Minutes of the Microbiological Safety of Blood and Tissues for Transplantation vCJD Subgroup

Meeting 1: Monday 17 February 2003
Avonmouth House, 6 Avonmouth Street, London SE1

Present:

Chair
Professor Don Jeffries (St Bartholomew's Hospital)

Members
Dr Trevor Barrowcliffe (NIBSC)
Dr Moira Carter (SNBTS)
Dr Jonathan Clewley (PHLS) attended for Dr Philip Mortimer
Dr Roger Eglin (NBS)
Dr Kieran Morris (NIBTS)
Dr Neil Raven (CAMR)
Dr Angela Robinson (NBS) attended for Mr Peter Garwood
Mr Graham Rowe (WBS)
Dr John Saunders (DH/MRC Advisory Group)
Dr Marc Turner (SNBTS)

Officials
Dr Pip Edwards (DH)
Mrs Mary Holt (DH)
Dr Rowena Jecock (DH)
Dr Vicki King (DH)
Mr Stephen Lee (MDA) attended for Mrs Jill Dhell
Dr John Stephenson (DH)

Secretariat
Ms Sara Johnston (DH)
Dr Linda Lazarus (DH)
Mr Charles Lister (DH)

Agenda item 1 Welcome and Chairman's introduction

1. The Chair opened the meeting and welcomed members. This was followed by round table introductions. The Chair explained that the subgroup's aim was to devise a workplan, starting from a clean sheet, that will best serve the UK as a whole and provide an ethical way forward in preparing for the introduction of a blood 'screening' test for vCJD. The first meeting would comprise scene-setting presentations.

2. A number of papers were tabled:
   - Updated agenda
   - Molecular Diagnostic Tests for TSEs (copies of slides to accompany presentation at agenda item 5)
   - Regulation of test kits for vCJD under the IVD Directive (copy of paper [17/2/03 – 5] including all annexes and copy of slide presentation)
   - Media reporting of vCJD tests [17/2/03 - 8]

Agenda item 2 Apologies for absence

3. Apologies were received from Dr Peter Bennett (Economics and Operational Research, DH), Mrs Jill Dhell (MDA), Mr Peter Garwood (NBS) and Dr Philip Mortimer (PHLS).

Agenda item 3 Terms of Reference and Membership [17/2/03 – 2]

4. The terms of reference were agreed unchanged as:

> "To advise the Department of Health on the preparative work which needs to be carried out to enable a rapid response to the introduction of a vCJD blood screening test once one becomes available."

5. Members were advised that officials from the devolved UK health departments were being copied the papers and minutes of the meetings to keep them informed.

6. Members were asked to consider, during the course of the meeting, whether any additional expertise was needed on the subgroup, for example from the veterinary research side. Views would be sought under Any Other Business.

Agenda item 4 Declaration of interests [17/2/03 – 3]

7. Members were reminded to complete the declaration of interest form and return it to the Secretariat. The Chair declared a research interest in protein detection on surgical instruments as this could have potential for blood screening assays.

> **Action 1(1):** Members who have yet to do so are requested to complete and return their declaration of interest forms.

Agenda item 5 Molecular "Diagnostic" Tests for TSEs [tabled slides]

8. This presentation began with a clarification of terminology and agreement that 'screening' rather than 'diagnostic' test should be used to refer to assays for detecting transmissible spongiform encephalopathies (TSEs) (and surrogate markers) in blood. This acknowledged the unknown clinical significance of a positive blood test result. The word diagnosis was felt to imply a prognosis, i.e. that if a test is positive there is some risk of disease, and this could cause future communication difficulties with blood donors. Calling a test a diagnostic test also infers that there will be a confirmatory test to back up the initial 'screening', which may not be the case for vCJD. Ideally, the initial 'screening' test should be backed up with two or three independent tests that measure different parameters.

9. The various tests for TSEs currently available were outlined. Most are based on detection of the abnormal prion protein (PrP^{Sc}), whose presence is associated with but not synonymous with disease. The tests can be divided into three types, according to their purpose.

> (1) Post mortem tests are conducted on high-risk animal tissue (e.g. brain) for food safety surveillance and are unlikely to be of use in developing a blood 'screening' test.

