The Krever inquiry: time to drop the appeals

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Résumé

LES RÉACTIONS DES DÉCIDEURS des États-Unis et du Canada aux premiers avertissements selon lesquels l'agent étiologique du SIDA s'était infiltré dans l'approvisionnement en sang a découlé d'erreurs de jugement scientifique et d'une prudence bureaucratique excessive. En fondant leur politique sur des estimations excessivement optimistes du risque, les décideurs n'ont pas agi rapidement et énergiquement pour mettre en oeuvre des mesures de réduction du risque. Au moment d'aller sous presse, des appels en justice qui visent à empêcher la Commission de d'attribuer la responsabilité bloquent toujours la publication du rapport final de la Commission d'enquête sur l'approvisionnement en sang au Canada (la Commission Krever). Il est temps de mettre fin à cette enquête douloureuse et de se mettre à la tâche qui consiste à assurer que l'approvisionnement en sang du Canada est le plus sûr possible.

On Jan. 4, 1983, at a meeting convened by the US Centers for Disease Control (CDC), members of the blood services community considered how best to respond to emerging evidence that the postulated infectious agent that caused AIDS had entered the blood supply.[1] The previous summer the CDC had reported 3 cases of AIDS in people with hemophilia who had no known risk factors for AIDS and had received Factor VIII concentrate.[2] By January 1983 AIDS had been reported in 5 more people with hemophilia and in a 20-month-old infant who had received multiple transfusions, including platelets from a donor subsequently diagnosed with AIDS.[1] In view of these reports, the CDC anticipated that the various agencies represented at the meeting would agree on the implementation of safety measures such as donor screening and laboratory testing of donated blood for surrogate markers of infection.[3]

No consensus emerged. Questions of cost, the concerns of special interest groups and a sceptical view of the CDC's evidence stalled the adoption of aggressive risk-reduction measures for at least another year.[4] Lamentably, the response of decision-makers in both Canada and the US to the first warnings that blood recipients were at risk of AIDS was governed by errors of scientific judgement, excessive bureaucratic caution and a failure to inform physicians and patients of the full range of options, resulting in the unnecessary infection and subsequent death of thousands of people.

The crucial scientific error was to underestimate the risk of contracting AIDS from blood and blood products. In calculating this risk it was necessary to take into account not only the incidence of AIDS among recipients of blood and blood products, but also the duration of asymptomatic infection (the incubation period). The longer the incubation period, the higher the real prevalence of infection. As early as autumn 1982 it was suspected that AIDS could have an asymptomatic stage, and at the January 1983 meeting the CDC presented data to suggest an incubation period of 4 to 17 months.[5] Speculation that the incubation period might be much longer went unheeded. In June 1983 the American Association of Blood Banks, the US Council of Community Blood Centers and the American Red Cross stated that "it appears at this time that the risk of possible transfusion-associated AIDS is on the order of one case per million patients transfused."[6]

The crucial bureaucratic stumble was to accept this optimistic estimate as the basis for policy decisions: "When blood bank officials estimated the risk of trans-

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mitting AIDS as 'one per million' transfusions, they chose a rate that was low enough to justify their reluctance to take further action."[7] Decision-makers stuck to that estimate and to their policy of inaction throughout 1983 in spite of accumulating evidence that the risk was much higher.[7]

Even as late as July 1984 the Canadian Red Cross Society was still advocating and using a policy for donor screening that was inadequate and uninformed. Donors for whom there was "any possibility" of being "at increased risk of contracting AIDS" were asked to exclude themselves from blood donation.[8] Evidently, this casual approach was founded in the sanctimonious belief that "as donation is entirely voluntary in Canada, donors have a particularly high sense of community responsibility and will, therefore, refrain from donating if they are properly informed and are not caused embarrassment."[8] This was an extraordinary tack to take in the face of mounting evidence that the original risk estimates were too low, especially for people receiving treatment for hemophilia. Lagging about 6 months behind the US and 3 to 4 months after some European countries, Canada did not implement HIV testing of donated blood until November 1985.

Risk management involves 3 separate activities: the assessment of risk, the development of policy options (and assessment of those options) and, finally, communication of the risk to the public. Ideally, the estimation of risk should be carried out objectively and independently, without regard to policy implications. However, given the scientific uncertainty that surrounded all aspects of AIDS, decision-makers were at liberty to pick and choose their scientific conclusions, and thus to accept premises that preserved the status quo and "exposed [them] and their organizations to a minimum of criticism."[9] They did not develop policy options around a range of risk estimates but, rather, chose the lowest estimate and developed a single policy. The "one per million transfusions" estimate, together with a failure to appreciate the high case-fatality rate of AIDS, led decision-makers to conclude that the costs of possible interventions such as donor selection and donor blood testing would far outweigh the benefits. Lastly, there was inadequate communication of risk estimates to the public. A desire to avoid causing alarm amounted, in practice, to keeping people in the dark. For example, despite the CDC's strong epidemiologic evidence that the causative agent of AIDS could be transmitted through the blood supply, a committee of the American Association of Blood Banks reported in January 1983 that "we do not want anything that we do now to be interpreted by society (or by legal authorities) as agreeing with the concept — as yet unproven — that AIDS can be spread by blood."[10]

The question of the safety of the blood supply is not limited to the issue of AIDS. The interim report of the Commission of Inquiry on the Blood System in Canada — the Krever inquiry — notes that "more than twenty-five different infectious agents are known to have been transmitted through the use of blood or blood products. Other known and emerging infectious agents can, potentially, be transmitted by blood and blood products."[11] Creutzfeldt–Jakob disease and CJD variant may be on the horizon. We may well be making some of the same mistakes now.

More than 14 years after the CDC reported the transmission of the agent now known as HIV through the blood supply, we do not know who was responsible for our failure to heed that warning in this country. Nor do we have recommendations that might help us to avoid making similar errors in the future.

When, in March of this year, the Canadian Red Cross Society fired its secretary general, Mr. Douglas Lindores, there was speculation that the way was being paved for changes in the role of the Canadian Red Cross and for a new responsiveness to the public's concerns.[12] As we go to press the release of the Krever inquiry's final report is still being held up by legal appeals intended to prevent the inquiry from making direct allegations of misconduct. The Red Cross and its coappellants should now drop their appeals. The Red Cross, Health Canada and the federal government have shown remarkable loyalty to their employees. However, it is time to bring this painful inquiry to an end, to learn from past mistakes and to ensure that systems are in place to deal swiftly and effectively with any future crisis of the Canadian blood supply.

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