

Northern Regional Haemophilia Service

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DRAFT

Ref: PH/LM

7 November, 1997

Miss P. Hurd,
Customer Services Manager,
Bio Products Laboratory,
Dagger Lane,
Elstree,
Herts.
WD6 3BX

Dear Miss Hurd,

Product Recall

I am very concerned at the way the Bio Products Laboratory are handling CJD product recalls.

As the consultant in charge of this Haemophilia Centre in the absence of my colleague Dr. Jones, I object to letters being addressed to the sister in charge about therapeutic products. I would remind you it is doctors, not nurses, who prescribe factor VIII concentrate.

(I also note in passing that if you write to someone you should spell their name correctly and I hope you will have the courtesy to apologise to Sister Fearn.)

The main point of this letter, and the one which I am most concerned about, is your lack of appreciation of the sensitivity of the doctor/patient relationship. You can only advise and cannot, should not and must not attempt to intervene in our relationship with patients by telling nurses, let alone doctors themselves, that products which have been prescribed to individual patients must be recalled and taken away from a patient.

You then compound the problem by telling us that we do not need to tell the patient why we are asking them to surrender the product prescribed and this raises ethical problems.

Labro

Directors: Dr. Peter Jones, MD FRCP DCH; Dr. Peter Hamilton, MA BM BCH FRCP FRCPath;
Clinical Nurse Specialist: Sister Maureen Fearn; Clinical Specialist in Physiotherapy: Mrs. Brenda Buzzard;
Social Workers: Mrs. Pat Latimer; Mrs. Anne Wilson; Secretarial Staff: Mrs. Linda McBride; Mrs. Michelle Stenhouse

Whoever the Lothian Ethics Committee are, their remit for solving ethical dilemmas involved in the provision of health care does not run outside their own region and certainly not south of the border. I remain responsible for the ethics of my practice guided by my own local Ethics Committee.

Patients cannot and should not be treated as mindless automatons whose drugs can be surrendered without question at the whim of some government committee (your use of abbreviations MCA and PCMP is to be deplored). Of course such committees can make recommendations and it would be foolish for the doctor to ignore them but at the same time the doctor has responsibility to his patient to keep them informed of what is going on and not tell them lies. How are we going to deal with the patient who has used some of the product already when he learns that the government recommend that the product be withdrawn and we refuse to tell him why?

Why aren't we going to own up to patients that they have received this potentially contaminated product and that they have been given a product which we do not think is "safe" to give any more?

Hushing things up and being economical with the truth with patients always causes long term problems. Furthermore, in later years it may be if CJD contaminated products prove to be dangerous that we could be seen to be participating in a conspiracy and not kept patients informed.

It does seem that there is urgent need to implement the UKHCDO Guidelines of October 1996 and the purchasers be instructed that we follow Europe and recommend the use of recombinant products forthwith.

Kind Regards,

Yours sincerely,

PETER HAMILTON
Consultant Haematologist

PS α $\rightarrow$ I note in passing etc.

cc. Chief Executive, National Blood Authority
Dr. A. Robinson, Chief Medical Officer, National Blood Authority
Dr. A. Brewis
Dr. C. Ludlam, *Chairman, UKHCDO.*
Dr. P. Jones.
BMA Ethics Committee
MDU