Infected Blood Inquiry

Professor
Brian Edwards
26:10:20

Another Expert; Dr Colvin

The next expert witness is Dr Brian Colvin a former London Centre director with particular experience of clinical ethics. We continue to visit the complex world of haematology.

He explains the configuration of the Haemophilia centres in London and their relationship with associate centres who operated autonomously.

There was no formal structure, but the system worked on the basis of professional collaboration.

One key event he recalled was a paper in 1975 about a hepatitis outbreak in Bournemouth which drew attention to the risk of virus in Factor 8 being produced from large pools of blood.

Like other specialists he had given evidence to earlier inquiries in England, Scotland and Ireland. He is then taken through a series of further papers including the Sheffield study referred to earlier by Dr Winter.

All demonstrate growing awareness of the problems patients were experiencing following blood transfusions including chronic fatigue. Not surprisingly our witness did not recall what papers he had read forty years previously! There is an important exchange of letters between Dr Colvin and one of his colleague's Dr Kernoff in April 1979 which captures the views at that time of a haemophilia specialist at the Royal Free.

Here is an extract;

> *"The only way to stop a haemophiliac bleeding is to give him Factor 8. The only source is human blood, and the extraction process is both difficult and expensive. Cryoprecipitate, although relatively cheap to produce, has serious clinical disadvantages and in the UK and other countries is being superseded by semi-purified Factor 8 concentrates. Since the amount of concentrate being made by the NHS is inadequate the shortfall has to be met by buying commercial concentrate. Not only is*

> *commercial concentrate expensive there are both clinical and moral reasons for preferring the NHS product. There is a growing awareness of the probability that commercial concentrates have a higher risk of transmitting "Non A and Non B" hepatitis than NHS material and may therefore be importing a disease that is not yet endemic into the UK ".*

Dr Colvin tells the inquiry that with hindsight much of this turned out to be wrong. Commercial concentrates did not represent a higher risk than NHS material.

Both were contaminated.

The same letter, which was not picked up by Counsel with this witness, indicated that the Regional Treasurer [NE Metropolitan I think] had declined to create a central system for the funding of Factor 8.

He had offered to nominate a central purchasing team. No doubt we will hear more about this.

Home therapy with Factor 8, said Dr Colvin, was a tremendous step forward for patients.

Children in particular could go to school. Patients were required to keep a record of treatment including batch numbers of the Factor 8 they had taken [although this was sometimes difficult in deprived communities].

Dr Colvin is then taken through his clinical practice in treating patients with varying degrees of haemophilia including those for which factor 8 did not work.

He is pressed to explain why cryoprecipitate was not used more after doubts emerged about the safety of Factor 8. Dr Colvin gave a number of cogent reasons. It was clinically unreliable and "low tech" and only used in exceptional circumstances.

Counsel has pushed this point on a number of occasions now so there may be evidence to come later from other experts.

There is a long technical discussion about dosage. Dr Colvin used Factor 8 sparingly, but other clinicians gave patients much larger doses. The option of not treating a haemophiliac patient was not viable. A moderate haemophiliac patient did not mean mild bleeding.

Once bleeding started it had to be stopped.

This line of questioning highlights the quite wide variation in clinical practice at the time.

Aids was first reported in haemophiliacs in the USA in late 1982 and early 1983 and counsel tries hard to pin down when this resulted in a change of clinical practice in the UK.

A number of minutes and papers show discussion but little action. However, Dr Galbraith at the CDSC disease surveillance centre had seen the reports and in May 1983 recommended to the DHHS that imports from the USA be temporarily stopped until the evidence was clear.

Dr Colville had never seen this letter. If Galbraith's advice had been followed, he said, it would have cut the supply of Factor 8 by 50%.

This would have led ,probably ,to clinicians reducing the dosage given to patients[which would still have produced major benefits] and surgery for any other illnesses they were suffering from being stopped except in the case of major emergencies.

It might have accelerated the UK production, but we know now that that would also have been contaminated.

In July 1983 the Blood Transfusion Service was advising patients that HIV could be transmitted via blood and blood products.

In October 1983 Haemophilia Centre directors were reporting that patients were resisting Factor 8 because of the AIDs scare.

The Directors decided not to advise any changes in clinical practice.

Moving onto 1985;

NE Thames moved to stop using non heat-treated Factor 8 but only after existing stocks had been exhausted. Was this a clinical or a financial decision?

The Chair challenged the logic of using up stocks that might be unsafe.

The truth probably is that nobody knew for certain what was completely safe.

Patient consent is covered quite fully and particularly as to whether prior consent was required before stored serum could be tested. The BMA had had conflicting legal advice on the subject.

The message from this instructive session is that any judgement about action or inaction needs to be set in the context of the shifting scientific knowledge at the time.