(2) Clinical tests used for early diagnosis of disease in symptomatic individuals involve brain scans and/or tonsil biopsy and are therefore unsuitable for blood 'screening'. Cerebrospinal fluid (CSF) may also be of value for clinical investigation but less invasive samples (e.g. urine) would be needed for 'screening'.

(3) Potential pre-clinical tests used for animal disease surveillance hold the most promise as a source of a human blood 'screening' test. The majority of approved/developmental tests focus on three key properties of the prion protein, which can be exploited for separation or amplification.

- Firstly, the differential susceptibility of normal and abnormal prion to proteinase K digestion (abnormal protein is resistant);
- Secondly, the presence of a specific epitope on normal prion that requires unmasking by chaotropic agents in the abnormal protein;
- Thirdly, the differential solubility of the abnormal prion protein and its tendency to aggregate and to serve as a template for converting normal prion protein.

10. Other markers that are being researched include CSF proteins (correlate with non-specific neuronal damage) and erythrocyte development factor (ERDF). The latter shows reduced protein and mRNA expression during disease progression in several mouse models but the biological basis for this observation is unknown.

Agenda item 6 Research on TSE-related diagnosis: DH-funded research and UK facilities [17/2/03 – 4]

11. The presentation elaborated on the paper circulated before the meeting. The Department of Health (DH) funded over £5 million's worth of research into TSE diagnosis in total, including projects initiated following a joint call for proposals in 2001 co-ordinated by the Medical Research Council. While there is nothing immediately promising on the horizon in terms of pre-clinical 'screening' tests arising from this publicly funded work, such tests have significant commercial potential and may be in advanced development. An automated testing system based on the conformation-dependent immunoassay is undergoing field trials and the blood services will be following this closely as automation is a key requirement for a blood "screening" test.

12. In a recent development, three DH-funded research centres (CAMR, PHLS and NIBSC) have proposed establishing a Consortium against TSEs (CAT). If given the go-ahead, CAT would be well-placed to provide the facilities for evaluating a 'screening' test. Carefully validated collections of animal and human material, including post mortem specimens, anti-sera and so on, will also be needed to support any such evaluations.

13. Looking ahead to a blood 'screening' test becoming available, DH is planning to hold a workshop to rehearse/resolve the various ethical issues that are likely to arise.

Action 2(1): DH colleagues to keep Secretariat/subgroup informed of progress with setting up the workshop and ensure members are invited.

Agenda item 7 **Regulation of test kits for vCJD under the In Vitro Diagnostic Medical Devices Directive [17/2/03 – 5]**

14. The In Vitro Diagnostics (IVD) Medical Devices Directive is a European free trade initiative (not a patient safety directive) enabling manufacturers to sell their products anywhere in Europe. It is transposed into UK law by the Medical Devices Regulations 2002. The IVD Directive comes into force in December 2003, after which time it will be illegal to place on the market non-CE-marked devices. [The terms 'in vitro diagnostic (IVD)' and 'medical device' are very broadly defined – see Appendix B of paper [17/2/03 – 5] – and include the test kit itself plus reagents, control materials, instruments and so on.] CE marking will be required even for in-house IVD tests if they are transferred from one legal entity to another e.g. if one UK blood service provides a testing service for another blood service, or if the laboratory using them provides a commercial testing service. Devices used for research are not covered by the regulations.

15. The CE mark shows that the product complies with the relevant essential requirements of the Directive. The IVD Directive controls the safety, quality and performance of the kit as specified by the manufacturer. It does not cover wider issues such as purchasing or use, except in the context that they require appropriate labelling and instructions for use to be provided with the kit. In the UK, the Secretary of State for Health is designated the Competent Authority for enforcing the Directive and this responsibility is delegated to the Medical Devices Agency (MDA) (the Medicines and Healthcare products Regulatory Agency from 1 April 2003).

16. MDA were asked whether they would be able to advise DH/NBS if a manufacturer registers an IVD (a vCJD blood 'screening' test) with them as the Competent Authority for the UK. UK manufacturers must register with MDA when they place their kit on the market and non-UK manufacturers must notify MDA when they place a kit on the UK market. However, registration may occur simultaneously with marketing, thereby providing little or no advance notice. MDA are seeking legal advice on disclosure. It may be permissible for MDA to disclose to DH if, from the legal perspective, we are two parts of the same organisation (under the aegis of the Secretary of State for Health), but wider dissemination could breach confidentiality.

Action 3(1): MDA to confirm the legal position on disclosure.

