# Guidance and Advance Directive for the Treatment of Patients who decline Transfusion of Blood or Blood Products

**Reference Number:**

NHSCT/09/203

**Responsible Directorate:**

Planning, Performance Management & Support Services

**Replaces (if appropriate):**

United Hospitals HSS Trust  Guidance and Advance Directive for Patients who decline Transfusion of Blood and Blood Products – Ref: UHT/HV/02

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Transfusion Committee

**Type of document:**

Corporate Policy

**Approved by:**

Policy, Standards and Guidelines Committee

**Date Approved:**

7 July 2009

**Date Policy disseminated by Equality Unit:**

28 September 2009

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**NHSCT MISSION STATEMENT**

To provide for all the quality of services we would expect for our families and ourselves
Policy Title: **Guidance and Advance Directive for the Treatment of Patients who decline Transfusion of Blood or Blood Products**

Review date: This policy will be reviewed two years after the effective date

Lead Author: Aine McCartney – Haemovigilance Practitioner
(On behalf of Northern Trust Transfusion Committee)

**EQUALITY AND HUMAN RIGHTS STATEMENT:** Northern HSC Trust Trust’s equality and human rights statutory obligations have been considered during the development of this policy.
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Introduction

Any competent adult is entitled to accept surgery but also to exclude specifically certain aspects
of management such as the administration of a blood transfusion. Recommendations from the
Department of Health in respect of consent forms provide for the inclusion of a box for the patient
to complete and this may contain specific exclusions from the consent. This Advance Directive
supplements the Department of Health, Social Services and Public Safety Form 1 “CONSENT
FOR EXAMINATION, TREATMENT OR CARE” and it does not replace a current Jehovah’s
Witness’s “No Blood Health-Care Advance Directive” or card.

To administer blood to a patient who has steadfastly refused to accept it either by the provision
of an advance directive or by it’s exclusion in a consent form is unlawful, ethically unacceptable
and may lead to criminal and/or civil proceedings.

It is now a requirement of the DOH Better Blood 2 circular, (2003), that all persons who may
need a transfusion are informed of the need/possibility and reason for the transfusion. They
must also be informed of the risks, benefits, alternatives and their right to refuse. One alternative
is autologous transfusion, e.g., predonation of their own blood which may be used in the
procedure. (See Appendix 4 for the Trust requirements and procedure for autologous
transfusion).

In general most Jehovah’s Witness’s will not accept a transfusion of whole blood or its major
derivatives. This includes fresh frozen plasma (FFP), packed cells, white blood cells and
platelets. Absolute rules regarding blood products, however, do not exist and some Witnesses
may accept the use of plasma protein fractions, albumin, immunoglobulin and haemophilic
preparations with each Witness deciding individually whether to accept these. A competent adult
patient’s decision to consent to refuse the transfusion of individual blood products or alternate
measures such as Cell Salvage must be documented in the patient’s notes and held confidential.
The Advance Directive (see page 7) has been designed for this purpose for use in United
Hospitals HSS Trust.
Clinical Management of Patient who declines transfusion of blood or blood products

Anaesthetists have the right to refuse to anaesthetise an individual in an elective situation but should attempt to refer the case to a suitably qualified colleague prepared to undertake it. The Working Party for The Association of Anaesthetists of Great Britain and Ireland suggests that departments of anaesthesia carry out their own internal enquiries and have a list of anaesthetists willing to manage such patients. The surgeon should be informed as soon as possible if any difficulty ensues. In an emergency, the anaesthetist is obliged to provide care and must respect the patients competently expressed views.

The introduction of an early warning system for the delivery of a child to a Jehovah’s Witness mother can also be beneficial so that appropriate staff is available. This arrangement should apply to booking of delivery dates by both obstetricians and midwives. (See Appendix 1 for Trust procedures involving gynae/obstetric patients)

Full pre-operative investigations and consultations with the patient should take place as early as possible, in order to ascertain the degree of limitation on intra-operative management and introduce the Advance Directorate form.

