Refusal of Blood Treatment
Medico - Legal Issues

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Early identification of refusal is key to appropriate management

Patients should be asked at booking visit as to whether they will accept blood treatment

» Refusal is often on religious grounds but do not make assumptions based on the patient’s religion alone

› Many hospitals have experience of Catholics and Muslims who refuse blood, as well as patients who refuse for reasons other than religion, for example, fear of contamination

» Therefore vital that each patient must be asked about her views on blood treatment specifically
Refusal of treatment should trigger an internal procedure drafted especially for these purposes.

The procedure should involve the following:

- A very detailed consent process, including a detailed consent form and individualised treatment plan
  - “advised of risks” in the medical notes will not suffice
- Meetings between the patient and the clinicians involved in her care to discuss the following:
  - The scope of her refusal – is she willing to take plasma, platelets etc
  - Her condition
  - The risks and potential consequences of her condition and refusal
  - The treatment options
Recognise the risk of making assumptions regarding the patient’s knowledge:

- Patients intending to refuse blood may be very knowledgeable about the risks of non-transfusion generally and the availability of a diverse range of products and treatments

- **But** it is important ensure that her knowledge is complete and appropriately applied

- She may not know the risks arising from her own condition

- The limitations of any products or treatments viewed by the patient as alternatives must be clearly identified to her

- She may intend to rely on procedures that are either not available in the Hospital or which may not be suitable for her

- Her expectations as to what products like erythropoietin and NovoSeven can achieve may be unrealistic in light of her particular circumstances
Discussion of risks should be evidence based, non-judgmental, non-dramatic and in language that the patient will understand

» eg if there is a risk of catastrophic injury this must be explained in detail to her – the phrase itself is unlikely to be clear to most lay people

Use of professional interpreter is recommended where the patient’s first language is not English

» It is not appropriate to rely on friends or family members of the patient to translate for her

Patient should meet the team alone but she should be given time to consider the care plan and the risks and to discuss them with her family/religious advisers, as she considers appropriate and to meet with the team again

» Involvement of partners, family or religious advisers is only at the request of the patient
It is important that the patient understands that she can revoke the refusal at any stage and that no formalities are required for this.

If the refusal is not revoked, it is important that the patient understands that her refusal will remain in force even if she lapses into unconsciousness.
   » discuss whether this is what she intends

All meetings should be recorded in the medical notes and signed by the patient and the team.

All members of the clinical team must be willing to treat the patient in accordance with her wishes. Alternative clinicians must be identified to replace anyone who is not.
   » In an emergency where there is no time/no availability of alternative Clinicians, the Clinicians have a duty to treat the patient in accordance with her wishes, irrespective of their personal views - “Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances” (Medical Council Guide to Professional Conduct and Ethics, para 10.3)
The consent form should contain at least the following:

» the precise scope of the patient’s refusal following her meeting with the team, together with the information discussed with her regarding her condition, treatment plan and the risks associated with her refusal

» declaration by the patient that these issues have been explained to her and that she accepts, believes and understands the consequences of her refusal and has weighed the information in the balance prior to making her decision

» the patient’s views on blood treatment for the baby

» waiver of liability for Hospital and clinicians from consequences of her refusal

› this is a limited waiver – could not be relied upon where injuries are caused by negligence
Who should “consent” the patient?

» Multi-disciplinary input into the consent process – the Consultant Obstetrician, Consultant Anaesthetist and the Consultant Haematologist involved in the care of the patient will each need to be involved to inform the patient of the issues

» Role of Psychologist/Psychiatrist - to assist in assessment as to capacity where clinical team are in doubt, and/or to assist in presenting information to patient in a manner suitable to her

» In an emergency situation where there is either no Psychologist/Psychiatrist or no time to involve one, a view as to capacity must be reached by the clinical team

» If the view is that the patient lacks capacity, then this must be entered in the notes together with the identity of the Consultants who have reached this decision. Court should be asked to determine patient’s capacity and to authorise treatment if it finds that she lacks capacity
Elective Procedures:

» The refusal must be considered in the context of the previously recommended treatment plan

» Defer the treatment to allow time to consider the impact of the refusal on the treatment plan

» Balancing exercise - consider the rationale for the treatment/procedure which had been planned and consider whether it is still appropriate in light of the risks associated with the refusal

» Meet with the patient in keeping with the standard procedure and also with a view to deciding how best her treatment should be progressed in light of the refusal
What if the opportunity to “consent” the patient at an early stage is missed?