17. The subgroup was asked to consider the best way to regulate 'screening' tests for vCJD. It was agreed that vCJD should be included with the Annex II List A markers for which the risk of a false result to the patient, user or a third party is perceived to be the highest. **[The Secretariat was subsequently advised by MDA that the criteria for inclusion in Annex II List A are detailed in Article 14 of the IVD Directive. As not all of these criteria were specifically addressed by the subgroup, it will be necessary to consider Article 14 at the next meeting before making any recommendation to MDA about pursuing an amendment to Annex II List A.]** The process of amending the list is lengthy (it could take 3 years but could be achieved more quickly). Other EU states were unlikely to disagree with this assessment of the risk, but it has not been discussed at EU level yet. For devices in List A, a common technical specification (CTS) can be drawn up. This will be subject to negotiation within Europe. Use of a CTS is not mandatory but if it is not used, the manufacturer has to prove equivalence or higher. In practice, therefore, a CTS is likely to be used where one exists.

Action 4(1): MDA to provide relevant documentation and lead discussion on Article 14 of the IVD Directive at the next meeting to reach an agreed position which the Secretariat can then seek to have endorsed by MSBT.

18. The regulatory process for Annex II List A IVDs involves the greatest scrutiny and requires the manufacturer to adhere to the CTS. The CTS establishes performance evaluation and re-evaluation criteria. A Notified Body (designated by the Competent Authority) audits the quality assurance, assesses product design and verifies batch or product release to ensure it conforms with the CTS.

19. There are minimum requirements that manufacturers of all IVDs have to meet in order to CE mark their product, including a statement on the performance characteristics (e.g. sensitivity and specificity), taking account of current standards. There is likely to be an issue for manufacturers of early vCJD 'screening' tests of finding a suitable comparative test/gold standard for defining performance parameters. Another potential obstacle lies in procuring ethically acceptable human samples (i.e. obtained with informed consent for use in evaluating a commercial product). Suitable samples for test development/ evaluation could prove to be a significant obstacle to manufacturers.

20. NBS already sets higher performance standards for the Annex II List A kits it uses for blood 'screening' than are set by CE marking, which is a minimum standard. While it would not be possible to introduce legislation to prevent the placing of a CE-marked vCJD test on the market, the NBS, as a customer, could introduce its own purchasing specification for a vCJD test to include particular requirements in respect of performance. NBS have already done some developmental work on this in connection with an OJEC (Official Journal of the European Communities) tender. This could act as a guide for manufacturers until such time as a common technical specification is in operation. It was also pointed out that the NBS require a specific mandate from the Secretary of State for Health before introducing a new blood screening test. The European Blood Directive sets minimum standards but would not prevent the unilateral introduction of more stringent blood safety measures.

Action 5(1): NBS to provide a first draft of a UK purchasing specification for a CJD blood 'screening' test, based on work in connection with OJEC tender, including minimal functional requirements for a test.

Action 6(1): UK Blood Services to work up scenarios for evaluation, including examples of likely obstacles (practical, ethical, legal), of a vCJD blood 'screening' test becoming available from a range of likely sources (e.g. DH-funded research, commercial company, etc) and with varying timelines (i.e. what's feasible if a test becomes available in 6 months, 12 months, etc).

Action 7(1): EOR/NBS to prepare a paper on the impact of false test results (both false positive and false negative) on blood donor/recipient using a range of likely test sensitivities/specificities to help inform Actions 4 (criteria for Annex IIA listing) and 5 (minimal functional requirements).

Microbiological Diagnostics Assessment Service (MiDAS)

21. MiDAS has been providing a post-marketing evaluation service of high-risk markers (Annex II List A) for the MDA (and NBS) for approximately 10 years to assist NHS purchasers in decisions about purchase/usage. Once CE marking

becomes mandatory for all new in vitro diagnostic devices, MDA does not plan to commission evaluations of IVDs for which a CTS exists.

Agenda item 8 Introduction of New Marker Testing into NBS [17/2/03 – 6]

22. The procedure for introducing a new marker into blood testing services was outlined. Certain of the key criteria, such as whether it is a transfusion transmissible infection, what its prevalence is in the population and whether it is pathogenic (if transmitted through blood) have not been proven for CJD.

23. The next stage is to identify an appropriate assay. Ideally, several assays would be evaluated together in a reference laboratory setting before proceeding to an operational environment.

