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Should automatic external defibrillators (AED) be available in the donor collection setting (esp. at mobile sites)?

A blood banker in a Rocky Mountain state would like to know if anyone is using or considering using automated external defibrillators (AED) such as those used in airplanes, shopping malls, etc, in the donor collection setting, particularly with mobile collections. Of particular interest is how people are addressing the personnel requirements of who is allowed to use the device, how they are trained, donor consent and legal/liability issues. (Interestingly, the inquiring blood banker reports that it was necessary for her staff to call 911 for a donor on a mobile a few weeks ago, and the fire department team who responded asked why they did not have an AED device aboard their coach.)

The following responses were received.

1. **Laurie J. Sutor, M.D., Chief Medical Officer, Carter BloodCare, Bedford, TX** (attribution used with permission) did an email survey of medical directors affiliated with the **Blood Centers of America** (BCA) in February 2002 on their possible plans for purchase of AEDs. At that time 10 of 11 respondents said that they had **no plans** to purchase AEDs. One respondent said the question was under consideration. Issues that weighed **against** AEDs in the blood center setting were those regarding liabilities while having AEDs on the premises, such as the following:

- Will they work when you need them?
- How are you going to keep everyone trained?
- Will you be able to find them when you need them?

Of related interest, 10 of 11 centers require at least some of their personnel to have **basic CPR training** (usually collection personnel, but sometimes managers and drivers).

ADDENDA Dec. 13, 2002

2. **A very experienced blood banker** reports that perhaps it is testimony to the effectiveness of donor screening, but over his 30-year career he has never seen a donor fatality. He reports being aware of only a handful of donor deaths, and several of those were related to operating a motor vehicle post donation. He adds that donors are, by the nature of the process, in good health and truthful. He comments that even the routine collection of older donors and autologous donors has not changed the rate of serious complications. In summary, he agrees with the concerns raised by Dr. Sutor, and would add that if a case can be made for blood collection teams having defibrillators routinely available, then they should be available virtually everywhere.

ADDENDA Dec. 17, 2002

3. **A blood banker from Spain** reports that in his experience over the past five years he has never heard of a donor suffering cardiac arrest in Spain. At his blood bank, after 24 years of activity, there have been no casualties; health problems have been mainly from hypotension. His center keeps a basic resuscitation kit, including intubation canulas, Guedel tubes, adrenalin, etc., but they have never had to use them, even for severe tonic-clonic seizures. All staff undergo basic resuscitation training, but in his opinion, **using a defibrillator would be unwarranted**. Keeping up to date with basic training in CPR is difficult enough. He would NOT have a defibrillator at a hospital-based blood collection site. In this situation it is much safer to call a physician who is trained in dealing with such emergencies.

ADDENDA Dec. 18, 2002

4. **Another US blood banker** reports that he has been fortunate to not have any donor fatalities during my 17 years of practice at 4 different blood centers. However, he reports having performed **CPR on a staff member** during this time and has had at least 2 other staff members requiring CPR at satellite donor centers when he was not on site. He is of the opinion that donor centers employ many individuals and there are some who might have significant risk factors for a

cardiopulmonary arrest. Also, donor centers, like other public facilities have daily visitors who may also be at risk for such events. He reports that **his center is in the process of budgeting for next fiscal year to purchase AEDs for all of their fixed sites**. He concludes that they will then determine if AEDs should be put on their donor coaches.

