blood products, if possible. Readiness to act promptly to prevent or stop bleeding is paramount.

- Consider booking high-risk patients into a unit with facilities such as ultrasound scanning, analgesia, and surgical expertise.
- Please ensure that the consultant obstetrician and anaesthetist are aware of Jehovah’s Witness has been admitted in labour.
- All such patients should have the third stage of labour actively managed with oxytocic drugs together with early cord clamping and controlled cord traction after placental separation. Do not leave the patient alone for the first hour after delivery.

Risk factors predisposing to postpartum haemorrhage (PPH):

If the patient has any of the risk factors below, an IV infusion of oxytocin (Sustacvim) should be considered after delivery of the baby.

- Previous history of bleeding, cure or postpartum haemorrhage
- Prolonged labour (especially when augmented with oxytocin)
- Abnormal placenta
- Large baby (>3.5 kg) and/or polyhydramnios
- Increased maternal age (>40 yrs)
- Fibroids/myomectomy scars
- More than 3 children
- Maternal obesity
- Multiple pregnancy

Management of active haemorrhage:

First steps: Involve obstetric, anaesthetic and haematology consultants. Establish IV access and infusion e.g. Gelofusine. Give oxytocic drugs first, then exclude retained products of conception or trauma (this could save lives). Proceed with manual uterine compression. Give oxygen. Catherise and monitor urine output. Consider CVP line. Aortic compression against the spine, using a fat just above the umbilicus, may buy time in an emergency. Slow but persistent blood loss requires action. Anticipate coagulation problems. Keep patient fully informed. Proceed with following strategies if bleeding continues:

- Ergometrine with oxytocin (Systostrin) marginally more effective than oxytocin alone. If patient is hypertensive, use oxytocin 10U (not 5U) by slow IV injection (to help), beware of the higher dose outweighs the risks.
- Carboprost (Hemabate) 250mcg/ml IV can be repeated at 15 min. This intra-amniotic injection is faster (less hazards at open operation). If not available use 1 or 2 Geninoprost pessaries in the uterus.
- Oral misoprostol (Cycotec 200mcg tablets) 600mcg (3 tablets, prostaglandin E analogue), use when unresponsive to oxytocin and ergometrine. Intravenous misoprostol 800mcg (4 tablets), has been successfully used when refractory to oxytocin, ergometrine and also to carboprost. Rectal misoprostol 600 or 1000mcg (5 tablets) rapid absoprtion and control of haemorrhage reported when unresponsive to oxytocin and ergometrine, avoids problems associated with oral administration. Misoprostol does not cause hypertension.
- Recombinant factor VIIa (NovoSeven) 50mcg/kg, provides the specific fibrinogen generation. Increasingly used to successfully treat uncontrolled haemorrhage, for example: in placenta accreta/persysis, ruptured uterus, uterine artery and HELLP syndrome. (In 741 of these cases bleeding was controlled and the patients discharged from DIC despite the failure of all conventional therapies, including packing of the abdomen and hysterectomy.)
- Expert advice on the use of this drug will be available from the local Haemorrhage Co-ordinator Care Centre or Novo Nordisk 24-hour medical advice line (0845 400 3655, emergency SCP-wide delivery available). Some hospitals now hold a small stock of factor VIIa in case of emergency. Apiximias (Xarelto), 20000 U followed by 50000 U or tranexamic acid (Cyklokapron), 1gm IV tds, both are anti-fibrinolytic agents well established for controlling haemorrhage. Additionally, consider IV vitamin K.
- Intravenous bolus tannopax: Smartphone balloon of a Swan-Button-Shaped tube used to control PPH in 14 of 18 cases, including bleeding from an amniotic urinoma in 9 cases. Only 15% of women had uterine artery embolisation, balloon, iliac, or transverse pelvic or umbilical vein. Balloon, instillation with able to indicate if bleeding will stop (as measured via catherisation, but the tamponade effect, thus avoiding unnecessary surgery. Systemic uterine plexus helps in an option.
- B-Lymph brace system. Simple nature and control massive haemorrhage can be combined with intravenous balloon cather if bleeding persists. Vascular prophylactic orintation of the nature has been used in high risk caesarean sections.
- Embolisation of internal iliac arteries, or embolisation/bilateral balloon ligature of uterine vessels can also be considered. Edematous may be life-saving if instrumental blood loss anticipated. Check if acceptable to patient. Used at caesarean section in at least 400 reported cases, without complications of maternal fluid embolism or coagulopathy.
- A cell saver with leucocyte depletion filter together with separate suction (one for maternal fluid and one for blood salvage) minimizes maternal fluid contamination.
- Hysterectomy: subtotal hysterectomy can be just as effective, also quicker and safer. Clamp uterine arteries as early as possible.

Management of postpartum anaemia:

- For severe anaemia give oxygen and use recombinant human erythropoietin (EPO, Neorecormon or Expan) 300 UI/kg (not 50 UI) x 3 weekly subcutaneously IV until recovery. Or 1000mcg/kg IV weekly subcutaneously IV until recovery. Arginine with iron, vitamin B12 and folate acid.
- Iron supplementation essential with EPO. Iron is too slow and unreliable. Use IV iron sucrose (Velosef) by deep infusion or slow IV bolus (200mcg x 3 weekly).
- This drug has strong association with anaphylaxis. Optimum dose of iron hemoglobin solution: When anaphylaxis to iron, slow iron can be administered in slow infusion from deficiency. The addition of EPO which does not cross the placenta and is reportedly more effective in prevention of anaemia in maternal anaemia is evidently effective.
- Consider early hysterectomy in the ICU. Use microsurgical techniques (such as HaemoCore haemostatic analyser).
- Hyperbaric oxygen therapy is an option in life-threatening anaemia due to PPH with 0151 648 8800 (24-hours) for available centres.

This document reflects current clinical and scientific knowledge but is subject to change. The strategies are not intended as an exclusive guide to treatment. Good clinical judgement, taking into account individual circumstances, may require adjustments.

*Refereed by committee on obstetrics and gynaecology, anaesthetics and haematology (including experts in haemorrhage).

Hospital Information Services for Jehovah’s Witnesses: 020 896 2111 (24-hours); hib@wfb.org.uk. (PDF copyright)
References


Recommendation to Mothers: You have two copies of this document, one of which should be placed in your obstetric notes (usually a toiler in which your nuneatol wuoripre hoek are kept). It should be discussed with the moseroter cliniarnet at the meesernal visit. The other copy should be presented to the obsteric on admission to the maternity/laurely ward for delivery of the baby.