24. Some of the lessons learned from introducing hepatitis C screening in the early 1990s were described. For example, how surrogate marker testing (anti-HBc and alanine aminotransferase) would have picked up only a proportion of hepatitis C positive donations and how the high false positive rate (up to 10%) associated with first-generation assays would have resulted in rejection of a substantial proportion of donations.

25. The more recent introduction of anti-HTLV I/II testing was outlined. This had involved the Kit Evaluation Group. The available tests were not very specific and testing individual samples was expensive. However, in true cases of infection, antibody levels are very high making sample pooling an attractive possibility. Using pools of 48 (as generated for HCV NAT testing), 98% sensitivity was achieved. Having only a single assay suitable for this screening is not ideal (in case of product shortages/withdrawal) and contingency plans are needed.

    Action 8(1): NBS to explain the role/timing of involvement of the Kit Evaluation Group.

26. Using a project management approach had enabled NBS to address a range of other important issues in their implementation plan (for introducing HTLV I/II screening) including work with donor centres, information for and availability of counselling for those found to be infected and lookback arrangements.

27. Other issues to resolve in relation to any CJD test include what constitutes an acceptable test, striking a balance between a high false positive rate and blood shortage and accessibility of counselling. [An initial reactive rate of >0.5% with a 10-fold reduction on repeat testing would result in too high a discard rate. Also detrimental would be a test with a high false negative rate as this could undermine patient confidence in blood transfusion.] It was pointed out that CE marking of a test would reduce the need for sensitivity evaluations but would never be a substitute for specificity analysis. Testing against a representative subset of the UK blood donor population is essential (i.e. in operational context) to give an idea of the likely number of reactive donations. Specificity will be determined by comparisons with tests on blood donations from an unexposed population (e.g. blood donors from USA).

Agenda item 9 Ethical issues surrounding the use of anonymised versus named samples in relation to vCJD testing

28. This presentation outlined considerations underlying the choice of anonymised (without explicit consent) or named (with informed consent) testing for CJD.

[Powerpoint file attached.] Two key reasons for testing were identified: (i) to understand the epidemiology of vCJD (research/public health objective) and (ii) to protect blood recipients (therapeutic objective). For prospective epidemiological studies of CJD, linkage of samples allowing follow-up of individuals over time has the potential to provide the most useful information. However, a duty of care is invoked (because clinically relevant information may emerge) and informed consent is required for such studies.

29. The proposed prospective study of tonsils for vCJD is an exception. Unlinked anonymous methodology has been advocated on practical grounds to maximise the number of eligible specimens that could be collected. Tonsils from children born after January 1996 would be excluded from the survey as the children should not have been exposed to prions through the food chain. Procedures for informed consent for participation in the study were likely to take too long to establish with ENT surgeons and the window of opportunity to conduct a prospective study would be lost.

30. NBS explained that they were not proposing an epidemiological study, which raised the question of how they would know if reactive specimens identified were relevant. Serial samples specific for human vCJD (akin to the seroconversion panels for HIV etc used to evaluate sensitivity) are not available. However, serial bleeds from experimentally infected animals might give an idea of relevance in a test that showed cross-species reactivity. At present, the stage of CJD incubation at which a blood 'screening' test might give a positive result remains unknown.

    Action 9(1): DH R&D to consider future need for epidemiological studies in large cohort.

    Action 10(1): DH R&D to raise at the Joint Funders Group whether experiments have been or need to be set up to provide serial bleeds from TSE-infected animals that could be used in evaluating a vCJD blood 'screening' test.

31. NBS reported that a survey of blood donors' attitudes to a CJD test was being repeated. When it was first undertaken **[Query for NBS – what year was this undertaken?]**, a correlation was found between increased awareness and reluctance to donate, i.e. because samples have to be linked (and traceable) donors would not have the option of not being informed if their blood gave a reactive result. Given the current uncertainties of the clinical significance of such information, it could have profound implications for individual donors and their families. [SNBTS reported a similar experience.]

32. However, information is not neutral. If we believe it is important to test donated blood despite the uncertainties, the message to blood donors could be that testing is morally justified because of our responsibility to society (to protect blood recipients from harm). Assurances need to offered to minimise the harmful effects on the individual. This could take the form of providing counselling, reaching agreements with the insurance industry and so on.

