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Guideline for the Care of Women who refuse blood transfusion During Pregnancy, Labour and Postpartum

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Guidelines Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person

Equality Impact Assessment Statement

This Procedure has been subject to a full equality assessment and no impact has been identified.

Related Guidelines (CTUHB General)

- Blood Transfusion Policy
- Blood Transfusion Procedure for Prince Charles Hospital, Ysbyty Cwm Cynon, and the Merthyr Tydfil and Cynon Locality
- Blood Transfusion Policy for Royal Glamorgan Hospital, Ysbyty Cwm Rhondda and Y Bwthyn
- Consent Policy

Related Guidelines (Maternity)

- Antenatal Care
- Antepartum haemorrhage
- Postpartum Haemorrhage
- Maternal Death

Contents

Purpose

The purpose of this guideline is to provide advice to health professionals caring for women who refuse blood transfusion. It is for guidance only in relation to the wishes of the woman and planning for birth. It is not intended to be used as a guide for care management or blood product usage in an emergency situation. For this information, please access the relevant guidelines.

Background

most women who refuse blood transfusion are Jehovah's Witnesses who do so because of religious conviction. Jehovah's Witnesses believe that blood transfusion is forbidden by Biblical passages such as: 'Only flesh with its soul-its blood-you must not eat' (Genesis 9:3,4); '[You must] pour its blood out and cover it with dust' (Leviticus 17:13, 14); and 'Abstain from ... fornication and from what is strangled and from blood.' (Acts 15 : 19-21). Whilst these verses are not stated in medical terms, Witnesses view them as ruling out transfusion of whole blood, packed red blood cells, white blood cells, plasma, and platelets. However, Witnesses' religious understanding does not *absolutely* prohibit the use of minor blood fractions, such as albumin, clotting factors, and immune globulins. For this reason, each Jehovah's Witness should have completed an Advanced Decision Document which clearly states which products they will and will not accept, as this may be different in each case. This also releases Health Professionals and their employers of responsibility for any damages that might be caused by their refusal of blood.

Refusing blood does not make Jehovah's Witnesses anti-medicine. There are many effective non-blood medical alternatives to homologous blood. For example, non-blood volume expanders are

acceptable, and re-infusion of their own blood is often permitted by many Witnesses via the use of Cell Salvage.

Massive obstetric haemorrhage is often unpredictable and can become life threatening very rapidly. In most cases blood product usage can save the woman's live and very few women refuse blood transfusion in these circumstances. If it is thought likely that a woman may do so, the management of massive haemorrhage should be considered in advance.

Booking for Maternity Care

At the booking appointment all women should be asked their religious beliefs and whether they have any objections to receiving a blood transfusion. If a woman is a Jehovah's Witness or likely to refuse blood transfusion for other reasons, this should be documented clearly in the maternal case notes.

If she asks about the risks of refusing blood transfusion, she should be given all available information. This must be done in a non-judgmental manner. She should be advised that if massive haemorrhage occurs there is an increased risk that hysterectomy will be required.
If she decides against accepting blood products in any circumstances, she should be booked for delivery in a unit which has all facilities for prompt management of haemorrhage, including hysterectomy.

The woman should be asked if she has a signed Advanced Decision Document, sometimes known as a ‘No Blood Card’. If not, she should be advised to contact her Church for advice on how to complete one

before her estimated due date. Information and support can also be found at;
http://avoidjw.org/2016/04/advance-decision-document-2016/
Women who refuse blood transfusion but are not Jehovah's Witnesses should be encouraged to use the same paperwork as a way of making their wishes clear.

Antenatal Care

The woman's blood group and antibody status should be checked in the usual way when booking bloods are taken, and the haemoglobin should be checked at the antenatal appointments at 28 and 34-36 weeks. Oral iron therapy may be considered during the pregnancy to optimise stores at the point of birth.

An ultrasound scan should be carried out to identify the placental site at the time of anomaly scan.

Blood storage should not be suggested to pregnant women, as the amounts of blood required to treat massive obstetric haemorrhage are far in excess of the amount that could be donated during pregnancy.

