Management of Blood Refusal Procedure

This guideline is an adjunct to the Blood Transfusion Consent and Consumer Information Guideline and the RCH Blood Transfusion Procedure.

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1. Purpose

To guide clinical staff making decisions in situations where consent for blood transfusion is withheld.

2. Background:

Parents occasionally refuse blood transfusions for their children. It is a matter fundamental to the beliefs held by Jehovah's Witnesses that they, and the children for whom they are responsible, do not receive transfusions of blood products. A request for consent for blood product transfusion is likely to be refused in any circumstance. Most Jehovah's Witnesses refuse to accept the major blood fractions (Whole Blood, Red Blood Cells, Plasma (FFP) and Platelets), however the minor blood fractions (Albumin, IVIG, cryoprecipitate etc) are usually considered matters of conscience for each individual to decide. Beliefs about what blood products are acceptable are not completely uniform among all Jehovah's Witnesses.

From time to time non Jehovah's Witnesses may also refuse blood transfusions, for reasons that may include fear of contracting blood borne infections.

Refusal of blood transfusion may be immediately life threatening or may risk serious long term damage to the child.

3. Key Terms:

**Transfusion Consent:** A consent process must be undertaken for all blood transfusions. The consent process will include an explanation of the medical reasons for blood transfusion, the type of blood product to be used, and the risks associated with the procedure and products. Any feasible alternatives should also be discussed, including techniques such as acute normovolaemic haemodilution, blood salvage, use of non-blood products and pre-surgical optimisation of haemoglobin (e.g. through the use of iron and recombinant erythropoietin). The opportunity for the parents and patient to ask questions should also be offered.

In emergency life threatening circumstances, where there is no time to obtain consent, transfusion can proceed without consent but the parents and patient should be fully informed as to the procedure as soon as possible after it has occurred. This will include an
explanation of the indication for transfusion, type and risk profile of blood product and offer the parents and patient the opportunity to ask questions.

**Blood Refusal:** Blood refusal refers to a situation where parents or young person has been given the information described above and has decided to not consent to blood transfusion. This may include refusal of the major fractions of blood; red cells, platelets or plasma or minor fractions such as Albumex, IVIG or clotting factors.

**Parents/guardians:** In Victoria the legal age of maturity is 18 years. Therefore for children and young people under the age of 18 as a general principle, parents or guardians are required to give consent for treatment, including consent for blood transfusion.

**Mature Minors:** Minors below the age of 18 years may be legally able to give consent to treatment, provided that the doctor is satisfied that the young person has reached sufficient level of maturity and intelligence to be competent to give consent. Competency would be decided on determination of the child's ability to comprehend the particular treatment proposed, its side effects, the consequences of non-treatment and other treatment options. Australian law is not clear on whether a child can refuse treatment.

### 4. Procedures

#### 4.1 When parents first indicate reluctance or refusal

When parents first indicate that they do not want their child to have a blood transfusion, if time permits, you should:

1. Take the parents' concerns and beliefs seriously and treat them, their beliefs and the difficult position they find themselves in with respect and compassion.
2. Clarify the parents' understanding of their child's medical situation and what will happen to the child medically if blood transfusion is not given.
3. Clarify what the parents are refusing, and what their reasons are. Bear in mind that their reasons may be religious and may not be related to perceived physical risks and benefits of transfusion.
4. Discuss alternatives which may be medically viable and acceptable to the parents.
5. Explain to parents what the process will be if they continue to refuse blood transfusion. If it is likely that the parents' wishes will be overridden, aim to make this as non-adversarial a situation as possible. Explain to the parents the ethical imperative for doctors to save the child's life.
4.2 If parents continue to refuse

If the parents continue to refuse the blood transfusion, every effort should be made to honour this decision, unless the child is likely to die or suffer serious and permanent damage without the transfusion. It is also important to determine whether the situation is time-critical or not as this will affect how you should proceed.