33. The subgroup was reminded that, following the introduction of HIV testing in 1985, there was a 10% drop in donation.

Agenda item 10 Further information requirements and workplan

The following issues needed further exploration/development:

34. Identify risks associated with a vCJD blood 'screening' test coming on to the market/being CE-marked before an amendment to Annex II List A can be made (i.e. what protection does Annex IIA listing afford?). What are the likely barriers to amending Annex IIA? What performance evaluation is required by manufacturers to obtain CE marking for Annex II List A devices and how does this differ for 'unlisted' devices? What evaluation can UK blood services do that would not be in breach of the IVD Directive?

    Action 11(1): MDA to work up a paper covering these and related issues discussed by the subgroup as the basis for seeking ministerial agreement for the UK to propose amending Annex II List A of the IVD Directive.

35. What sort of samples would we wish to store for evaluating a blood 'screening' test? One model assumes that the panel comprises multiple aliquots from a representative subset of the donor population, so that new generations of tests can be evaluated against the same specimens, to allow comparisons to be made over time. The samples would be unlinked and anonymous but could retain some demographic information (e.g. age band, sex, donor centre where collected). On ethical grounds, donors would have to be informed that some donations were being diverted in this way.

36. Alternative strategies need to be considered. It was proposed, for example, that salvaging the 250 ml of plasma that is currently discarded from each donation and collecting white cells from leucodepletion filters (both by-products of CJD risk reduction strategies) would be attractive both from cost and patient acceptability perspectives. There would still be a question of storage and a sample retrieval system.

37. While CSF and brain clearly cannot be collected, saliva and urine seem like viable alternatives to blood. These should be considered alongside blood and its components/fractions. The reasons why each of these sources is/is not suitable needs to be documented, taking into account costs of replacing donations diverted from the blood supply to create a test-evaluation panel, the expectations of donors, storage requirements and so on.

    Action 12(1): NBS (in collaboration with other UK blood services) to consider possible specimens and sources (including currently discarded plasma and white cells removed by leucodepletion, components nearing the end of their natural shelf-life and other easily sampled body fluids) and match specimen requirements to likely/promising assay platforms.

38. Laboratory facilities were not discussed in detail. Guidance on safe working and the prevention of infection with TSEs (issued by the Advisory Committee on Dangerous Pathogens and SEAC) is under revision. Paper [17/2/03 – 4] listed the currently available research facilities for TSEs. Containment Level 3 is recommended, especially when working with concentrated material. Therefore, higher-risk aspects of test evaluation might be undertaken in collaboration with research institutes that already have such facilities. Some derogations from full containment Level 3 may be acceptable (subject to risk assessment) for non-research work.

Action 13(1): NBS to conduct a risk assessment, in consultation with the Health and Safety Executive, including consideration of derogations from full containment Level 3 that may be acceptable for test evaluation work.

Agenda item 11 Any other business

39. Membership: Members were content with the current composition of the subgroup.

40. The programme for a consensus conference on vCJD screening of blood donors being held in Quebec, Canada on 27 and 28 March had been circulated [17/2/03 – 7]. It was noted that a number of speakers had been invited from the UK (e.g. from SNBTS and NBS). The Secretariat requested that written feedback be provided from colleagues attending or presenting at the conference for discussion at the next meeting.

Action 14(1): Secretariat, SNBTS and NBS to seek feedback from colleagues attending or presenting at the Canadian consensus conference for discussion at the next meeting.

41. Some recent examples of media reports on CJD tests were tabled for information [17/2/03 – 8], including clarification from SNBTS on the nature of the discovery arising from their collaboration with Gradipore. Rather than being a blood 'screening' test for vCJD, it was in fact a pre-assay processing step.

Agenda item 12 Dates of next meetings

42. The next two meetings will be held on:
    - 8 April 2003 at 2pm-5pm in room 281D Skipton House
    - 16 May 2003 at 10.30am-1.30pm in room 125A Skipton House.

Action Points

Action 1(1): Members who have yet to do so are requested to complete and return their declaration of interest forms.

Action 2(1): DH colleagues to keep Secretariat/subgroup informed of progress with setting up the workshop and ensure members are invited.

Action 3(1): MDA to confirm the legal position on disclosure.

Action 4(1): MDA to provide relevant documentation and lead discussion on Article 14 of the IVD Directive at the next meeting to reach an agreed position which the Secretariat can then seek to have endorsed by MSBT.