At the pre-operative visit it is important to take the opportunity to see the patient without relatives or members of the local community who may influence and impede full and frank discussions of the acceptability of certain forms of treatment. At the patient’s request, members of the Hospital Liaison Committee for Jehovah’s Witnesses may be part of these discussions. They, and the Medical staff, may request the Trust’s Haemovigilance Practitioner to attend these discussions primarily to avoid confrontation and assist understanding on both sides.

Factors to take into account in the anaesthetic/surgical fields are:

- Pre-Operative anaemia should be investigated and treated. It may be beneficial to discuss the individual cases with a haematologist.
- Major procedures can be carried out in stages in order to limit acute blood loss and the choice of operative technique may also influence outcome: examples are performing a unilateral procedure on two separate occasions rather than bilaterally in one session.

(See appendix 3 for medical alternatives to Blood Transfusion)

(See appendix 5 for clinical strategies references for Managing Haemorrhage and anaemia without Blood Transfusion in: Critically ill Patients ICU Surgical Patients Obstetrics and Gynaecology)
**Trauma Situation involving Jehovah’s Witness Patient**
In the management of trauma or when dealing with an unconscious patient whose status as a Jehovah’s Witness may be unknown, the doctor caring for the patient will be expected to perform to the best of his ability and this may include the administration of blood transfusion. However, there may be opinions put forward by relatives or associates of the patient suggesting that the patient would not accept a blood transfusion even if that resulted in death. Such relatives must be invited to produce evidence of the patient’s status as a Jehovah’s Witness. Most Jehovah’s Witnesses carry a ‘NO BLOOD’ card. It is not uncommon for Jehovah’s Witnesses to lodge a copy of their advance directives with their General Practitioner, who should be contacted if possible.

**Children of Jehovah’s Witnesses**
The well being of the child is overriding and, if the parents refuse to give permission for blood transfusion, it may be necessary to apply for a legal ‘Specific Issue Order’ via the high court in order to legally administer the blood transfusion. (See Appendix 2 for the procedure to follow). It is important, however, before this serious step is taken, that two doctors of consultant status should make an unambiguous, clear and signed entry in the clinical record that blood transfusion is essential, or likely to become so, to save life or prevent serious permanent harm. In the event that a court order is sought, it is strongly recommended that the parents be given the opportunity to be properly represented and are kept fully informed of the practitioner’s intention to apply for the order.

In the case of children over 12 years who are capable of understanding the issues, the anaesthetists will be able to rely upon their consent.

**Children of Jehovah’s Witnesses in Trauma Situation:**
The management of a child of a Jehovah’s Witness in an emergency situation who is likely to succumb without the immediate administration of blood is viewed in law in a different light. In this situation, application to the courts will be too time consuming and the blood should be transfused without consulting the court. The courts are likely to uphold the decision of the doctors who give blood. In the instance of this happening the consultant who decides to transfuse such a child must inform the Medical Director as soon as possible.
**Statement of Healthcare Professional**

<table>
<thead>
<tr>
<th>Proposed Procedure/Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated expected blood loss: __________ml</td>
</tr>
</tbody>
</table>

*If expected blood loss > 500ml Consultant Surgeon / Physician must be involved*

- Patient informed about procedure and blood loss: YES □ NO □
- FBC and clotting checked: YES □ NO □
- Warfarin and aspirin to be stopped before procedure: YES □ NO □
- Iron supplementation if required: YES □ NO □

*If blood loss > 500ml expected:*

- **Is a suitable alternative treatment possible?** YES □ NO □
- Has this been explained to the patient: YES □ NO □
- Does the patient still wish to proceed with proposed procedure: YES □ NO □

*If the patient wishes to proceed with procedure with blood loss > 500ml expected*

- Patient referred to Anaesthetist at earliest opportunity: YES □ NO □
- Patient referred to Haematologist at earliest opportunity to consider optimisation pre-op: YES □ NO □
- Patient given consent information booklet and advised to take time to make a fully informed decision: YES □ NO □
- Patient advised of additional risk of morbidity / mortality because of refusal to accept blood products: YES □ NO □

