Review

How to approach major surgery where patients refuse blood transfusion (including Jehovah's Witnesses)

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Jehovah's Witnesses do not permit the use of allogeneic blood products. An increasing number of patients are refusing blood transfusion for non-religious reasons. In addition, blood stores are decreasing, and costs are increasing. Transfusion avoidance strategies are, therefore, desirable.

Bloodless surgery refers to the co-ordinated peri-operative care of patients aiming to avoid blood transfusion, and improve patient outcomes. These principles are likely to gain popularity, and become standard practice for all patients.

This review offers a practical approach to the surgical management of Jehovah's Witnesses, and an introduction to the principles of bloodless surgery that can be applied to the management of all patients.

Key words: Bloodless surgery – Jehovah's Witness – Blood transfusion

The surgical management of a Jehovah's Witness can be challenging since their beliefs do not permit the use of allogeneic blood products.^{1,2} This, along with a generally greater awareness amongst surgeons of transfusion risks and escalating costs (around £100 per unit of red blood cells³) has resulted in a recent increase in popularity of transfusion avoidance strategies, often termed 'bloodless surgery'. These principles should not be limited to the Jehovah's Witness, but should form an integral part of everyday surgical practice. Since any surgeon may encounter this scenario, the aim of this article is to summarise the key concepts of bloodless surgery and to offer a practical guide on how to approach such cases.

Jehovah's Witnesses

Background

Jehovah's Witnesses have been active in Britain since the 1880s and they now report a membership in England, Scotland and Wales of 125,000. Worldwide membership now exceeds 6.3 million with numbers having doubled since the mid 1980s. Hence the development of appropriate management strategies for Witness patients is increasingly important. Beliefs regarding blood products originate from distinctive interpretations of specific passages from the Bible.¹

You must not eat the flesh with the life, which is the blood still in it

Genesis Ch.9 v.4 (*New English Bible*)

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You are to abstain from ... blood

Acts Ch.15 v.29 (*New English Bible*)

The refusal of blood products is a core value of the faith,^{1,2} and transfusion without consent would be regarded by members as a gross physical violation.

What is acceptable?

As a rule, Jehovah's Witnesses will accept most medical treatments, surgical procedures and administration of fluids such as crystalloids, colloids and starch.⁴ The treatments that are viewed as unacceptable are the transfusion of whole blood, packed red cells, platelets, white cells or plasma.⁵ However, derivatives of these are viewed as a matter of individual choice, for example products such as albumin, immunoglobulin, vaccines and clotting factors.⁶ When referring to the use of such 'fractions' of blood components, Jehovah's Witnesses are encouraged to reach their own conscientious decisions. Similarly, organ transplantation (and donation) is viewed as a matter of individual choice.⁵ Predonation of blood for the purposes of later autotransfusion (pre-deposit) is unacceptable,⁷ although many Jehovah's Witnesses will accept peri- and postoperative autologous procedures based on a personal decision, especially when the removal and transfusion of blood can be managed via a continuous circuit such as heart bypass, acute normovolaemic haemodilution, dialysis or cell salvage machines.^{8,9}

In recent years, some Witness patients have accepted the use of haemoglobin-based oxygen carriers without offending either conscience or community,¹⁰ although many Jehovah's Witnesses may refuse such novel medications. Therefore, each patient's individual needs, values and beliefs must be assessed, acknowledged and respected. Specific treatments should be carefully discussed with the patient and family in order to clarify exactly what is acceptable. This may require a multidisciplinary approach, with medical and nursing staff as well as local representatives from the Jehovah's Witness hospital liaison committee, who can be of great assistance.