Action 5(1): NBS to provide a first draft of a UK purchasing specification for a CJD blood 'screening' test, based on work in connection with OJEC tender, including minimal functional requirements for a test. [Paper]

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Action 8(1): NBS to explain the role/timing of involvement of the Kit Evaluation Group. [Paper]

Action 9(1): DH R&D to consider future need for epidemiological studies in large cohort.

Action 10(1): DH R&D to raise at the Joint Funders Group whether experiments have been or need to be set up to provide serial bleeds from TSE-infected animals that could be used in evaluating a vCJD blood 'screening' test.

Action 11(1): MDA to work up a paper covering these and related issues discussed by the subgroup as the basis for seeking ministerial agreement for the UK to propose amending Annex II List A of the IVD Directive. [Paper]

Action 12(1): NBS (in collaboration with other UK blood services) to consider possible specimens and sources (including currently discarded plasma and white cells removed by leucodepletion, components nearing the end of their natural shelf-life and other easily sampled body fluids) and match specimen requirements to likely/promising assay platforms. [Paper]

Action 13(1): NBS to conduct a risk assessment, in consultation with the Health and Safety Executive, including consideration of derogations from full containment Level 3 that may be acceptable for test evaluation work.

Action 14(1): Secretariat, SNBTS and NBS to seek feedback from colleagues attending or presenting at the Canadian consensus conference to report back at the next meeting.

1 Using anonymised versus named samples for vCJD testing: ethical issues

John Saunders

Committee for ethical issues in medicine, Royal College of Physicians; chairman, MREC for Wales; fellow, Centre for Philosophy & Health Care, University of Wales, Swansea

2 Assumptions 1

- Unknown prevalence
- Unknown specificity/sensitivity (i.e. false +ve, -ve), predictive value
- Unknown transmissibility
- Unknown significance of true +ve
- ? unknown test costs

3 Assumptions 2

- +ve test = risk of (untreatable) vCJD (implication for donor)
- Disease transmitted by transfusion (implication for recipient)
- Costs not prohibitive (implication for society)

4 Moral conditions as threshold standards (1)

- 1. Humaneness: based on principles of autonomy & human dignity.

Public policy goal & means must respect dignity, autonomy & privacy.

Burden on policy makers to justify infringement.

5 Moral conditions as threshold standards (2)

- 2. Proportionality: based on well-being & non-maleficence

If harm unavoidable, not only must policy benefit justify foreseen harm, but the policy means should represent the least restrictive harm of last resort

6 Moral conditions as threshold standards (3)

- 3. Efficacy: based on principle of well-being.

Policies must be capable of achieving their stated ends of public benefit. (Don't adopt the policy unless it works).

7 Moral conditions as threshold standards (4)

- 4. Non-discrimination: based on principle of justice

Policies that separate out persons by considerations not relevant to the policy issue are unjustified.

8 Moral conditions as threshold standards (5)

- 5. Feasibility: based on principles of social solidarity & well-being

Public policies must be practicable & adaptable to circumstances, culture, attitudes & traditions i.e. mustn't undermine the social/cultural order

9 Unlinked anonymous testing; experience with DoH programme for HIV 1989

- 1. Awareness <50% everywhere (Wales 41%, SW England 21%)
- 2. 26% disagreed with unlinked anonymous testing
- 3. Almost twice the disagreement if unaware of policy (31 v. 17%)
- 4. Testing for other 'usually fatal' diseases gave similar results

Kessel et al. BMJ 2000;320:90-1

10 Patient consent preferences in research

- 123 patients: 17 interviewed, 106 surveyed
- 26% opt out, 74% opt in
- 57% wanted specific information
- No distinction between identifiable & anonymous information

Willison et al. BMJ 2003;326:373-6

11 pro-consent

- Infringes autonomy
- Need to know result (therefore shouldn't anonymise)

Patient is being asked to relinquish the opportunity to learn the result & should know benefits & burdens

Hence failure of duty of care.

12 pro-consent ?

Since not aware of being tested & no consent given, to inform would be a paternalistic assumption that the professional knows best

13

- Knowing there is an unidentifiable person with a positive test does not invade that person's privacy or dignity; nor can there be a duty of care to someone unknown.

