

# Development and Implementation of a Bloodless Medicine and Surgery Program

*Carol Jefferson Ratcliffe, R.N., FACHE, vice president of patient care services,  
Medical Center East, Birmingham, Alabama*

## **ORGANIZATIONAL INFORMATION**

The hospital discussed in this Fellow Project is a 392-bed, Joint Commission–accredited, faith-based organization located in the southeastern United States. Its market base consists of a regional heart center, a regional cancer center, a Commission on Accreditation of Rehab Facility inpatient rehabilitation center, school-based health centers, a freestanding home care company, and a physician-hospital organization. The hospital is a member of one of the top ten Catholic healthcare systems in the United States and is cosponsored by two congregations of Sisters. It has been serving its community of 70,000 for more than 95 years. As a regional referral center, it serves a much broader population of 200,000.

## **BRIEF SUMMARY OF THE PROBLEM**

*Bloodless medicine* is quality medical care employing alternative nonblood medical management as well as minimizing blood loss. It was initiated in the 1980s through the organized efforts of Jehovah's Witnesses, which began in Canada and spread to the United States.

In our community, local hospitals and physicians provided medical treatment for Jehovah's Witnesses, but no hospitals were designated or recognized by the Hospital Liaison Committee (HLC) for Jehovah's Witnesses. In fact, no hospitals in our state were recognized. Approximately 1,500 Jehovah's Witnesses live in our service area, and approximately 150 congregations of Jehovah's Witnesses exist in our state. With patient rights, potential health risks, and the desire for treatment without the use of blood products as drivers, our organization identified a community need for a bloodless medicine program.

## **DESCRIPTION OF THE PROBLEM**

For years, we have used blood, in whole or in part, as an essential element in quality medical treatment. Since the early 1980s, however, the potential health risks associated with blood treatment have raised concerns with consumers and the medical community. Diseases such as AIDS and hepatitis became topics of concern among healthcare professionals and the public. Based on misconceptions, many people nationwide decided not to donate blood for fear of contracting HIV. In our

region, we were experiencing intermittent blood shortages, some of which were severe.

Alternatives were already becoming necessary to meet the needs of patients requiring treatment with nonblood medical management for religious reasons. In balancing the issues and possible religious conscious of patients, the ethical responsibility of the medical and legal professionals became the primary focus.

Many physicians in our community were providing medical treatment for Jehovah's Witnesses, but several practiced under the assumption that they would override religious tenets and obtain a court order for blood-product administration when faced with a critical life and death situation. Prior to my joining the organization, there were specific cases in which a court order had been obtained for blood administration. These cases involved adults who could make their own decisions and choices regarding care. I was also aware of litigation in other states in which patients were awarded astronomical dollar amounts for wrongful transfusion of blood. We needed to embark on a new way of thinking about and providing patient care and to renew our commitment to patient rights.

### **ADMINISTRATIVE DECISIONS**

My previous employer was recognized by the HLC as a bloodless medicine and surgery provider. I received first-hand experience of bloodless medicine through this program and witnessed its positive impact on the provision of patient rights. Protocols were established to minimize and conserve blood loss, and alternatives to blood medical management were offered to all patients. This became the norm for every surgical patient regardless of religious affiliation.

Several key elements were required to lay the foundation for the hospital's program. Determining support was key to our success. As an executive in a faith-based organization, my first step was to determine if the Ethical and Religious Directives for Catholic Healthcare Services would prohibit this program. We also needed support from the Sisters with whose order the hospital is affiliated, administration, physicians, and the local Jehovah's Witness community. We met with the vice president of mission and integration for our hospital, reviewed the Ethical and Religious Directives, and met with a representative for our local bishop. Then, we determined that we could move forward with no prohibition or objection.

Dialog with the local district attorney's office regarding risk management, the treatment of adults, and the treatment of children was vital. This important meeting clarified for us the laws in our state governing the provision of healthcare and specifically the treatment of children. Based on this meeting, we determined that our program would focus on the care of the adult patient. We also took the important step of thoroughly reviewing previous litigation and judicial involvement with our risk manager as it related to Jehovah's Witnesses and the administration of blood.

Informal meetings with members of the medical staff revealed an adequate level of interest in establishing a program. Several physicians were interested in

learning more about nonblood medical management and alternatives to blood treatment. Through these conversations, it was determined that physicians, clinicians, and support staff would require extensive education.

The most difficult challenge was making contact with the local Jehovah's Witness community. Numerous phone calls to the local Kingdom Halls were unsuccessful, so a physician friend assisted me in making contact with an HLC member in another state. The HLC member was excited about our desire to establish a program and agreed to make contact with the HLC covering our region on my behalf. As I waited to find out the result of this contact, a Jehovah's Witness knocked on my front door while conducting weekend ministry, and I took this opportunity to talk about the program our hospital wanted to develop. This conversation was the beginning of a long, positive relationship with the Jehovah's Witness community. Through this initial contact, I arranged to meet with two elders of the local congregation the following week. Simultaneously, the local HLC had received notification from my out-of-state contact. Through these efforts, the foundation for our program was established.