The following summarises the position set out in this procedure:

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<th>Non Life threatening, non serious and/or elective procedure</th>
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<td>Time-Critical</td>
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<td>HONOUR PARENTS’ WISHES AND MANAGE THE SITUATION</td>
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<td>Not Time-Critical</td>
<td>CONSULT EXECUTIVE AND LEGAL (with a view to obtaining approval to perform transfusion) (see sub-heading 4.2.2)</td>
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4.2.1. Likelihood of death or serious and permanent damage - TIME-CRITICAL

A situation will be considered time-critical where there is not enough time to:

- Consult with the hospital executive and Legal to obtain a court order permitting transfusion against parental wishes;
- Use medical management, such as non-blood products, and techniques which might reduce the need for transfusion; OR
- Have extended discussions with the family (including obtaining the child's view - see sub-heading 4.2.2).

In these cases, a blood transfusion can be performed without parental consent if the child is likely to die (see note 2 below) or suffer serious and permanent damage without the transfusion, in accordance with the following procedure:
1. Consult with senior medical colleagues, to the extent that time allows, to confirm assessment of medical situation, need for transfusion and likelihood of death or serious and permanent harm without transfusion - where possible a Consultant should be included in these discussions.
2. Transfuse lifesaving products only.
3. Provide information to the parent/guardian and child as soon as possible: before the transfusion, if feasible or after the transfusion.
4. Notify the relevant Hospital Executive, as the decision to override parental wishes may pose a legal risk to the clinician and RCH.
5. Consult with the Duty Clinical Haematologist, who will provide advice regarding how to minimise the need for further transfusion after the initial emergency transfusion.
6. Notify Clinical Ethics, if there is a likelihood that further blood transfusion will be needed. Clinical ethics will provide support in decision-making around further transfusions, and will involve RCH legal counsel, if necessary.
7. Document in the medical record a thorough description of the process, including at least the following points:
   a. Other medical opinion sought before transfusion (a second opinion from a Consultant is legally required for protection under the Human Tissue Act - see note 1 below)
   b. Reason for transfusion;
   c. Outcome of transfusion;
   d. Discussion with family including
      i. The reasons for refusal;
      ii. the products refused;
      iii. reasons for proceeding with the transfusion;
      iv. the support provided; and
   v. the Medical staff involved in the decision to override parental refusal.

Notes:

1. Under section 24 of the Human Tissue Act 1982, a medical practitioner can lawfully administer a blood transfusion to a child without parental consent if, in the opinion of the medical practitioner:
   a. A blood transfusion is a reasonable and proper treatment for the condition from which the child is suffering;
   b. Without a blood transfusion the child is likely to die, and
   c. A second medical practitioner concurs with that opinion (the RCH requires this second opinion to be from a Consultant wherever possible).
2. A child is 'likely to die' if there is a real, not a remote chance or possibility death, regardless of whether it is less than 50 per cent. This means the RCH does not have to wait until an adverse event (such as a haemorrhage) which is likely to culminate in death actually occurs. If at an earlier time two medical practitioners consider it is a
real and not remote possibility that death will occur, this is sufficient for legal protection.

3. In the event that a child is not 'likely to die' but two medical practitioners (including at least one Consultant) believe that the child is likely to suffer serious and permanent damage if a blood transfusion is not performed, the RCH would support a clinical decision to transfuse without parental consent on the basis that this would be their ethical duty, but only in emergency situations. In such cases, the process outlined above must be followed. In all other cases where time permits, the process set out below must be followed.

