file donor cons (A).
Copy to MSC file

Dear Jack —
Sorry you missed us
So low was what I said at MSC
what I said to you the day after.

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

EDINBURGH & S.E. SCOTLAND
BLOOD TRANSFUSION SERVICE

DIRECTOR'S OFFICE
18/10/95

MEMORANDUM

File No.

I think we should continue discussion. It's my responsibility to correct the minute and I will.

FROM: Dr J Gillon

TO: Dr DBL McClelland

Copy: Professor JD Cash

REF: JG/SS

DATE: 17th October 1995

Dear Brian

GRO-C

24.10.95

Re: Personal Interview of Donors - MSC 10th October 1995

I have received the minutes of last week's MSC Discussion, and was alarmed to see that the minutes did not accord with the comments you made to me the day after the meeting. I understood you to mean that you had offered to ask me to consider once more if there were any feasible ways of evaluating the introduction of Personal Interviews. According to the minutes, you appeared to have committed SEBTS to a data collection exercise which makes little sense to me. I would make the following points:

1. According to the minutes, Dr Galea represented the Donor Consultants Group as having decided that evaluation of the policy would be to costly and long term to be pursued. This is certainly not my view. I have repeatedly made the point that the time to evaluate the policy is at its introduction, and that the only window of opportunity for anything resembling a prospective trial is now.

2. The data collection exercise that has apparently been agreed, if it were feasible, would test the efficacy of the HIV exclusion criteria as much as the method of implementation of these criteria. I presume that HIV seroprevalence is the main focus of interest, and I shall take each of the categories for which we have been volunteered in turn.

   1) Donors who have not been interviewed. These are very few in number, and almost by definition are donors who have turned on their heels without discussing any aspect of the eligibility in detail. The information will therefore be sketchy, and the donors, having taken offence, would, in my view, be impossible to approach further.

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2) Donors who have been interviewed and accepted. These, of course, are the donors who provide the current statistics on seroprevalence. We know that there is a problem with the data for regular donors, in that the statistics tend to relate to attendances rather than the donors, but the new donor data showing a prevalence of approximately 1 in 25,000 across the country, with some regional variation, must be considered to be accurate.

3) Donors who have been interviewed and deferred. It may indeed be possible to enlist such donors in a study of seroprevalence, but the numbers will be so small that it will be impossible to obtain meaningful data. Currently we have fewer than 100 such donors a year identified in SEBTS, and the numbers in the other regions are almost certainly much smaller. What seroprevalence level in these donors would be considered significantly increased? Even if the seroprevalence in this donor population was as high as 1 in 200 (which is extremely unlikely) it would take us around 10 years to be sure that this was indeed the seroprevalence. This is, of course, statistical nonsense. There may well be surrogate markers that could be studied, eg. Anti-HBC, but again the small numbers suggest to me that it would be unlikely that we would be able to mount a valid study (and we would require a control group. This would all very rapidly become expensive).

3. The issue which can be addressed, and in my view should be addressed, is that of the efficacy of the interview procedure in identifying donors who ought to be excluded on the basis of high risk behaviour. Thus we start with the premise that if the criteria are reasonable, better implementation of the criteria should be seen as a quality gain that can only make the blood supply safer. I fully accept that the data which we have provided showing that personal interviews increased the detection of such donors are historical and therefore open to criticism, but it is not now possible for us to turn the clock back. The other Scottish Regions are ideally placed to mount such an exercise. Since our data showed a 100% increase in detection, and the comparative data with Aberdeen indicated that we identify ten times as many at risk donors in Edinburgh indicated that it would be possible to confirm or refute these findings relatively quickly. It would not be expensive - and might even save a little money since any such evaluation would need a control arm in which certain sessions were run in parallel without personal interviewing.

I have made it clear at the Donor Consultants Meeting that I would be happy to help in any such exercise.

Yours sincerely

GRO-C

Dr J Gillon
Consultant