Legal considerations

A decision to refuse medical treatment from an informed, competent, adult patient must be respected by the medical practitioner, whether the reasons for such refusal are 'rational, irrational, unknown or even non-existent'.¹¹ The refusal of blood products may conflict with medical responsibilities for preserving life. In elective surgery this should rarely be an issue, providing decisions have been made clearly in advance (Table 1). However, a difficult situation would be the management of an unconscious Jehovah's Witness patient with severe haemorrhage. In

Table 1 *Approaching surgery in Jehovah's Witnesses*

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- Involve hospital liaison committee
 - Clarify what is acceptable
 - Scrutinise the Advance Directive
 - Informed consent with contingency planning
 - Plan for principles of bloodless surgery
-

these circumstances, the doctor should search for clear evidence, such as an Advance Directive, stating that the patient would not accept blood products, even with life-threatening bleeding. In the absence of such evidence, the doctor should act in what he or she sees as the best interests of the patient with or without the use of blood.⁸ For children of Jehovah's Witnesses, legal precedent supports life-saving transfusion against parents' wishes, but two doctors of consultant status should clearly document the reasons for transfusion.⁸ In less urgent cases, the matter may be referred to the courts.⁹

Advance Directive

Many Jehovah's Witnesses will have given prior consideration to the use of blood products, and should produce a detailed Health Care Advance Directive. This is a document stating the patient's wishes regarding the use of blood products or in relation to any other treatment and a copy may have been given to the GP. The wishes outlined in an Advance Directive must be respected, but doctors should scrutinise the form in detail and satisfy themselves that its content is valid and applicable in the given circumstances. The implications relevant to the case should be discussed with the patient. A copy should be kept within the hospital notes. There is no defined 'legally acceptable' format for an Advance Directive, but Jehovah's Witnesses have two standardised forms (Appendix 1, 2), the second of which is characteristically carried at all times and is designed to provide succinct directives in an emergency situation.

Consent

In the case of Jehovah's Witnesses, specific details as to which treatments would be acceptable should be clearly established and documented. The specific risks and benefits of any procedure including the added risk of blood refusal should be considered and discussed with the patient. The threshold for surgical treatment may be altered in some cases. Explanation of risks should include local complication rates, and the surgeon might need to consider giving an explanation of the risk of needing transfusion under ordinary circumstances. The UK Department of Health has produced a series of consent

Table 2 The principles of bloodless surgery

Pre-operatively	Thorough assessment and optimisation Consider improving haemopoiesis Ensure adequate planning (equipment & personnel)
Intra-operatively	Meticulous haemostasis and haemostatic aids Anaesthetic techniques Acute normovolaemic haemodilution Intra- and postoperative cell salvage
Postoperatively	Early detection of blood loss Paediatric size sampling Increase haemopoiesis Maximise respiratory function and cardiac output Sepsis prevention

forms. Appendix 3 shows an example of a locally modified DoH consent form for use with Jehovah's Witnesses.

Bloodless surgery

Background

The principles of bloodless surgery originate from the 1960s when the availability of blood for transfusion resulted in increasingly major surgery being undertaken, from which patients refusing blood were excluded.¹² The term 'bloodless surgery' refers to a series of measures in the pre-, peri- and postoperative care of patients that aim to reduce the need for allogeneic blood transfusion, and improve patient outcomes. These principles have gained popularity of late, and many centres of bloodless surgery exist in North America. This approach has gained credence, as the deleterious effects of blood transfusion become more apparent. Severe acute respiratory syndrome (SARS),¹³ West Nile virus¹⁴ and prion-related diseases¹⁵ are the latest to join human immunodeficiency virus (HIV), hepatitis B, C and others on the list of potentially transmissible diseases. Furthermore, in an attempt to reduce the risk of transmitting infection, the donor pool for blood products has been curtailed.¹⁶ The principles of bloodless surgery are summarised in Table 2.

Pre-operative measures

Patient assessment

A detailed history and thorough clinical examination are important. This will allow assessment of physiological reserve and, therefore, ability to withstand hypovolaemia. Pre-existing cardiac or respiratory disease should be optimised prior to surgery. The patient should also be questioned about bleeding disorders, and medication that

may increase blood loss (e.g. NSAIDs, steroids) should be reviewed, and preferably stopped. Coagulation defects should be corrected.

Improve haemopoiesis

Pre-operative anaemia requires appropriate investigation, with suitable supplementation of iron, folate and vitamin B₁₂. Even in the absence of anaemia, Epoetin (human recombinant erythropoietin) can be used to improve red cell mass.^{9,17} Patient response to Epoetin is variable, but the manufacturers of Epoetin-beta (Roche, UK) offer a service to predict the response to Epoetin in each individual patient. Haematology expertise is usually required, as this treatment needs careful dose calculation and adequate iron supplementation, often by the intravenous route.¹⁸

Planning

Bloodless surgery requires a co-ordinated multidisciplinary approach. Senior surgical, anaesthetic and theatre staff should discuss cases in advance, and the skill mix and number of support staff may need to be modified to facilitate blood conservation strategies (e.g. cell salvage). The surgeon should ensure that the appropriate equipment is available.

