SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Title: **Obstetric Care for Women Refusing Blood Products**	**Policy**

PURPOSE:

Patients may refuse blood transfusions based on personal, cultural, or religious reasons; an advance directive completed and signed by the patient, documenting refusal of blood transfusion, is indicated. The directive must make clear which transfusion alternatives are acceptable to the patient, as well as the potential for adverse outcomes (i.e. organ injury or death) as a consequence of transfusion refusal. Research has shown that pregnant women who refuse blood transfusion are at a 44-fold increased risk of overall maternal morbidity, a 130-fold increased risk of morbidity due to hemorrhage, and a 6-fold increased risk of maternal death. Therefore, appropriate pre-delivery planning for obstetric and gynecologic patients refusing blood transfusion can potentially decrease severe morbidity or mortality.

Guidelines Specific to Patients of Jehovah's Witness (JW) Faith

According to Jehovah's Witnesses, allogeneic blood and blood components defile the body; thus transfusion is forbidden. Many JW believers would rather die than receive blood or primary blood components. Whole blood, red blood cells, white blood cells, platelets and unfractionated plasma are forbidden. Continuous circuit blood management techniques and "derivatives of a blood fraction" are considered matters of conscience by the Church Council and need delineation when counseling a JW patient. Plasma proteins are recognized by JWs as passing through the placental barrier from the mother to the fetus while primary blood components do not. Just as meat and its juices (which contain plasma proteins) are acceptable to JWs for consumption, protein "fractions" may be accepted by the JW patient for infusion. In general, 'fractions' refer to protein products derived from plasma such as cryoprecipitate, cryo-poor plasma (referred to as 'cryo-supernatant' by JW Church) pooled clotting factors, albumin, RhoGam, globulins, thrombin products, etc. Procedures such as intraoperative hemodilution and cell salvage are generally accepted as long as the blood travels in a continuous circuit without becoming disconnected. Autologous pre-donation is typically refused by JW patients because it requires removal and remote storage of the blood.

PROCEDURES

1. Antepartum Care Coordination

a. Identify that patient will not accept blood products early in care and document in the problem list

b. Provider should review UNM Blood Transfusion Refusal Procedure (Appendix A)

c. If patient is seen primarily by the Midwifery service, arrange a onetime antepartum consult visit with an OB provider for counseling on blood product refusal.

d. If patient is seen primarily by a general family medicine provider, arrange a onetime antepartum consult visit with the MCH consultant or OB provider for counseling on blood product refusal.

e. If patient is considered high risk of bleeding refer to pre-op anesthesia clinic. Use the "OB pre-op anesthesia consult request" under Ad Hoc Consult Forms to place the request. (Refer to UNM OB Hemorrhage Care SOP for hemorrhage risk stratification.)

f. Review the patient's advance directive if available. Encourage the patient to obtain education/information through her religious leaders.

g. Document the patient's desires and load advance directive and refusal of blood product consent (Appendix B) into EMR. Consent should be scanned into EMR and one copy should be given to the patient.

h. Take steps to minimize risk of peri-partum hemorrhage such as encouraging avoidance of excessive weight gain that may lead to macrosomia, gestational hypertension, or macrosomia.

i. Summary: Antepartum checklist:

    i. Update problem list: refuses blood products

    ii. Refer to OB Physician or MCH Consultant for one time consult on blood product refusal

    iii. Have patient sign UNM Refusal of Blood Product Consent (Appendix B).

    iv. Review and have patient complete advance directive

2. Antepartum Optimization

    a. Optimize hematocrit prior to labor

        i. Consider prescription of high dose iron supplementation, folate, Vit B12, or EPO

        ii. Consider recombinant erythropoietin or IV Iron if a rapid increase in red blood cell is needed. Recombinant erythropoietin can show benefit within 3 days, and increase blood volumes the equivalent of 1 unit of blood in 7 days and 5 units of blood in 28 days. If considering these options, consult Pathology/Blood Bank and Hematology.

        iii. Encourage protein intake

        iv. Minimize any unnecessary phlebotomy or laboratory testing, consider pediatric collection tubes

        v. Consider stopping anticoagulation or transition to heparin as can this can be reversed