4.2.2. Likelihood of death or serious and permanent damage - NOT Time-Critical (including non-urgent or elective)

Where parents have refused, or indicated that they will refuse, blood transfusion and the situation is NOT time-critical (including where blood transfusion is the only treatment needed or where blood transfusion is known or is reasonably likely to be needed as part of another form of treatment such as surgery or chemotherapy):

1. Consult with senior medical colleagues to confirm assessment of medical situation, need for transfusion and likelihood of death or serious and permanent harm without transfusion.
2. Consult with the Duty Clinical Haematologist, who will provide advice on conservative blood management.
3. Discuss the situation with parents, including:
   a. Alternative options for medical management, such as non-blood products, and techniques which might reduce the need for transfusion, or minimise the number of transfusions required;
   b. Options for timing e.g. performing transfusion when parents are not present; and
   c. Likely effects on child and family if transfusion is done against parents' wishes.
4. Reassure parents that clinical staff will do their best to honour the family's wishes but make clear to them that the consultant(s) in charge may find it necessary to administer blood products if they judge the situation has become life-threatening or likely to cause serious and permanent damage or disability to the child.
5. Reassure the family that the use of blood products under such circumstances will always be disclosed to them, unless they request otherwise.
6. Notify the relevant Hospital Executive.
7. Consult with clinical ethics (if necessary) and RCH legal counsel.
8. Formulate a management plan, including any steps that will be taken to try to avoid transfusion occurring, and any circumstances under which blood transfusion will be deemed necessary and given without parental consent.

10. Document in the medical record a thorough description of the process, including the following points:
   a. Other medical opinions sought regarding need for transfusion and conservative blood management;
   b. Clinical ethics referral and outcome of that, when known;
   c. Consultation with RCH Legal Counsel and outcomes of that, when known;
   d. Management plan;
   e. Include other members of the multidisciplinary team e.g. social work / mental health practitioner in discussion with family including:
      i. The parents' beliefs, understanding and reasons for refusal of blood transfusion;
      ii. the products refused and accepted (if any);
      iii. options offered to parents; and
      iv. the support provided to patient, parents and family.

Notes:

1. Once parents are informed that it is likely that a blood transfusion will be required as a result of a particular surgery, they may feel unable to consent to the surgery. The surgery then cannot be performed without consent unless it is an emergency situation. It is likely that the appropriate course in such situations would be to obtain an order from the court authorising the surgery without the parents' consent if the surgery is necessary to avoid serious and permanent damage.

2. In a situation where serious and permanent damage is foreseeable but there is sufficient time to consult with the hospital executive and legal and obtain a court order authorising the transfusion, it is not acceptable to transfuse against parental wishes without taking these steps.

4.2.3 Non-life-threatening, non-serious and/or non-permanent damage (i.e. Sub-optimal result)

Where the parents' refusal of a blood transfusion may result in a sub-optimal outcome but this is not serious, permanent or life-threatening, then the parent's wishes should generally be honoured and the management plan should incorporate all steps available to optimise the outcome. This includes, for example, where the parents elect not to proceed with an elective but recommended surgery because it might result in the child needing a blood transfusion.

4.3 Obtaining the child's view
Where a child is old enough to understand the situation, even if only in a general way, and the situation is not time-critical, you should obtain the child’s view wherever possible.

**4.3.1 Child also refuses blood transfusion**

If the child agrees with the parents and does not want the transfusion, then the processes outlined above should be followed.

**4.3.2 Child does not agree with parents and wants blood transfusion**

If the child does not agree with the parents and wants the transfusion you need to assess whether the child is a mature minor - in doing so, you need to consider whether the child has reached a sufficient level of maturity and intelligence to fully understand the risks and benefits of the treatment (including the psychosocial risk of consenting to a blood transfusion against his or her parents’ beliefs).

If the child is a mature minor, then his or her consent for the transfusion overrides the parents’ refusal and the transfusion should be performed. The assessment of the child as a mature minor, including the reasons for believing he or she fully understands the consequences of the decision, should be recorded on the medical record, as well as the fact that the child is providing consent despite parents refusal.

If the child is not assessed to be a mature minor he or she may still be old enough to understand in a general way what will happen if the blood transfusion does not proceed and express a desire to have the transfusion in those circumstances even though the parents refuse. This should be taken seriously, and carefully recorded on the medical record, and advice should be sought from Social Work, Clinical Ethics, Legal Services and the Executive as appropriate.