Intra-operative measures

Surgical techniques

The surgeon will need to pay meticulous attention to haemostasis during the operation. There is a trend to the increased use of diathermy dissection during surgery. This is a safe and effective surgical tool, which can reduce blood loss.¹⁹ Other technological advances that may minimise blood loss include the harmonic scalpel. The use of local haemostatic aids such as bone wax, or absorbable cellulose or collagens may reduce unnecessary haemorrhage.¹² Also, when feasible, procedures should be performed in stages to minimise loss of a large blood volume. For example, a bilateral mastectomy could be performed in two stages. Minimally invasive techniques, which are usually associated with less blood loss, should also be considered where appropriate.

Anaesthetic techniques

The anaesthetic team can manipulate the physiological response during surgery to reduce bleeding. Controlled hypotension is a well recognised technique whereby the mean arterial pressure is maintained at a low level during surgery, to minimise intra-operative bleeding.²⁰ This carries numerous risks. A hypotensive state may result in irreversible ischaemic damage to kidneys, brain or myocardium.²¹ In addition, haemostasis performed during controlled hypotension may be inadequate when the

patient returns to a normotensive state. This could result in severe postoperative haemorrhage. Consequently, blood pressure is returned to normal prior to completing the operation.

Acute normovolaemic haemodilution (ANH)

ANH involves the removal of whole blood from the patient pre-operatively, and replacement with crystalloid or colloid fluids to maintain intravascular volume. Blood lost during surgery and in the postoperative period has a reduced haemoglobin concentration, resulting in fewer red blood cells lost. The technique relies on an adequate physiological compensation to the acute blood loss, primarily by an increase in cardiac output.²² The removed blood is available for transfusion should it be needed. Factors such as co-existing illness, response to venesection and experience of the team all influence the quantity of blood withdrawn, and no universally accepted guidelines exist. Relative contraindications to ANH include severe anaemia, ischaemic heart disease and renal failure.²² ANH may be acceptable to Jehovah's Witness patients, especially if the removed blood can be kept in a closed circuit.⁹

Autologous blood transfusion

Blood lost intra- and postoperatively can be collected and transfused back to the patient, with the use of specialist equipment. Cell salvage machines can be used during surgery and are able to collect and filter blood removed by suction and in swabs, which can then be given back to the patient.²³ Drains can also be attached to sterile collection systems to allow transfusion, a procedure most commonly seen in orthopaedic surgery. Although adverse effects of cell salvage have been reported,²⁴ these are extremely rare. Many surgeons advocate the use of cell salvage in cases of malignancy and infection as the risks are thought to be low.^{25,26} However, further research is needed to clarify the role of cell salvage in these patients. It is worth noting that some Jehovah's Witnesses may not accept blood salvaged from used swabs, because this involves a temporary interruption in the blood 'circuit'.

Postoperative measures

Reducing blood loss (early detection)

The surgical team should remain vigilant to the possibility of reactionary or secondary haemorrhage. Continued bleeding should be aggressively managed by postoperative blood salvage, or surgical intervention to stop haemorrhage. Prolonged hypertension should be avoided in the postoperative period. Postoperative blood tests should be rationalised and samples sent in paediatric or adult micro-sample tubes (Becton, Dickinson and Company, NJ, USA).

Increase haemopoiesis

Anaemia should be adequately treated prior to surgery. However, significant intra-operative blood loss may require specific measures to increase red blood cell production. Iron, vitamin B₁₂ and folate should be adequately supplemented, and recombinant erythropoietin can be used if necessary.^{12,27} In some cases, poor nutrition may result in impaired red cell production.¹² Nutritional supplementation should, therefore, be offered at an early stage in appropriate patients.

