DOI: 10.1308/rcsbull.2019.16

# Jehovah's Witnesses and surgery

## Anna Sayburn explores the consent issues that surgeons face when operating on patients who refuse blood transfusions

Surgeons go to work intending to do their best for every patient, using the treatments that are most likely to offer a successful outcome. But what if the patient doesn't want that treatment? What if that treatment is forbidden by their religion? That's the dilemma that faces surgical teams treating any of the estimated 140,000 Jehovah's Witnesses in the UK,[1] who refuse blood transfusions.

The situation raises both ethical and clinical dilemmas but good communication, clear information, and modern medical and surgical techniques can ensure the best outcome in this potentially challenging situation. We talked to surgeons, haematologists and Jehovah's Witness representatives to find out more.

### JEHOVAH'S WITNESS BELIEFS ABOUT BLOOD

The majority of Jehovah's Witness patients will not accept transfusions of whole blood, red blood cells, white blood cells, platelets or plasma.[1] This is based on an interpretation of passages in the Bible that prohibit consumption of blood.

However, Jehovah's Witnesses do not object to medical or surgical treatments in general, only to the use of blood products.[1]

Beyond whole blood and its components are a range of treatments that individual Jehovah's Witnesses may accept or not. Simon Etches, Jehovah's Witness hospital liaison committee member for Nottingham, describes them as 'conscience issues' that are not clearly prohibited. They include:[2]

- blood derivatives such as platelet fractions, cryoprecipitate, albumin, immunoglobulins, haemoglobin and interferons
- recombinant erythropoietin and recombinant factor VIIa
- procedures such as intraoperative cell salvage and acute normovolaemic haemodilution

These treatments, where appropriate, may mitigate some of the risks, especially of elective surgery.

Many Jehovah's Witness patients have completed an advance decision document, which they carry for use in an emergency and to inform treatment planning before elective surgery. These signed and witnessed documents set out which specific treatments they find acceptable. Their use is encouraged but 'not obligatory', says Mr Etches.

## LEGAL POSITION AND GUIDANCE

Legally, patients have a clear right to refuse treatment as long as they are competent to do so. Competence is assessed in line with the 2005 Mental Capacity Act, which explicitly states: 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision'.[3] This is re-emphasised in the National Institute for Health and Care Excellence guideline on decision making and mental capacity published in 2018.[4]

Advance decisions to refuse life-sustaining treatment must be documented, signed and witnessed, and can only be made by people aged 18 years and over.[4] A valid, applicable advance decision is legally binding so surgeons must abide by the document unless the patient has changed his or her mind, or does not have capacity to consent and has appointed someone with a lasting power of attorney since the document was signed.

Advance decisions apply only to refusal of treatment; no one can insist on having a treatment. If a situation were to arise where a surgeon felt that the risks of performing a procedure under the restrictions placed on it by a patient outweighed the benefits, the surgeon could not be compelled to operate.

The 2016 Royal College of Surgeons of England (RCS) guidance *Caring for Patients Who Refuse Blood* sets out the position of Jehovah's Witnesses on blood transfusion, issues around ethical considerations and consent, and clinical considerations around surgery that conserves blood.[1] It says surgeons 'are duty-bound to respect patients' religious freedoms' but that they 'have the right to choose not to treat patients if they feel that the restrictions placed on them […] are contrary to their values as a doctor'. In this case, they must refer patients to a doctor who is qualified and prepared to take on the patient in these circumstances.

Children under 18 years of age cannot make legally binding advance decisions although under-16s judged to have competency to make or withhold consent for treatment can do so. NHS trusts can obtain court orders to overrule the refusal of life-sustaining or life-saving procedures by children or their parents.

In an emergency, where there is insufficient time to obtain a court order, the clinician must act in the best interests of the child – which may include administering a blood transfusion. However, 'every effort must be made to respect the beliefs of the family and avoid the use of blood or blood products wherever possible'.[1]

## OPTIMISATION AND MITIGATION OF RISK

Mr Peter Lamont, Consultant Vascular Surgeon at Southmead Hospital, Bristol and standards lead at the RCS, says: 'I have never come across a situation where I've had to refuse somebody [treatment because of their beliefs]'. Techniques developed over recent decades have gone a long way to mitigate the risk of elective surgery without blood transfusion. Preoperatively, patients' haemoglobin levels may be optimised by use of intravenous iron to correct anaemia, other deficiencies such as low folate can be addressed, and any anticoagulant or antiplatelet drugs can be adjusted or stopped to reduce risk of bleeding, if appropriate. Erythropoietin may be considered.

> *"Every effort must be made to respect the beliefs of the family and avoid the use of blood or blood products wherever possible"*

Some elective procedures are suitable for use of intraoperative autologous cell salvage, where blood is collected from the wound, filtered to remove contaminants and returned to the patient. Where this can be done without breaking the circulation, most Jehovah's Witnesses will now accept it.

'Blood salvage is a good technique whether you are a Jehovah's Witness or not', says Dr Jonathan Wallis, chair of the National Blood Transfusion Committee and consultant haematologist at Freeman Hospital in Newcastle. 'Cardiac surgeons use it all the time. It's particularly suitable where you have a lot of blood loss'.

However, cell salvage cannot be used in all situations. Where the patient has sepsis, for example, the risk of reintroducing pathogens into the blood is too high. In emergency situations, the patient may

have already lost blood into tissue. In other operations, the small amount of expected blood loss means 'a lot of fuss and you end up giving back a bit of a dribble', says Dr Wallis.