**Estimated danger to life for the above procedure if transfusion refused by patient:**

- □ High
- □ Moderate
- □ Low

Comments:

(Print full name)

**Completed by:** [Signature]: Consultant/SpReg/Staff grade-delete

**Date:** [ ] **Time:** [ ]
Advance Directive for the Consent or Refusal of Blood Products and Transfusion alternatives

Ideally this must be gained by an informed Consultant practitioner after the patient has had sufficient information and adequate time (to consult others if necessary) to make a fully informed consenting decision. This section is to be co-signed by the Consultant Anaesthetist or Consultant Surgeon or Consultant Physician

I, ____________________________________________________________,

born on the ___th day of _____________(month), __________(year), am of sound mind and I voluntarily make this health care advance directive. This will remain in force until specifically revoked by me.

Concerning the following medical treatments:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Patients wishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion from a donor</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Blood transfusion pre donated by me</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Red blood cell from a donor</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Red blood cell pre donated by me</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>White blood cells</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Platelets</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Albumin</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Recombinant Factor V11 (Nova V11)</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Coagulation factors in fresh frozen plasma/Cryo</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Recombinant Coagulation factors</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Immunoglobulin (including Anti-D)</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Crystalloids (Saline, Hartmann's, Dextrose)</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Colloids (Gelofusion, Haemacoll, Dextran)</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Recombinant Erythropoietin</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Dialysis</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Cell-saver / salvage</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Blood salvage &amp; storage</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
<tr>
<td>Other (please give details):</td>
<td>I will accept ☐ I will not accept ☐</td>
</tr>
</tbody>
</table>

(Print Full Name)

Patient: Signature: Date: Time:

(Print Full Name)

Completed by: Signature: Consultant
Date: Time:
Appendix 1

The treatment of obstetric haemorrhage in women who refuse blood transfusion

In 1991-93, assuming normal fertility rates, the death rate from haemorrhage in this group would be approximately 1 in 1000 maternities compared with an expected incidence of less than 1 in 100,000 maternities.

Massive obstetric haemorrhage is often unpredictable and can become life threatening in a short time. In most cases blood transfusion can save the woman's life 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.

The management of women refusing blood transfusion

(i) Booking

a) At the booking clinic all women are normally asked their religious beliefs, and should also be asked if they have any objections to blood transfusion. If a woman is a Jehovah's Witness or likely to refuse blood transfusion for other reasons, this should be noted in the case notes and a copy of the ‘Care plan for Women in Labour refusing a Blood Transfusion’ added to her notes along with the completed advance directive. Copies of this care plan are kept in the Delivery Suite Ward Managers Office, the Haemovigilance Office and the consultant Haematologist office.

b) If she asks about the risks of refusing blood transfusion, she should be given all relevant information. This must be done in a non-confrontational manner.

She would be advised that if massive haemorrhage occurs there is an increased risk that hysterectomy will be required, and the woman and her partner should be offered the opportunity to read and discuss the treatment guidelines in this Annexe.

c) If she decides against accepting blood transfusion in any circumstances, she should be booked for delivery in a unit which has all facilities for prompt management of haemorrhage, including hysterectomy, as outlined in this Annexe.

(ii) Antenatal Care

a) The woman's blood group and antibody status should be checked in the usual way and the haemoglobin should be checked at the antenatal appointments at 28 and 34/36 weeks. Haematinics should be given throughout pregnancy to maximise iron stores.

b) An ultrasound scan should be carried out to identify the placental site.

c) There are well-described procedures for elective surgery in Jehovah's Witnesses: some Witnesses will donate blood before surgery for subsequent auto-transfusion if necessary though others consider that this too is forbidden in their religion. 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.

d) If any complication is noted during the ante-natal period, the consultant Obstetrician must be informed.
(iii) **Labour**

a) The consultant obstetrician should be informed when a woman who will refuse blood transfusion is admitted in labour. Consultants in other specialities need not be alerted unless complications occur.

b) The labour should be managed routinely, by experienced staff.

c) Oxytocics should be given when the baby is delivered. The woman should not be left alone for at least an hour after delivery.

d) If caesarean section is necessary it should be carried out by an experienced obstetrician.