Increase oxygen delivery

Postoperative patients may have impaired oxygen delivery via a number of mechanisms. Respiratory function should be optimised, involving routine breathing exercises and supplemental oxygen therapy for all patients and more aggressive chest physiotherapy for high-risk patients. The surgical team should be alert to the risk of postoperative respiratory complications, and ensure appropriate patient monitoring or escalation of treatment as required. A multidisciplinary approach is often required, including physiotherapists, nursing staff, respiratory physicians and critical care staff.

Intravascular volume should be monitored and adequately maintained. This, along with thorough pre-operative cardiac assessment will help to maximise cardiac output and, therefore, oxygen delivery. The use of hyperbaric oxygen has been described,²⁸ but has a very limited role in routine postoperative patient care.

Reduce oxygen consumption and sepsis prevention

The physiological responses to infection and pain may result in an increased metabolic rate, and consequently higher oxygen consumption. Analgesia should be optimised, and appropriate prophylactic measures against infection should be used. Epidural analgesia usually provides excellent pain relief, and may also reduce postoperative respiratory complications.^{29,30} In experienced hands, sedation or paralysis and ventilation may also be used to control oxygen consumption.

Conclusions

The refusal of blood products by patients has led to greater awareness of blood conservation strategies, such as those described in this article. Adherence to these principles may help to reduce blood loss and the need for transfusion, although some techniques carry risks that should be considered when planning patient management. Many of these principles should be applied to the management of all surgical patients, since Jehovah's Witnesses are not the only group of patients that refuse blood products. Increased awareness of the risks of transfusion, including communicable diseases such as HIV has resulted in

greater numbers of patients not accepting blood for non-religious reasons. The surgical team should, therefore, be familiar with the risks of blood transfusion, and be prepared to communicate these to the patient.

There may be considerable variation in individual thresholds for requesting and administering cross-matched blood among medical professionals. Transfusion 'triggers' should, therefore, be agreed for individual patients to reduce the risk of unnecessary transfusion. It may be appropriate to have local audit information on transfusion needs for major operations, and discuss this with the patient as part of informed consent.

Implementing the principles of bloodless surgery requires a co-ordinated team approach, across all phases of peri-operative care. Already standard in many centres across the world, these principles are likely to become increasingly prevalent in UK surgical practice.

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To follow

Appendix 1

Health Care Advance Directive

Appendix 2

Advance Medical Directive/Release

Appendix 3

Consent form

HEALTH-CARE ADVANCE DIRECTIVE

- (1) I, _____, Print your full name
- born the _____ th day of _____, 19 _____, am of sound mind and I voluntarily make this Health-Care Advance Directive. This document revokes any prior health-care advance directive and shall take effect upon my incapacity. It will remain in force unless and until specifically revoked in writing by me.
- (2) I am one of Jehovah's Witnesses. On the basis of my firmly held religious convictions (founded on Bible directions such as at Acts 15:28, 29) and on the basis of my desire to avoid the numerous hazards and complications of blood transfusions, **I absolutely REFUSE allogeneic blood** (another person's blood); **the primary blood components red cells, white cells, platelets and/or plasma; and stored (predonated) autologous blood** (my own stored blood) **under any and all circumstances, no matter what the consequences. I also refuse to predonate any of my blood for storage and later reinfusion into me or anyone else.**
- (3) The refusal in clause (2) above is not to be overridden by a purported consent of a spouse, relative or other person or body.¹
- (4) **I request and will accept alternative non-blood medical management** to build up or conserve my own blood, to avoid or minimise blood loss, to replace lost circulatory volume, or to stop bleeding. Hence such volume expanders as dextran, saline solution, Ringer's solution modified fluid gelatin, hetastarch, and perflurochemicals; and oral or parenteral iron would be acceptable to me.
- (5) Medical products: [Initial one of the three choices below.]
- _____ (a) I refuse all fractions derived from any primary component of blood.
- _____ (b) I accept all fractions derived from any primary component of blood.
- _____ (c) I want to qualify either (5a) or (5b) above and my instructions are as follows:
- _____
- _____
- (6) Medical procedures involving my own blood that do not involve storage of my blood for later infusion into me or someone else: [Initial one of the three choices(s) below.]
- _____ (a) I refuse any procedure involving the use of my blood during an operation or ongoing treatment.
- _____ (b) I accept any procedure involving the use of my blood during an operation or ongoing treatment.
- _____ (c) I accept only the following procedures involving my blood:
- _____
- _____
- (7) With respect **to end-of-life decisions, I CHOOSE:** [Initial one of the three choices below.] (As to pregnancy see (9) overleaf.)
- _____ (a) **NOT TO PROLONG LIFE.** That is, if to a *reasonable degree of medical certainty* my condition is *considered hopeless*. (For example, if to a reasonable degree of medical certainty I have an incurable and irreversible condition that will result in my death within a relatively short time, or if I am unconscious and to a reasonable degree of medical certainty will not regain consciousness, or if I have brain damage or a brain disease that makes me unable to recognise people or communicate and to a reasonable degree of medical certainty my condition will not improve.) In such situations, I refuse