14

- "Unlinked (anonymised) seroprevalence surveillance programmes comprise research studies designed to inform policy & practice....they are not screening for the purposes of individuals"

(A Pinching)

15 Reasons for testing

- Epidemiology of vCJD (= research)
- Protect blood recipients (= therapy)

16

- Anonymous unlinked testing is not a means for the diagnosis of vCJD
- A voluntary named testing programme is needed for this.
- In principle, the two could co-exist

17 Why not consent?

- Risk of introducing bias into research
- Risk of psychological, social harm
- Costs
- Difficulty of contacting participants (stored samples or records)

18 Exception to consent?

If

- epidemiological research and
- possible long term benefits and
- consent not practical and
- no implications for the patient,

then

moral balance favours RECs having discretion to approve research & journals to publish.

19 From 1998-2000, 0.55% of patients attending GU clinics & 1 in 1000 pregnant women refused tests by anonymous unlinked technique; 6-7.5% of drug users.

- Should patients be able to opt out of their tissue being used in public health surveys employing the unlinked anonymous technique?

Human Bodies, Human Choices, 2002, 9H

20 Public versus private

- Duty of individuals to protect the public good & contribute to it

(may infringe freedom e.g. public health legislation, compulsory education, conscription); free riding is unfair

- Duty of others to respect autonomy

Sacrifice of either principle leads to harm

21 But.....

if we are interested in more than basic epidemiological data (e.g. follow up of donors), then linkage is essential; and with linkage, comes consent. The patient is identifiable & a duty of care can plausibly be said to exist.

22 In summary...

- It is best to inform & consent whenever practicable.
- Notices (etc) are worthwhile but not adequate.
- Anonymous unlinked studies are acceptable in research studies where consent is impractical.
- Named testing with consent could co-exist; & is necessary for linked studies.

Microbiological Safety of Blood and Tissues for Transplantation
vCJD Subgroup

Declaration of Interest

1. All those taking part in the Committee have been asked to complete declarations of interest. These should be submitted to the Secretariat either before or at the first meeting using the attached form. Declarations may be made available for scrutiny and may be discussed by the Committee.

2. The kinds of interest that should be declared are as follows:

   - Close links with, or an interest in, proposals where the institution that the individual is associated with (e.g. their university) stands to gain (e.g. research funding) from a decision.
   - Commercial or financial interest in any matter under consideration.
   - Personal or family interest.
   - Involvement in litigation relevant to the business of the committee.

3. A member may declare a previously undisclosed interest to the secretariat or chairman at any time - and should do so - once they recognise there is a potential for conflict (or for a perception there could be a conflict). It can be worth a member reminding the committee during the course of its business that he or she has a particular interest relevant to a specific item of business. It may be appropriate to absent themselves for that discussion or meeting.

Confidentiality

4. The Government is committed to openness in its processes and key decisions. However, the deliberations of committees are themselves confidential, to allow free and frank expression of opinions, to protect the confidence of referees and individuals, and to avoid premature disclosure of intentions. In addition, information may be provided to committees with an expectation that it is not revealed to third parties.

5. Nevertheless, it can be desirable and advantageous for committee members to consult with individuals outside the committee and with their broader constituencies. The chairman, secretariat and members have a responsibility to clarify the balance between disclosure and confidentiality that members have, ensuring that this is consistent with the general principles of the Code, and must respect this balance in spirit and in practice.

6. The Chairman and the supporting Secretariat are responsible for communicating the recommendations and advice of the committee.

Freedom of Information

7. Under the Freedom of Information Act members of the public, MPs etc may ask to see any papers considered by the Group and the minutes of the meetings. Therefore in the official minutes comments will not be attributed to named individuals, and for clarity, a separate named action list will be circulated.

Declaration of Interest Form

Name:

Please complete the declaration of ALL interest that may be perceived as potentially or actually a conflict of interest. Brief descriptions will suffice – we can seek further information from you if required.

1. About you:

What interests have you relevant to the committee of a financial, lobby/political, research funding, that may be relevant? Do you or your organisation receive remuneration from these activities?

2. About your organisation:

What relevant interests has your university department, or the charity or other organisation which employs you, or for whom you work for a significant proportion of your time? Have any close colleagues strong interests in the decisions made by the Committee?

3. Other relevant interests you would like to declare

This information will be available on request to any bona fide enquirer.

Thank you for your help.

Signature:..... Date:.....