Diagnostic testing of blood donor specimens

Most clinicians working within the New Zealand public service are accustomed to using the National Health Index Number (NHI). This is a common number used to identify patients when they access different parts of the health system.

The New Zealand Blood Service (NZBS) uses an entirely different number when testing donor blood. The current IT systems in NZBS have been set up so that they do not allow the NHI to be used. This number is not available to other clinicians and very few clinicians are aware of its existence.

Donors are informed that their information will not be made available to other agencies. When donor blood is tested, if abnormalities arise, the NZBS medical team will inform donors and will recommend that this information be provided to the GP and where appropriate seek consent to contact the GP to provide additional information. In the event that test results that might impact on future transfusion requirements then NZBS seeks permission from the donor to include the information on the patient side of the database (Peter Flanagan, Medical Director, NZBS, Personal Communication).

It is not clear how many clinicians in New Zealand know that test results from NZBS are not routinely available. Our reliance on the NHI as the index for all laboratory results may mean that abnormal tests or clinically significant changes in results ordered by NZBS go unnoticed. GPs and other treating clinicians may not know if their patients are regular donors and are very unlikely to know if there are relevant test results in an entirely different database.

This letter is to make all clinicians aware of the potential risk. To the best of my knowledge no significant adverse effects of this system have been recorded. I also hope to encourage debate about the ethical obligations to donors who potentially may be disadvantaged by the current system.

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