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

(iv) **Haemorrhage**

a) The principle of management of haemorrhage in these cases is to avoid delay. Rapid decision making may be necessary, particularly with regard to surgical intervention.

b) 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 quantify any abnormal bleeding and to detect complications, such as clotting abnormalities, as promptly as possible.

c) 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.

d) Dextran should be avoided for fluid replacement because of its possible effects on haemostasis. Intravenous crystalloid and artificial plasma expanders such as Volufen / Haemaccel should be used.

e) In cases of severe bleeding, refer to the Trust Massive Obstetric Haemorrhage Protocol in delivery suite. Management of the patient should be discussed with a consultant Haematologist.

f) The woman should be kept fully informed about what is happening. Information must be given in a professional way, ideally by someone she knows and trusts. 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.
g) The doctor must be satisfied that the woman is not being subjected to pressure from others. It is reasonable to ask the accompanying persons 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, member of the Hospital Liaison Committee for Jehovah’s Witnesses to support her as she communicates her decision to the doctor.

h) 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.

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

j) Massive obstetric haemorrhage usually occurs in the form of postpartum haemorrhage. In the case of life threatening ante partum haemorrhage in which the baby is still alive, the baby should be delivered promptly, by caesarean section if necessary.

k) 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. It is advisable to consult a consultant colleague when such decisions are to be made.

l) When hysterectomy is performed the uterine arteries should be clamped as early as possible in the procedure. Subtotal hysterectomy can be just as effective as total hysterectomy, as well as being quicker and safer. In some cases there may be a place for internal iliac artery ligation.

m) The timing of hysterectomy is a decision for the consultant on the spot. When making this decision it may be helpful to note that the shortest time from delivery to death recorded in these Reports was in 1985-1987 when a woman died within 3 hours of delivery with a haemoglobin concentration,(Hb), of 3.4g/dl. Survival without hysterectomy has been recorded with a haemoglobin concentration of 4.9g/dl (Reid et al 1986).

n) With the use of hyperbaric oxygen, survival has been reported with a Hb of 2.6g/dl. However, it would be unrealistic to recommend that these women should only be booked for delivery where such a specialised facility was available.

o) If the woman survives the acute episode and is transferred to an intensive care unit, the management there should include erythropoietin, parenteral iron therapy
and adequate protein for Hb synthesis. The reports by Mann et al (1992) and Buscuttil and Copplestone (1995) may be helpful.

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

q) 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.
Appendix 2

Simplified Procedure for application to courts for a ‘Specific Issue Order’

1. Child and parents refuse consent to treatment. Doctors believe treatment must be given, in the best interests of the child. This would not be an emergency situation – if it is, the doctor should act in the best interests of the child, having taken a second opinion, and record his actions carefully in the medical records.

2. Doctors seek advice from their Trust Legal Department or Chief Executive who in turn seeks solicitors’ advice. Parents should be kept informed and invited to case conferences.

3. If solicitors advise proceeding, they will involve the Official Solicitor, a Government-appointed solicitor, whose function is to represent the interests of minors or others who are ‘incompetent’. The Official Solicitor or a member of his staff will probably wish to see the parents and the child, to discuss the situation. The Official Solicitor may then instruct solicitors to act on his and the child’s behalf.

4. The Trust applies to the High Court for an order giving consent to the proposed treatment. The terms of the proposed order should be discussed in advance with the Official Solicitor.