**4.4 When parents disagree**

If only one parent refuses the blood transfusion but the other consents to the transfusion or to a surgery which is likely to result in a transfusion, in the majority of cases the consenting parent’s agreement will be sufficient and the transfusion or surgery can proceed. If the parents are separated, and time permits, ensure that there are not any court orders which affect the consenting parent’s right to consent on behalf of the child.
Although the transfusion can technically proceed with the consent of only one parent, every attempt should be made to obtain the agreement of both parents. Where the parents still disagree, advice should be sought from Clinical Ethics, Legal Services and the Executive to determine the appropriate course of action.

4.5 When a competent patient over 18 refuses a blood transfusion

Occasionally patients over 18 years of age are admitted to RCH. A fully informed, competent adult patient is entitled to make the decision to accept treatment or refuse medical treatment, including blood transfusion, even if they are likely to die as a result. If this occurs at the RCH:

- There is an obligation for clinical staff to provide the patient with all the necessary information so that the patient may make an informed decision and answer any questions the patient may have;
- If the patient is unconscious or not competent to make an informed decision the staff should make every effort to notify next of kin or other representatives to discuss treatment options;
- Clinical staff must accept and act on the patient's informed decision irrespective of their own personal beliefs and opinions; and
- The refusal of the treatment should be carefully and completely recorded on the medical record and hospital executive notified.

Links:

Blood Refusal Map and Guideline available from this [web-link](http://www.rch.org.au/bloodtrans/circumstances.cfm?doc_id=7424) or following web address:
| **Likelihood of death or serious and permanent damage without transfusion** | **Likelihood of death or serious and permanent damage without transfusion** | **Sub optimal outcome**  
(Non-life-threatening, non-serious and/or non-permanent damage) |
| --- | --- | --- |
| **Time Critical**  
(Emergency transfusion) | **Non-Time Critical**  
(Non-emergency, elective surgery) |  |
| 1. **Consult** with senior medical colleagues – as time allows.  
2. **Confirm** agreement by one other medical practitioner at consultant level.  
3. **Transfuse** in a timely and conservative fashion (e.g. transfuse the life-saving products only).  
4. **Inform** the parents/guardian and child as soon as possible after the transfusion.  
5. **Notify** the relevant Hospital Executive.  
6. **Consult** with the Duty Clinical Haematologist about future conservative blood management.  
7. **Consult** Clinical Ethics, if there is a likelihood that further blood transfusion will be needed.  
8. **Document** in the medical record a thorough description of the process, including the following points:  
  a. Other medical opinion sought before transfusion.  
  b. Reason for transfusion. | 1. **Consult** with senior medical colleagues.  
2. **Consult** with the Duty Clinical Haematologist.  
3. **Discuss** the situation with parents.  
4. **Consult** with Clinical Ethics and RCH Legal Counsel.  
5. **Notify** the relevant Hospital Executive.  
6. **Formulate** a management plan.  
7. **Inform** parents of the management plan.  
8. **Document** in the medical record a thorough description of the process including the following points:  
  a. Other medical opinions  
  b. Clinical ethics referral  
  c. RCH Legal Counsel advice  
  d. Management plan  
  e. Discussions with family | 1. **Consult** with senior medical colleagues.  
2. **Consult** with the Duty Clinical Haematologist.  
3. **Discuss** the situation with parents.  
4. **Formulate** a management plan.  
5. **Inform** parents of the management plan.  
6. **Document** in the medical record a thorough description of the process, including the following points:  
  a. Other medical opinions  
  b. Clinical ethics referral  
  c. RCH Legal Counsel advice  
  d. Management plan  
  e. Discussions with family |
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<tr>
<td>c. <strong>Outcome of transfusion.</strong></td>
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<td></td>
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<tr>
<td>d. <strong>Discussion with family.</strong></td>
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