Cell salvage adds complexity to a procedure but Dr Wallis notes that if it's done routinely, it's not so much of a problem. Jehovah's Witnesses undergoing surgery where blood loss is expected 'should go to a unit that does that sort of surgery all the time', he says.

## CLINICAL JUDGEMENT

So what is a surgeon to do when a patient refuses blood for a procedure with a high risk of haemorrhage, without the option of a transfusion should things go wrong? In that situation, the surgeon's clinical judgement comes into play.

'If you're going to do something where you anticipate blood is going to be needed and the patient says "I'm not having blood", you're then placed in the position of saying what would be the natural outcome if I didn't do the procedure, against what if I did the procedure without using blood? That's got to be a case-by-case analysis', says Mr Lamont. He adds: 'If the patient has got a potentially fatal condition, you should do what you can using what you can'.

> *"Techniques developed over recent decades have gone a long way to mitigate the risk of elective surgery without blood transfusion"*

Professor Dileep Lobo, professor of gastrointestinal surgery at the University of Nottingham, says that although 'cell salvage can save life', it does not completely mitigate risk because you can only give back what is captured and it doesn't help if a patient haemorrhages postoperatively. 'I would be very reluctant to operate without the possibility of cell salvage. We are trying to extend the patient's life. We don't want to get into a situation where the operation kills the patient.'

Professor Lobo says decisions must be based on the balance of probabilities. 'For my own practice, with pancreatic cancer, some are resectable and some are borderline. With [borderline cases], it's not worth taking the risk.' He points to the potential impact, not just on the patient but also on the treating team. 'We're all trained to save lives and make operations as safe and easy as possible. You can't legislate for unexpected bleeding. For the team, it's very difficult to accept if you have a situation where the patient dies from blood loss and you have no opportunity to save the patient's life.'

## VALID CONSENT

In order to provide valid consent, a patient must not be subject to undue influence or coercion.[4] Clearly, clinicians must be careful that the provision of information does not spill over into undue influence. In addition, if a clinician feels that a patient may be under pressure from family or faith representatives, the clinician should see the patient alone, to be sure the patient is happy with the decision.

As well as having capacity to make the decision (and making it free from undue influence), the patient must understand the options available, and the benefits and risks attached to them. Given that different Jehovah's Witness patients may have differing views about the acceptability of certain blood products or derivatives, it is advisable to use a checklist that asks explicitly about the different treatment options, and also to ask about specific circumstances.[1] For example, do they wish not to receive blood products even if their life may be at imminent risk if these are not given?

The consent process should usually be guided by the surgeon who plans to carry out the procedure although haematologists may have a role in explaining and asking for consent for specific interventions, such as preoperative treatments to optimise haemoglobin.

## UNCLEAR CONSENT

Difficulties are most likely to arise if consent is unclear. The local Hospital Liaison Committee for Jehovah's Witnesses (HLC) may be able to help if patients are confused about which treatments are or are not acceptable, or if patients want help in making the decision. Mr Etches says that HLC members receive rigorous training to ensure they do not exercise undue influence while helping to explain treatments and their status to patients. 'It doesn't matter to us what the decision is; it matters that they are supported in the decision making process', he says. The HLC may also be helpful when reassurance is required, such as if a patient is uncertain or suspicious that a non-blood product is actually blood-derived.

Emergency situations, where a patient is unable to provide consent (and where there is no valid, written advance directive) but there are strong grounds to believe the patient is a Jehovah's Witness, pose perhaps the greatest challenge. If a friend or relative insists that an unconscious patient, with a condition that would usually require transfusion, would not want transfusion, what is the treating team to do?

General Medical Council guidance is clear that emergency treatment to save life or prevent deterioration can be provided in the absence of consent.[6] The RCS guidance says that in such a situation 'every effort should be made to avoid the use of blood and blood products [...] However, in serious or life-threatening situations the use of blood and blood products should be based on the judgement of the clinician responsible'.[1]

'It's very awkward because your contract is with the patient, not their relatives', says Mr Lamont. 'I think you would have to proceed

on the basis they probably are a Jehovah's Witness and attempt not to use blood products but if it was a question of the patient living or dying, then you have to use your own judgement.'

Nevertheless, should blood products be used, the decision making process should be documented, and the clinical teams' actions and reasons for acting should be explained to the patient subsequently.[1]

**CONCLUSION**

While there is no doubt that refusal of blood products can create clinical and ethical challenges, much can now be done to streamline the process and optimise the situation, at least in an elective setting. Dr Wallis believes that treating Jehovah's Witness patients has 'helped focus our minds on avoiding blood loss and looking at alternatives to transfusion'.

Mr Lamont, however, says that there are 'all sorts of drivers' to reduce blood loss in surgery. While he is sceptical that Jehovah's Witness patients have advanced the field, he notes that research into avoiding bank blood has been beneficial for Jehovah's Witnesses.

Despite this, the challenge in emergency situations remains unresolved. 'It would be extremely difficult to accept if a patient died from blood loss and we had no opportunity to save the patient's life', says Professor Lobo. 'We don't give transfusions without thinking hard about them, but [transfusion] is there to save life.'

**References**


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## About the author

Anna Sayburn is a freelance medical journalist who writes regularly for professional and patient-facing media. She is based in London.

## RCS guidelines

The RCS document *Caring for patients who refuse blood* is available to view onine at: http://bit.ly/2BCwFG1.