continued overleaf . . .

mechanical respiration (ventilation), cardiopulmonary resuscitation (CPR), tube feeding (artificial nutrition or hydration), etc., but I accept basic palliative care—treatment for comfort.

_____ (b) **TO PROLONG LIFE.** That is, I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards but subject to my absolute refusal of blood and those blood components described herein, although I realise this means that I might be kept alive on machines for years in a hopeless condition.

_____ (c) **OTHER.** [If you do not completely agree with either (a) or (b) above, initial here and write your own end-of-life instructions in the space provided.] _____

(8) Other instructions: [Write any other health-care instructions here.] _____

(9) _____ [This clause applies only to women of child-bearing age.] If I am pregnant, and there is a reasonable chance that my unborn child could survive, I want my life to be prolonged for the sake of my unborn child. This is subject to the refusal of blood for myself and my unborn child as set out above. After any efforts to save my unborn child I direct that my doctors manage my care in harmony with the instructions in (7) and (8) above.ⁱⁱ

(initial)

(10) If my health-care providers will not or cannot undertake a surgical operation, or administer any other form of medical treatment, without the use of blood or any blood products specifically prohibited by myself in this document, I direct my health-care providers to co-operate fully with the appointed representative(s) of the local Hospital Liaison Committee for Jehovah's Witnesses in discussing treatment options. Thereafter if a transfer is subsequently deemed necessary I direct that all my medical records, including a copy of this document, be transferred promptly to the other health-care provider to ensure that my health-care instructions herein will be respected.

(11) A copy of this document shall be as valid as the original. I ask that a copy of this document be made part of my permanent medical record. I have provided a copy of this document to my registered general practitioner.

(12) The provisions of this entire document are separable, so that the invalidity of one or more provisions shall not affect any others.

(13) **MY DECISION to refuse blood and choose non-blood management MUST BE RESPECTED EVEN IF MY LIFE OR HEALTH IS THREATENED by my refusal. Any attempt to administer blood contrary to my instructions will be a violation of my rights of bodily self-determination and personal autonomy, and accordingly will constitute an actionable trespass to my person.**^{iii iv v vi}

- (15) SIGNED: _____
Your signature Date

Address

- Signature of Witness 1

Signature of Witness 2 _____

Print Name _____

Print Name _____

Occupation or Profession

Occupation or Profession

Home Address

Home Address

Home Telephone

Home Telephone

Work Telephone

Work Telephone

vii *re C* [1994] 1 FLR 31.

Appendix 2

ADVANCE MEDICAL DIRECTIVE/RELEASE

I the undersigned
born the _____ day of _____ 19____, being one of
Jehovah's Witnesses with firm religious convictions have resolutely
decided to obey the Bible command "Keep abstaining . . . from
blood" (Acts 15:28,29). With full realisation of the implications of
this position I HEREBY:

1. **CONSENT** (subject to the *exclusion of the transfusing of blood or primary blood components*) to all such necessary emergency treatment including general anaesthesia and surgery as the doctors treating me may in their professional judgement deem appropriate to maintain life. I will accept non-blood volume expanders.

