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Should volunteer whole blood donors be allowed to donate more often than every 8 weeks during critical blood shortages?

A colleague in Los Angeles County asks if, during this critical blood shortage, anyone has considered allowing regular blood donors to donate more frequently. She points out that **directed** donors (with Medical Director approval) are allowed to donate more frequently than once every 8 weeks, as are patients who wish to have **autologous** blood products collected and stored for their upcoming surgery. Many of their employees who donated at a blood drive in early December of 2003 would be willing to donate again.

The following responses have been received:

ADDENDA Jan. 15, 2004

1. **Dr. Neil Blumberg** at the University of Rochester Medical Center (attribution used with permission) reports that even in upstate New York, where they rarely have blood shortages, blood is short, so he can only imagine how tough things are in the big cities in the Northeast, given the weather, the flu and the aging blood donor population. He suggests that we **need to consider thinking "out of the box"** and writes "I don't see any coming decrease in blood transfusion needs, what with increasing living donor partial liver transplantations, double autologous transplants for multiple myeloma and other new interventions that keep coming along. So I think **both new and old ideas need to be considered**, including paid blood donors, more frequent donation by those who are iron replete, more requests to have family and friends donate to the community when patients use lots of blood during surgery, etc. I don't think 'business as usual' is acceptable in the developing supply crisis. As long as there is a due regard for both donor and patient safety, it's time to consider increasing the responsibility of those who benefit from the community supply to recruit new donors. This can simply mean surgeons telling families of patients who undergo surgery that uses allogeneic blood that it would be very important that they recruit some blood donors for the next patient. We should be pushing bloodless medicine and surgery programs in our institution to retrain physicians to operate and treat with less or minimal transfusion, but that will be a very slow process. More reliably and rapidly, we need to consider using donors we don't now use due to being held hostage to old ideas, old procedures and old problems. This includes using donors more frequently who are iron replete and willing as suggested. There is no evidence that would be bad for such individual donors. Would paid donors be a significantly increased risk to patients? I doubt it in the current era of infectious disease testing. Would we get more donors? You bet. We shouldn't let our emotions and habits stand in the way of medical needs and progress."
2. **Dr. Mary Jo Drew** of Henry Ford Hospital in Detroit, MI (attribution used with permission) agrees with Dr. Blumberg (see reply #1 above) on many of the points that he makes in his response. According to Dr. Drew "Transfusion medicine physicians are more than able to manage donor medical issues such as determination of iron stores and recommending the use of iron supplements in those donors in whom they would be helpful, and this would permit more frequent, safe donation by some donors. However, I believe that **several other issues are also at play**. The **first** of these, alluded to by Dr. Blumberg, is the changing demographic of the blood donor population. Related to this is the difference in recruiting strategies that must be employed in order to find and maintain the pool of the "gen X" donors who are now entering their peak potential donation years. Appealing strictly to idealism and helping one's fellow man may no longer resonate! **Second**, we have to consider the effect of donor deferrals, most specifically, the deferral for theoretical risk of vCJD exposure. This is not to say that this deferral

should immediately be dropped, but nothing should be written in stone. When new information comes to our attention, the industry should study if the criteria for such deferrals need to be modified. This deferral is exacerbating the current "holiday" shortages that we usually see, especially in areas with a large military population, which, due to this deferral, have lost a substantial proportion of their active donor bases. **Third**, multiple component collection can be a great help in "retooling" our donor base to more closely match actual usage of products by ABO type in hospitals. However, these programs can be expensive to start up, require additional recruiting and other support, and apply to only a portion of the donor base. Dr. Ron Gilcher's editorial in the December 2003 issue of Transfusion (Transfusion 2003;43:1658-60) reviews the potential of these technologies for averting shortages. And **finally**, why are hospitals using random donor platelets being forced to use surrogate testing methods that cannot reliably detect bacteria, but that add to wastage of an already scarce product? Once again, the perversion of the precautionary principle is coming home to roost. We moan about blood shortages. Yet, as an industry, we continue to insist that anything that can be done should be done in the name of blood safety, apparently without consideration of collateral risks. **When does the risk of not having blood available outweigh the benefit of such interventions?"**

ADDENDA Jan. 21, 2004

3. **Dr. Ronald E. Domen** at Milton S. Hershey Medical Center of Penn State University College of Medicine offers the following comments:

"**I agree** with the comments of Drs. Blumberg and Drew. I have long supported a reexamination of the use of **paid blood donors**. The world of blood banking is much different today than when the switch to an all-volunteer blood supply occurred back in the early 1970's. However, even back then there were many paid blood programs that did **not** have high rates of post-transfusion hepatitis because they had excellent programs that did things the proper way. It was a few high-profile collection facilities that recruited the wrong type of donor that contributed to give everyone a bad name. Today there are some paid donor programs that have demonstrated that it is possible to collect blood that is just as safe as volunteer blood. I also agree that it is time to reconsider the **56-day waiting period** as there is probably a significant number of donors who could donate more frequently. We are also considering **two-unit collections**, but as noted, the equipment and start up can be expensive."

ADDENDA May 7, 2008

4. In her **recent CBBS lecture 'I Don't Care What They Say, I Won't Stay in a World Without Blood'** **Dr. Janice M. Nelson**, Medical Director of the Transfusion Service at the Los Angeles County/USC Medical Center (attribution used with permission) proposed that to help alleviate blood shortages, it was time to break down taboos and **consider a change in policy** that would **permit accepting as a blood donor anyone gay or straight who does not "practice" risky behavior**. She also **proposes a change the California law to allow "pedigreed" (paid) blood donors**. The law in question is referred to a 'Beilenson' (AB 410;1976), which essentially eliminated paid whole blood donations in California in the late 1970's and then eliminated paid platelet donors in January 2003. A copy of Dr. Nelson's lecture handout is available [HERE](#) for those who attended the 2008 CBBS annual meeting.

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

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