POLICY IN CONFIDENCE

Ref: Cana62

ACQ 15

Mr J Canavan HC(A)4B

From: Dr A Rejman HC(M)2

Date: 6 February 1992

Copy: Mr Wilson HC(A)
Mr Scofield HC(A)4
Mr Blake SOLB4
Mr Kendall FA1
Mr Thompson AIDS Unit
Mr Chinque CH(A)4

HIV INFECTED BLOOD TRANSFUSION AND TISSUE RECIPIENTS

1. Thank you for your minute dated 29 January. I apologise for the delay in replying.

2. I have had the benefit of seeing Mr Thompson's minute dated 31 January and Mr Chinque's dated 3 February.

3. In para 9 I would suggest that the date would probably better be 1979 rather than 1980.

4. Regarding para 15 I think it is important to remember what happened to the original "look-back" pilot suggested by EAGA There was considerable resistance from some Consultants to inform recipients who might be at risk of HIV, and various reasons were put forward for this including (i) not being of any benefit to a patient who was likely to die from his primary disease in the near future and (ii) the distress that could be caused to a patient or his family of knowing that he was infected with HIV, when he was actually dying of another disease. There was also opposition from some local ethical committees on similar grounds. It is possible that the prospect of financial gain may make "look-back" easier on this occasion.

5. It would also be worth considering what to do about patients who have died without having been tested for HIV. If these patients had been given blood from a donor who was known to have been HIV positive at the time it is not certain that they would have become HIV positive. How would these patients by dealt with? If the patient died soon after transfusion (less than 3 months) it would be reasonable to assume he had not seroconverted. In the case of a patient who had died and who did not have any stored blood samples which could be tested and if the donor was now known to be HIV positive, but was not known to be HIV positive at the time, how would this situation be handled?

6. Some of the above points refer to comments made by Mr Thompson.

7. I Would take issue with the suggestion at the end of para 2 of Mr Thompson's minute stating that denying people who do not know that they are HIV positive financial assistance is at all relevant. The purpose of the financial assistance is to help them overcome a problem which the patient has as a result of his HIV, whether it be problems with life insurance, employment and clinical disease.

8. In respect of Mr Chinque's minute, I would suggest that in para 3 that there is no alternative but to insist that a counselling session be arranged prior to testing by a physician and giving the patient the result.

9. In respect of para 5 Mr Chinque will be interested to know that in the haemophilia cases some infected individuals have obviously not told their partner that they are HIV positive. We have been advised by solicitors that there is nothing we can do about this.

10. In your para 5 you asked about the theoretical number of infected blood and tissue recipients. I enclose a brief very theoretical calculation of the numbers that might be infected by blood donation over the various years. Obviously this figure has to be treated with great caution. Unfortunately, we cannot go outside for a more detailed estimate, but I would be grateful for Mr Thompson's view. I have discussed briefly with Dr H Williams.

GRO-C

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