2. **DIRECT** (a) that such consent is temporary and only effective until such time as I am conscious and sufficiently capable of discussing further proposed treatment and giving informed consent;

(b) that such consent and any subsequent consent that I may give **EXCLUDES the transfusion of blood or primary blood components** (red cells, white cells, plasma or platelets);

(c) that my express refusal of blood is absolute and is not to be overridden in ANY circumstances by a purported consent of a relative or other person. Such refusal remains 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;

and (d) that this Advance Directive shall remain in force and bind all those treating me unless and until I expressly revoke it in writing.

3. **ACCEPT** full legal responsibility for this decision and **RELEASE** all those treating me from any liability for any consequences resulting from such exclusion.

Dated the _____ day of _____ 20____

Signed: _____

Witnesses to Signature:

Signature: _____ Relationship: _____

Signature: _____ Relationship: _____

md-E Bi 3/99

Printed in Britain

Appendix 3

Gloucestershire Hospitals
NHS Trust

Gloucestershire Hospitals NHS Trust

Consent Form 5:

Patients (to include Jehovah's Witnesses) refusing the use of blood transfusion or blood components,

This consent form **excludes** the transfusion of allogeneic blood, the primary blood components (red cells, white cells, platelets and/or plasma) and stored (predonated) autologous blood but does **include** the administration of **non-blood** volume expanders such as saline, dextran, Haemaccel, Ringers Lactate, Gelofusine and other crystalloids or colloids. All further references to 'blood, blood transfusion or blood components' are to be understood as defined above.

The competent patient's express refusal of all blood and blood components is absolute and cannot be overridden by any other person, relative, health professional or court order. Such refusal remains irrevocably in force even though the patient may be affected by medication, unconscious or in a life-threatening situation.

The **patient must be aware** of all the implications that a refusal of blood transfusion or blood components may have because **such refusal may be life threatening**.

Patient Details / PAS Label:

Surname

Forenames

Date of Birth Hospital Number

☐ Male

☐ Female

Responsible health professional
(Usually Consultant)

Special Requirements
(e.g. other language / other communication method)

References: Policy for the Treatment of Jehovah's Witnesses, Policy for the Care of Children whose Parents are Jehovah's Witnesses and Treatment of Obstetric Haemorrhage in Women who Refuse Blood Transfusions – March 2003.

To be retained in patient's notes

Name of Proposed procedure or course of treatment (include brief explanation if medical terms not clear)

.....

Statement of health professional (to be filled in by a health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained to the procedure to the patient. In particular, I have explained:

The intended benefits

Serious or frequently occurring risks

I have explained and emphasised my clinical opinion of the potential risk of **refusing blood or blood components**, which may be found necessary during the course of the operation or treatment. I have explained that such **refusal may be life threatening**. I acknowledge the **patients right to refuse blood** or blood components and agree that treatment of this patient **will not** include the transfusion of blood or blood products under any circumstance.

I have also discussed what the procedure is likely to involve, the benefits and risks of any alternative treatments (including no treatment) and any particular concerns of this patient.

☐ The following information has been provided

This procedure may involve:

☐ General and / or regional anaesthesia ☐ local anaesthesia ☐ sedation

which will be further discussed by your anaesthetist.

Signed..... Date.....

Name (print)..... Job Title.....

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed..... Date.....

Name (print).....

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should have already seen page 2, which describes the benefits and risks of the proposed treatment. If you have any further questions do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

As a **Jehovah's Witness** (delete if not appropriate) I adamantly **refuse the transfusion of** allogeneic **blood**, the primary blood components (red cells, white cells, platelets and/or plasma) and stored (predonated) autologous blood under any circumstance **even though those treating me may consider that such refusal may be life threatening.**

In signing this consent form you are accepting full legal responsibility for your decision to refuse blood and blood components and release all those treating you from any liability for any adverse consequences directly arising from their management options being curtailed by the exclusion of blood or blood components.

I have been told about significant foreseeable procedures, which may become necessary during my treatment. I have listed below any procedures, which I do not wish to be carried out without further discussion

Patient's signature Date.....

Name (print)

Confirmation of Consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed Date.....

Name (print) Job title

☐ See also living will / advance medical directive / Health Care Advance Directive.

Important Notes: (tick if applicable)

☐ Patient has withdrawn consent (ask patient to sign/date here)

To be retained in patient's notes.

Produced: 15/05/02
Review Date: 01 / 03 / 04