1) Intrapartum Care Coordination (Admission to L&D)

    a. On admission to labor and delivery, every parturient should affirm plans to accept or decline blood products and this should be documented in admission H&P.

    b. Primary team should confirm/complete “Refusal of Blood Transfusion” Consent (Appendix B)

        i. Discussion should include increased risk of hysterectomy, ICU admission, and death if blood products are refused

        ii. The patient should also be informed that if she changes her mind, we will be willing to provide blood products in an emergent situation and we will abide by all patient privacy laws and not discuss accepting blood products in front of her family or clergy without her consent.

c. Notify Anesthesia team & obtain consult on patients identified as refusing blood products

    i. Anesthesia Resident or Attending will consent the patient using Blood Product Definitions Form (Appendix C) and Blood Product and Technique Acceptance Form (Appendix D) and complete note in record documenting what products patient will accept

    ii. Informed consent should be completed with the physician, patient, and official witness only

d. Notify OB Resident, OB Attending, MCH consultant, and Charge RN of patient's blood refusal status

e. Update Tracking Board with Blood Refusal Status

f. Consider consultation with The Hospital Liaison Committee for Jehovah's Witnesses of Albuquerque/Santa Fe, New Mexico 24 hours a day which can be contacted through the Physicians' Access Line (PALS)

g. Summary: Intrapartum Care Coordination checklist:

    i. Affirm Patient's plan to accept or decline blood products

    ii. Confirm Completion of "Refusal of Blood Transfusion" Consent

    iii. Place Anesthesia Consult

    iv. Anesthesia Team to fill out "Blood Product and Technique Acceptance Form"

    v. Notify OB Team and Charge RN

    vi. Notify MCH consultant if on MCH service

    vii. Update tracking board

3. Intrapartum Medical Optimization/Management

    a. Minimize any unnecessary phlebotomy or laboratory testing, consider pediatric collection tubes

b. Identify and address promptly developments that increase risk of peripartum hemorrhage such as dysfunctional labor, infectious complications and prolonged inductions. Have active management of the third stage of labor

c. Cesarean delivery or any operative procedure:

   i. Utilize good surgical principals to minimize tissue trauma and blood loss. Maintain hemostasis by addressing any bleeding areas as soon as possible.

   ii. Administer Tranexamic Acid- 1G IV load over 10 minutes

   iii. Identify and address promptly developments that increase the risk of intraoperative bleeding such as anticoagulation, liver disease, poor hematocrit, infection, and significant adhesive disease

   iv. Work closely with anesthesia/nursing to optimize fluid resuscitation and communicate effectively throughout case/delivery regarding ongoing blood loss

   v. Utilize Cell Saver Technology- ACOG supports the use of cell saver technology in Obstetrics despite the theoretical risk of amniotic fluid embolism

   vi. Aggressively manage hemorrhage with fluid resuscitation, medications, surgical intervention, monitoring of vital signs, and maternal status. Consider a lower threshold for hysterectomy.

4. Post-Partum Management

   a. Debrief with all delivery and OR staff regarding communication, management, and outcomes

   b. Readdress maternal blood refusal with Pediatrics team during report, as this may influence pediatric care and potentially require a court order to provide neonate with blood products if indicated.

5. Required Documentation

   a. Refusal of Blood Transfusion Consent (Appendix B)

b. Blood Product and Technique Acceptance Form (Appendix D)

c. Advanced Directives (Form provided by the patient from her church- this is not an UNM official document. Sometimes this is scanned in to the patient's electronic medical record under "Urgent Clinical Documents")

d. Power of Attorney (Typically included within the Advanced Directive documentation; clearly defines who the patient wishes to make medical decisions on her behalf if incapacitated). Power of attorney has the authority to overturn decisions about blood products if the patient is unable to respond.

CONSULTATION: Twenty-Four hour consultation is available by calling the Maternal Fetal Medicine service at the University of New Mexico Hospital, 1-888-866-7257.

REFERENCES

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APPROVAL

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Chair, Department of Obstetrics & Gynecology Date

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