The woman should be offered the opportunity to discuss her care with a consultant obstetrician and consultant anaesthetist as her care will require multi-disciplinary input. This will provide an opportunity to discuss her Advance Decision Document and counsel her. The woman should be given all relevant information. She should be informed of the risks she runs by refusing transfusion/primary blood products/and the non-primary blood products and the consequences to short term and long-term health. She should be advised that if massive haemorrhage occurs, there is an increased risk that hysterectomy will be required, and that there is a risk of death.

Conversations with the woman, along with her care plan should be clearly documented in the notes.

Anti-D

Anti-D is not considered to be a primary blood component by Jehovah Witness'. It is considered to be a blood fraction and a matter for the individual's conscience. (JW.Org.uk)

Labour

A Senior Obstetrician, and anaesthetist, should be informed when a woman who will refuse blood transfusion is admitted in labour. The labour should be managed routinely. Routine PPH Risk Assessment should be carried out. If appropriate, and the woman will accept it, the use of a cell salvage system could be anticipated and organised in good time before an emergency arises. However, it should not be used for vaginal blood loss due to possible bacterial contamination.

The midwife caring for the woman should be ask if she has an Advance Decision Document and should be aware of her wishes at that time, although she has the right to change her mind.

Oxytocics for management of the third stage should be advised.

The great majority of pregnancies will end without serious haemorrhage. When the woman is discharged from hospital, she should be advised to report promptly if she has any concerns about bleeding during the puerperium.

Haemorrhage

The principle of management of haemorrhage in these cases is to act promptly. 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. The threshold for intervention should be lower than in other patients. Extra vigilance should be exercised to identify any abnormal bleeding and to detect complications, such as clotting abnormalities, as promptly as possible.

Consultants in other specialties, particularly anaesthetics and haematology, are normally involved in the treatment of massive haemorrhage. When the patient is a woman who has refused blood transfusion, the consultant anaesthetist should be informed as soon as possible after abnormal bleeding has been detected. The consultant haematologist should also be notified, even though the options for treatment may be severely limited.

The woman should be kept fully informed about what is happening. Information must be given in a non-judgmental way. If standard treatment is not controlling the bleeding, she should be advised that blood transfusion is strongly recommended. Any patient is entitled to change their mind about a previously agreed treatment plan.

The doctor must be satisfied that the woman is not being subjected to pressure from others. It is reasonable to ask the birth partner(s) to leave the room for a while so that the doctor (with a midwife or other colleague) can ask her whether she is making her decision of her own free will. Likewise, the woman may ask for the company of a relative or member of Jehovah's Witnesses church to support her as she considers her decisions.

If she maintains her refusal to accept blood or blood products, her wishes should be respected. The legal position is that any adult patient (i.e. 18 years old or over) who has the necessary mental capacity to do so is entitled to refuse treatment, even if it is likely that refusal will result in the patient's death. No other person is legally able to consent to treatment for that adult or to refuse treatment on that person's behalf. Please also see CTMUHB Consent Policy http://cthb-intranet/Docs/Clinical/General%20Clinical%20Policies%20and%20Procedures/Consent%20Policy%20-%20Final%20Version%202%20%20151015.pdf

The staff must maintain a professional attitude. They must not lose the trust of the woman or her partner as further decisions - for example, about hysterectomy – may have to be made.

Hysterectomy is normally the last resort in the treatment of obstetric haemorrhage, but with such women delay may increase the risk. The woman's life may be saved timely by hysterectomy, though even this does not guarantee success.

In the event of a significant antepartum haemorrhage, emergency delivery by caesarean section should be considered early.

In the Event of a Death

If, in spite of all care, the woman dies, her relatives require support like any other bereaved family.

It is very distressing for staff to have to watch a woman bleed to death while refusing effective treatment. Support should be promptly available for staff in these circumstances.

Please also see CTMUHB Maternal Death Guideline

References

(2016). Advanced Decision Document.
https://avoidjw.org/en/doctrine/advance-decision-document-2016/