AD HOC COMMITTEE FOR PUBLIC POLICY ON AIDS, IRWIN MEMORIAL BLOOD BANK; MINUTES 5/2/85

Irwin Memorial Blood Bank
OF THE SAN FRANCISCO MEDICAL SOCIETY

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Ad Hoc Committee for Public Policy on AIDS

Minutes of May 2, 1985 Meeting

PRESENT

Brian McDonough, Margaret Bryan, Darlene Fontaine, Albert Jonsen, Ph.D., William Kapla, M.D., Kim Montour, Glenn Molyneaux, M.D., Mervyn Silverman, M.D., Holly Smith, Patricia Tanquary, Paul Volberding, M.D., Thomas Zuck, M.D.

Mr. McDonough explained how the Anti-HTLV-III test was standardized and reported that the blood bank is finding about 3 positives per 1,000, however, because of the clinical uncertainty of the test, it is not conclusive that all of the people who test positive actually have the antibody.

The blood bank faces three situations:

1. When the blood bank learns the identity of AIDS patients from various Bay Area Health Departments, records are checked to ascertain if any have ever been blood donors. If a donor is found, the recipients of all of the donor's previous donations are traced back to January of 1979.

   The blood bank then informs the directors of transfusion services at hospitals and encourages them to inform the physician and present the information to the patient that blood they received came from an individual who was later diagnosed with AIDS and they may have been exposed to the disease. (Of the 13 transfusion associated AIDS cases that Irwin has, four of them followed this cycle.)

   The blood bank records indicate that 223 patients have received products from people who now have AIDS. Approximately half of these patients have died from other causes.

2. Any unit found positive after the first Anti-HTLV-III test is called initially reactive. All initially reactive units are repeated in duplicate and those found positive are called repeatable positives.

From March 5, 1985 on, the blood bank recalled any initially reactive units already in hospitals and discarded any initially reactive units that were in-house.

Six products which tested repeatably positive had already been transfused.

A. Absent any policy from the blood bank's commission, should hospitals, physicians, and patients be notified of this possible exposure on the pure basis of a repeatable Elisa test?

B. Is it appropriate to do additional testing prior to notification?

Current MWR recommendations are that if the Elisa test repeats positive, the recipient should be notified. California law does not permit notifying donors of positive results at this time.

3. The blood bank commission reviewed the issue of notification of previous recipients of blood from donors who today test positive to Anti HTLV-III and stated basically that anyone for whom there is a probability of exposure from a blood transfusion should be notified. (Approximately 650 patients may have been exposed thus far.)

Mr. McDonough reported that a significant body of the blood banking community is meeting in Washington today to consider that previous recipients of blood from donors who now test positive to Anti-HTLV-III not be notified. They are also evaluating the recommendation that positive donors should not be notified unless they are Western Blot positive.

The National American Red Cross is very close to concuring with the aforementioned recommendations.

Dr. Zuck reported that the Army decided they would only notify and put on a central register those who are Western Blot positive -- P 40, PB 41, P 23 (only Blot those that confirm Elisa one of two). They also made the decision that all tests be done in one laboratory where the quality control could be monitored.

Two different ways of providing information were discussed.

1. To consider the impact of information for the one who receives it in terms of how it affects their decisions and how it might impact other persons with whom they have contact.

2. To consider that the person has a right to the information regardless of what the impact is.

Dr. Volberding asked the group to consider not only the impact to the recipient, but that notification could be a means of control of the entry of AIDS into the population. He urged that the blood bank notify as many people as possible with the hope that follow-up tests would alleviate alot of anxiety.

Ms. Smith recommended having a little better handle on what information is provided, which may require a waiting period.

Ms. Tanquary highlighted many of the problems with information filtering to the patient if the blood bank provides information to the directors of transfusion services.

Dr. Jonsen suggested an institutional policy that bridges the gap. The Ethics Committee at U.C. voted recently to recommend policy to the board that information from the blood bank be passed on to the patient, taking into consideration therapeutic privilege.

Dr. Zuck suggested going to the County Medical Society to ask for help in creating standards of care for patient information, as failure to provide quality care will carry a higher liability.

Dr. Volberding suggested each hospital could use existing social workers or nurses specially trained to relay information to patients.

Ms. Tanquary disagreed with Dr. Volberding's suggestion and proposed that Irwin may need to play a more active role in the notification process to assure quality control of the notification process.

Dr. Volberding inquired about the blood bank's policy of re-testing people who have been transfused with positive products. Mr. McDonough indicated that the blood bank feels a sense of obligation to support previous recipients if there is a particular request. Dr. Volberding suggested that testing could be part of recommendations for recipients with the added recommendation that they be tested again in three months.

CONSENSUS

Over notification carries less liability than under notification.

It is the blood bank's responsibility to notify potentially exposed recipients thereby reducing the risk of others getting exposed through contact.

Inform on the basis of two positive Elisas, however, only after the Western Blot &/or other tests have been performed regardless of the results. This would provide the recipients with as much information as possible. This policy could be modified later in light of new information.

The blood bank will put out a policy statement that offers assistance, packet of materials, but makes clear the responsibility the blood bank has to recipients and follow-up.

The Ad Hoc Committee will meet again at 5:30 p.m. on Monday, May 13th.