**Emergency procedures**

» Nominate a member of the team to call in additional resources – at least a Consultant Obstetrician, Consultant Anaesthetist, and Consultant Haematologist. Call a professional interpreter if necessary. Consider ordering additional products which may not be immediately to hand - NovoSeven

» Identify the scope and nature of the patient’s refusal and as thoroughly as possible in the time available, identify and warn patient of the risks of her particular condition and refusal and the different treatment options available

» Nominate a member of the team to take a *faithful* note of the scope and nature of the refusal, and of the risks, treatment options, alternatives/lack of alternatives discussed with the patient

» Language is important so try to avoid ambiguous language
  › For example “aware of risks” – does this mean that the patient has been informed of the risks or does it mean that she understands them?

» The entry in the notes should be signed by the Consultants responsible for the care of patient and the patient where possible
TREATMENT OF MINORS
Parents generally have the right to refuse treatment on behalf of their children, however:

- If the refusal of blood treatment places the life/health of the child in jeopardy, an application should be made to the Court for an Order authorising the treatment.
- Courts have demonstrated that they will override parental refusal in exceptional circumstances where the refusal results in a risk to the life/health of the child.
- Hospital/clinician not obliged to wait until the life/health of the baby is in jeopardy before making the application to the Court.
- Courts have said that they do not require doctors to engage in “brinksmanship” with the life/health of the baby.
- As with adult patients, identification of risk (and refusal) at an early stage is recommended so application to Court can be made otherwise than in context of clinical emergency.
» Case by case basis but preferable to take legal advice as soon as risk is identified and refusal is communicated

» The risk must be to the life/health of the child

» The risk does not need to be immediate – Court’s opposition to “brinksmanship”

› Recent case where Court facilitated an application *prior to delivery*

› Baby was very likely to be delivered at 24/25 weeks gestation; medical evidence was that transfusion was very likely to be required to safeguard life/health of baby either immediately upon delivery or shortly after

› High Court granted an Order authorising the administration of blood treatment immediately upon delivery provided it was necessary to safeguard the life/health of the child
Court process – adversarial format, but experience itself need not be

Instruct legal team as soon as possible

Parents must be given notice of application by the clinical team

» preferable to inform parents as soon as risk is identified and the refusal is communicated that application to court may follow

» where time allows, parents should be given copies of the documents prepared for the Court and time to prepare for the application/instruct a legal team

Role of the clinician in the application:

» Must prepare a detailed medical report including

  › the baby’s condition, the risks arising from that condition, the treatment required and when it should be administered
  › one transfusion or ongoing blood treatment?
Making the application

› time frames – how long will baby be in hospital? for what period is blood treatment likely to be required?

› likely future prognosis in the absence of blood treatment

› the availability of alternatives to blood treatment (if any) and the role of products such as erythropoietin

» Detailed discussion with the legal team

› Hospital/clinician/legal team all have duty of full and frank disclosure to the Court so team must be in a position to include the relevant information in the documents prepared for the Court

› the Order granted will be based on the information given to the Court

> therefore important for legal team and clinicians to work together to ensure that the Order sought adequately addresses the clinical issues
» Approve and swear affidavits

» Attend and give evidence in Court

- Considerable effort involved

» If no advance planning is undertaken, all of these steps may need to be taken at a time when Consultants are trying to deal with a clinical emergency and/or when they are likely to have clinical responsibilities for other patients

» Clear advantage to taking planned approach to these applications for the clinical team, the parents (and for legal team!)
It may be necessary to go to Court more than once

» For procedural reasons

› If the proceedings are litigated by the parents or if the Order is appealed

» If circumstances change the original Order may not safely be relied upon to treat the baby and a further application may be necessary so as to ensure that treatment is authorised, for example;