ADDENDA June 29, 2003

5. **A colleague in Mississippi** has noticed that automatic external defibrillators (AED's) are becoming more automated and less complicated, and that these devices are popping up in shopping malls, airports, courthouses, and the trunks of many police cars. He adds that in his opinion one of the keys to successful resuscitation is rapid response (CPR/Basic Life Support Training). He writes the following (verbatim):

"I think it would be helpful to consider our employees in this equation. I don't know about your blood center, but many in our workforce are certainly candidates for heart attacks. Even if we take donors out of the picture, what about our workers? Then again, lets just look at everyone in terms of their status as people ... neither as donors or employees, but just general public. AED's are now available for **less than \$1,500**. and training is quick and can become part of the annual required OSHA workplace training or any sort of refresher training we offer (as blood centers training and tracking training is one of the things we should be good at). Yes, it would mean another SOP and your Safety Officer or Compliance personnel would have to add it to their list. But if it can save a life (and that is kind of the basic business we are in) shouldn't we consider it? At the least, shouldn't every blood center employee have basic first aid and basic life support (CPR) training to help protect all of us at home and work?"

The Mississippi colleague also is of the opinion that a law passed during the Clinton administration allows for the use of AED's with the same indemnity as most states typical "Good Samaritan Laws". These laws generally provide that if you attempt to help someone within the reasonable scope of your understanding and ability (and without the intention of charging for that service) you are free from liability.

EDITOR'S NOTE: It would be prudent to **confirm** the actual degree of liability that you assume, in the event that you use an AED in your practice and an adverse outcome is realized.

ADDENDA June 30, 2003

6. **An anesthesiologist from Calgary, Alberta** comments that AEDs have saved the lives of many people. He reports that Calgary was one of the "trial balloons" in the testing of their efficacy and safety. He writes (verbatim):

"For those who are unfamiliar with these devices, they are **designed to be used by a lay person**. The machine does the interpretation of the rhythm, and verbally instructs the user in what to do. A quick instruction course in their use is all that is required. One does not need ACLS training. The issue of **liability is a double-edged sword**. Good Samaritan laws will protect users from using the machines. One needs to ask the question as to whether the **absence** of a piece of inexpensive equipment like this that has been in use for many years now, has been effective in saving many lives, and is becoming common in many public places, might not create a risk for lawsuit. The blood banker (#3) who commented on the provision of emergency kits with airway management tools, adrenalin, etc might ask himself what expertise exists in his clinic for the use of these much riskier interventions, including adrenalin, and intubation tools. Here ACLS training would be required, as well as the availability of a monitor, (which the AED is). As pointed out by some of the participants in the forum, it is **more than patients who may benefit** from the availability of an AED. Also, early resuscitation is the key to survival from an unanticipated cardiac event."

7. **A transfusion medicine physician in Southern California** reports that although none of the blood centers or mobile operations that she has been associated with have ever had an AED, she is aware of the advantages of such a device because she is married to a cardiologist. Her husband has informed her that the AEDs are widespread and easy to use.

According to him, these devices are not like a crash cart, but are easy to use with very simple instructions on the pack. She is of the opinion that the American Heart Association is pushing to get an AED device in almost every office building in the United States. According to her spouse there are basically two types of device on the market at this point:

- One type of device requires that the operator merely place the device's pads on the patient's chest and the **machine decides whether to shock or not**. Apparently if the device "sees" either asystole or sinus rhythm it does nothing. If it recognizes ventricular fibrillation it delivers a shock.
- The second type of device **requires the attendant to push the button** to deliver the shock, however it tells you when to do it.

The reasons the responding blood banker **would not be opposed to seeing AEDs available in donor centers** are twofold. Not only do donor centers have employees as well as donors and their

family members who are at risk for cardiac arrest, but as medical-type institutions that attempt to maintain a high profile in communities, it would be perfectly understandable if someone came to the donor center hoping for medical assistance with a friend or family member who had just arrested. She concludes saying (verbatim) "If flight attendants are expected to use these devices without intensive training I think it is reasonable for our nurses in buildings and buses with distinguishing medical symbols to have them available as well.

8. **Editor's Comment:** Although not directly relevant to this discussion, it is of interest to learn that AEDs have recently been reported to play a role in resuscitating children as young as one year of age who experience conditions requiring defibrillation, according to [new guidelines](#) published by the American Heart Association.

Please submit comments to the [e-Network Forum](#).



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