5. A hearing, which is generally heard in chambers but can be held in public with the names of the family, the hospital and the doctors directly involved kept confidential, permits the doctor(s) recommending treatment, together with the other options considered and the reasons for discarding those opinions. Independent expert advice may also be required. The Official Solicitor will probably call his own experts to give evidence. The parents may wish to have separate legal representation.

6. The court may grant the order and may impose further conditions. The court’s paramount consideration will be the welfare of the child.

7. The Trust and the doctors then consider how best to proceed in accordance with the court’s ruling.

8. The Trust may be required to pay a portion of the legal costs of the Official Solicitor, as well as its own.
Appendix 3

Medical Alternatives to Blood Transfusion
(those in italics need to be confirmed accepted by patients who are Jehovah’s Witnesses)

Surgical Devices to Minimise Blood Loss
- Electrocautery /Electrosurgery
- Laser Surgery
- Argon beam coagulator
- Stereotactic radiosurgery
- Microwave coagulation scalpel
- Ultrasonic scapel

Techniques and Devices to Control Bleeding and Shock
For Bleeding:
- Direct Pressure
- Ice Packs
- Elevate body part above level of heart
- Haemostatic agents (see next column)
- Prompt surgery
- Tourniquet
- Controlled hypotension

For Shock:
- Trendelenburg / shock position (patient supine with head lower than legs)
- Medical Antishock Trousers (M.A.S.T.)
- Appropriate volume replacement after bleeding controlled

Surgical and Anaesthetic Techniques to Limit Blood Loss
- Hypotensive anaesthesia
- Induced hypothermia
- Acute normovolemic haemodilution
- Hypervolemic haemodilution
  - *Intra operative/Post operative blood salvage*
- Laparoscopic surgery
- Reduce blood flow to skin
- Meticulous Haemostasis
- Arterial embolization
- Pre operative planning: Enlarged surgical team/ Minimal time
  - Surgical Positioning
  - Staging of complex procedures

Devices and Techniques That Limit Iatrogenic Blood Loss
- Transcutaneous oximeter
- Pulse oximeter
- Microsampling equipment
- Essential tests only
- Multiple tests per sample
- Smaller samples (paed tubes)
Volume Expanders
Crystalloids
   Ringer’s Lactate
   Normal Saline
   Hypertonic Saline
Colloids
   Pentastarch / Hetastarch
   Gelatin
   Dextran

Haemostatic Agents for Bleeding/Clotting
Topical:
   Avitene
   Gelfoam
   Oxycel
   Surgicel
   Tissue adhesives
Injectable:
   Tranexamic acid
   e- Aminocaproic acid
   Desmopressin
   Vitamin K
Other Agents:
   Aprotinin
   Conjugated oestrogens
   Vasopressin
   Cryoprecipitate
   Recombinant factor V11a

Therapeutic Agents and Techniques for Managing Anaemia
Stop any bleeding
Oxygen support
Haemoglobin solutions (when available)
Perfluorocarbon-based oxygen carriers (when available)
Maintain intravascular volume
Haematinics (iron, folic acid, Vit K)
**Erythropoietin (rHuEPO)**
Nutritional Support
Immunosuppressive agents is indicated
Hyperbaric oxygen therapy
Tolerate lower degree of normovolemic anaemia

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*Cell Salvage Techniques not performed in United Hospitals Trusts. Referral to BLL would be a possible option.*
*Erythropoetin will usually only be supplied after consultation with the Consultant Haematologist*
Appendix 4

Requirements and procedures for Trusts Autologous pre-donation Blood Transfusions.