› Condition/risk develops that was not before the Court when Order was granted

› If a specific time-frame was given to the Court and the indicators for treatment continue beyond that time frame
Form of the Order – Implications for Hospital/Clinicians

- Form of Court Order
  - “authorising the Hospital to administer to the baby all medically appropriate treatment as the Hospital considers necessary to safeguard her life, health and general welfare including, if necessary a blood transfusion and/or other products which are derived from blood components”

- What does this mean for the Hospital/Clinician?
  - May only rely on the Order to provide treatment where
    - Blood treatment is necessary to safeguard life, health and general welfare
    - Blood cannot be administered as a precaution or simply because that is what would usually be done with baby in that condition
    - Hospital/Clinician will be expected to have exhausted all appropriate options prior to administering blood treatment
    - Where condition/risk was before the court
- It is an authorisation to treat – not an Order to treat. Presence of Order is no defence if blood treatment was not the appropriate treatment to administer

- Good communication must be maintained between the Hospital/clinical team and the parents, notwithstanding the Court Order
  - Issues as to communication are not usually incorporated into the Order but Courts have said that they expect communication to be ongoing
  - Good communication includes providing the parents with accurate information about the scope and duration of the Order and the circumstances in which it will be relied upon and informing parents in good time if further applications are planned

- Court Order generally will not address the care of the baby once it is discharged
  - It is worthwhile to plan ahead and think of discharge planning
  - If ongoing care is required, referrals to HSE etc may be required
May rely on the doctrine of necessity to provide treatment notwithstanding parental refusal

*BUT*

Extreme Caution is necessary

- It must be a genuine necessity – not one caused by delay or by a preference not to seek the Court Order

- Clinicians are at risk of civil and/or criminal and/or professional conduct proceedings, Hospital at risk of civil proceedings

  > Necessity may be a defence to these proceedings, particularly if Court Order is likely to have been granted if time allowed for application to be made

  > If the necessity has been caused by inaction on the part of the Hospital/clinicians, a Court is likely to scrutinise the delay in detail and be extremely critical of the delay
Greater protection for the clinicians and for the Hospital if authorisation has been obtained from the Court prior to acting without parental consent

Prior to proceeding without parental consent and a Court Order

- At least two consultants should agree that blood treatment is necessary to save the life/health of the child
- Must also agree that the transfusion is required immediately
- Hospital should still instruct the legal team to commence the process – it may be possible to make the application on time
- Even where blood has been administered, application to Court should proceed, particularly if there is a need for ongoing treatment
Take Home Points

- Early identification of patients/parents intending to refuse blood treatment recommended

- Early identification of high risk patients/babies recommended
  - Facilitates planning for the consequences of the refusal
    - Implementation of dedicated hospital procedure
    - Optimising of medical care and allocation of resources
    - Helps to ensure that refusal of treatment does not dominate care of mother or baby

- Court Orders
  - Procedural steps to be followed except in dire emergencies
  - Use the time you have – do not create the emergency
  - Clinical and legal team to work together to ensure Order sought addresses the circumstances likely to arise
In the K case (Fitzpatrick & Ors v K & Ors, High Court [2008] IEHC 204), Judge Laffoy made the following suggestions for future management of this issue:

- All maternity hospitals should have documented procedures for management of patients who refuse blood and for management of obstetric haemorrhage in patients refusing blood.

- Information should be sought at booking visit to determine whether procedure needs to be implemented.

- Specialised procedure for urgent applications to the Courts in cases of medical emergency.

- Designation by the State of a legal officer to perform the type of functions performed by the Official Solicitor in the UK in relation to patients who refuse medical treatment where an issue as to capacity arises.

- Recognition of reliance on doctrine of necessity in the appropriate circumstances.
The contents of this Presentation are necessarily expressed in broad terms and limited to general information rather than detailed analyses or legal advice. If you would like to discuss this option, please contact Cliona Christie (6492442), Shauna Sugrue (6492310) or Kevin Power (6492951). Specialist professional advice should always be obtained to address legal and other issues arising in specific contexts.