## **RESULTS**

Research and networking revealed that successful programs were co-led by a coordinator and a physician. The coordinator role is a liaison between the hospital and the Jehovah's Witness community, supports the healthcare professionals, and serves as an information resource. The coordinator also provides education for patients, their families, and the professionals. The physician serves as the medical director, assisting in laying the clinical foundation for the program, and as a liaison with the medical staff. One surgeon was highly interested and agreed to serve as the medical director. Through collaboration with the HLC, we hired a coordinator for our program. Ideally, we desired a Jehovah's Witness with a clinical background, but none came forward. Instead we hired a Jehovah's Witness who was a self-starter, had worked in healthcare, was a good communicator, had the aptitude to effectively collaborate with the medical staff, and had the respect of the Jehovah's Witness community.

Our team initially consisted of the administrative leader (me), the coordinator, and the medical director but grew to involve additional physicians and key staff members, including the director of performance improvement, the blood bank supervisor, surgery staff, perfusionists, pharmacists, and nurses. Staff from many other disciplines, such as information management and finance, participated as needed.

We established a referral database comprising 30 percent of our medical staff representing all specialties on staff. We performed an extensive review of existing technology and determined what capital purchases were necessary. We were already in the process of enhancing and expanding our minimally invasive surgery program, and bloodless medicine became its complement.

Educational programs were provided for physicians, clinical and ancillary staff, and the community at large, which included Jehovah's Witnesses as a targeted audience. Numerous education seminars were provided, which included but were not limited to bloodless medicine and surgery, patient rights, minor blood fractions, alternatives to blood transfusions, blood salvage, hemodilution, the durable power of attorney for healthcare, and informed consent. Several renowned guest speakers on bloodless medicine were invited to educate our physicians and staff.

Written standards of care were developed and implemented for the bloodless medicine and surgery patients. These policies included patient identification with special armbands, computer system and chart identification for outcomes tracking, the durable power of attorney for healthcare, collaboration with the HLC, protocols for anemia, and phlebotomy. We established a database of resources for patient care. This involved becoming a member of the National Association of Bloodless Medicine and Surgery.

Through collaboration with the medical staff we selected seven key outcome measurements: length of stay (LOS), financial impact and cost effectiveness, readmission rate, patient satisfaction, mortality, utilization of services, and blood utilization rate. Because this was a new program, 100 percent of the cases were reviewed. We compared patient populations with the same diagnosis for those admitted under the bloodless program with those who were not. We saw a decrease in LOS, cost, and readmission rate, and we saw no difference in mortality. Because we could not monitor satisfaction specific to the bloodless patient, we measured overall hospital patient satisfaction, which continued to increase. Compared to our baseline Jehovah's Witness volume, our program volume increased by 112 percent. We also had many non-Jehovah's Witness patients registering for bloodless treatment. Although expected, overall hospital changes in use associated with blood administration were not seen.

Implementation of a bloodless medicine and surgery program requires a cultural transformation and greater coordination of specialists and caregivers. Our overall goal was to respect the wishes of patients, treat the members of our community individually, and honor a patient's conscience and concerns without compromise. We achieved this through diversity recognition, training, and collaboration as we established the first HLC-recognized program for bloodless medicine and surgery in our community and in our state.

#### **For Further Information**

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Carol Jefferson Ratcliffe, R.N., FACHE, is vice president of patient care services at Medical Center East, a 282-bed acute care facility in Birmingham, Alabama. She was previously vice president and chief nurse executive for CHRISTUS St. Patrick Hospital, a 392-bed acute care facility in Lake Charles, Louisiana. Ms. Ratcliffe achieved Fellow status with the American College of Healthcare Executives in March 2004.

A Selma, Alabama native, Ms. Ratcliffe received a bachelor of science degree in nursing from the University of Alabama in Tuscaloosa and a master of science degree in nursing administration from the University of Alabama at Birmingham. She completed an administrative residency at the University of Alabama Hospital in Birmingham. Her experience in the healthcare field encompasses more than 18 years, 14 of which were in progressive management and operations, business development, and quality improvement. Ms. Ratcliffe is a certified perioperative registered nurse, has served on numerous boards, and has been involved in healthcare advocacy at both the regional and Louisiana state level.

This case study represents a part of Ms. Ratcliffe's ACHE Fellow Project. It was voted one of the best case studies in 2003. To view this Fellow Project online, visit <http://ache.org/membership/AdvtoFellow/fellowproj.cfm>.