**Minimum requirements**
Definite surgery/procedure date

Needs advance notification and arrangement of 6-8 weeks

Initial Hb of minimum 13 g/dl for males, 12 g/dl for females
(exceptional circumstances of no compatible blood available allow 10 g/dl)

Certainty of need for transfusion

No upper age limit

Not suitable for patients with uncontrolled Hypertension

Not suitable for patients with significant aortic stenosis, prolonged and/or frequent angina

Not suitable for patients with significant narrowing of left main coronary artery and cyanotic heart disease

Not suitable for patients with a history of epilepsy

Not suitable for patients with active bacterial infection

Patient will have to donate their units in Belfast

Autologous pre-donation blood transfusions is an expensive and complicated process requiring arrangements with the Northern Ireland Blood Transfusion Service and the hospital blood bank. If a patient meets the minimum requirements, a referral to a Trust Consultant Haematologist is the next necessary step.
Appendix 5

Clinical Strategies for Managing Haemorrhage and Anaemia without Blood Transfusion

There is a series of detailed documents distributed by Hospital Information Services for Jehovah's Witnesses for:

- Critically ill Patients
- ICU
- Surgical Patients
- Obstetrics and Gynaecology

Copies are kept in the Haemovigilance Office in the Trust (Antrim Ext 4965 & Causeway 5738) and are freely available to copy.

They, and other reference material can be sourced at E-mail address: his@jw.org
Relevant Contact Details

Hospital Liaison Committee for Jehovah’s Witnesses
Members of the Hospital Liaison Committee, (HLC), are available to assist in emergency situations and they are pleased to act as a source of reference material gleaned from medical journals from around the world. They are able to put medical and surgical teams in contact with other professionals who have had experience in providing non-blood medical management for Witness patients.
Jehovah’s Witness patients may require the hospital staff to contact members of the HLC on their behalf

Members of Belfast Hospital Liaison Committee
David Farrow          Tel – 028 90 872556
Mob – 077 83 908739
David Chapman        Tel – 028 93 349135          E-mail – david.chapman5@sky.com
Ken Maguire           Tel – 028 90 282126          Email – kenneth.mcguire@ntlworld.com
Mob – 078 01 632151
Les Greenberg        Tel - 028 92 619189          Email – landegberg@aol.com
Mob – 078 95 211139
Robert Colville      Tel - 028 90 865392          Email – bcolvi1031@aol.com
Mob - 077 91 061217
Peter Armstrong      Tel – 028 91 457638          Email - peter_armstrong@zen.co.uk
Mob – 078 66 583895

Members of Londonderry Hospital Liaison Committee
Ronald Bacon          Tel 028 70 353502
Mob 07867 690764      Email doronron91@hotmail.com
John Mayne            Tel 028 71 882317
Mob 077 08 222583     Email maynejohnmayne@yahoo.co.uk
Timothy Nightingale   Tel 028 71 811784
Mob 079 35 223764     Email timandpol@tesco.net
David Benstead       Tel 00353 7497 36974
Mob 00353 8622 85077  Email daveandmaggie@eircom.net

Northern HSC Trust’s Haemovigilance Practitioner
Aine McCartney        Brettan Hall, Antrim Area Hospital
Tel – 028 94 424965 (internal ext 4965)
E-mail – aine.mccartney@northerntrust.hscni.net

Maureen Entwistle     Brettan Hall, Antrim Area Hospital
Tel – 028 94 424049 (internal ext 4049)
E-mail – Maureen.entwistle@northerntrust.hscni.net

Mairead Richmond      Causeway Laboratory, Causeway Hospital
Tel - 028 70 346738(internal ext 5738
E-mail – mairead.richmond@northerntrust.hscni.net

Northern HSC Trust Consultant Haematologists
Dr P Burnside        Tel 94 424116 (internal ext 4116)
Dr A Kyle             Tel Antrim internal ext 2041
Dr P Windrum         Tel 94 422096 (internal ext 2096)

Contact switchboard to contact the Consultant covering out of hours cover
References:


2. Treatment without Blood Transfusion, Ulster Community & Hospitals Trust


4. Clinical Strategies for Managing Haemorrhage and Anaemia without Blood Transfusion in Obstetrics and Gynaecology, Distributed by Hospital Information Services of Jehovah’s Witnesses, E-mail: his@jw.org

5. Care Plan for Women in Labour refusing a blood Transfusion (As referred to in the RCOG News (October 2000) of the Royal College of Obstetrics and Gynaecologists)