Automatic external defibrillators

To the Editor: Dr. Brown's Commentary[1] on the proposed mandating of AED availability in US schools was a welcome commonsense and well-reasoned appraisal of the actual, rather than the perceived, need for any such program.

Unfortunately, "perception of reality" actions are frequent in modern society whereby things are proposed or undertaken to give the public a reassurance that problems have been addressed but without any evidence that those actions will result in any benefit.

My first insight into AED usage comes from my 1996 to 2004 experience of being the Medical Director of an AED Program in a gated, adult (>55 years of age) community of approximately 1200 persons. The program comprised the initial training and then maintenance of skills of the 10 security guard staff. Maintenance of skills was assessed on an every 3 month basis, with a re-testing within 1 week when anyone failed a test. Tests were clinical scenarios involving assessment of the need for AED, its deployment and firing, and appropriate use of basic CPR, using a resuscitation model with a carotid pulse feature and electrode site attachments. Biweekly self-tests also had to be signed off. In our jurisdiction, the staff could only provide the AED under the medical licence of a physician. A report of any actual AED deployment had to be completed by the attendant within 24 hours of the incident and then reviewed by a physician.

My second insight comes from 22 years' experience as on-site physician and medical advisor to a private boarding school of 400–420 students, aged 12 to 18 yrs, plus providing both emergency and some regular family practice service to the academic, sports, house, and school ancillary staff. The school had a 24-hr nursing service, plus in-service training in CPR available for all staff, but it did not have an AED. Student activity, including contact-collision sports, was a 3-times-per-week occurrence, with visiting teams increasing the numbers participating.

The practical reality is that in the adult community project, where expectation of need should have been high, the AED was never required nor deployed, other than in what amounted to a human body practice (i.e., the individual had been dead for some time but the AED was used).

The financial cost of the AED program in the adult community included the capital cost of an initial AED unit plus a second (replacement) unit with a training module, a union-stipulated minimum 4 hours pay per guard per maintenance of skills session every 3 months plus a further 4 hours for re-testing for anyone who failed, a union-negotiated increase per hour because of the added responsibility of the staff using an AED, and my 3-monthly fee.

Interestingly, the AED program was terminated in mid-2004, not because of a decision that it was not needed or worth the outlay, but because the strata council's insurance company decided that it would not provide liability coverage for the AED actions of the security staff. They maintained that coverage should be provided by the supervising physician's personal medical liability insurance provider, deeming the AED action a "medical act." Not surprisingly, this was not personally acceptable, but, even if it had been, it would not have been possible because the sole provider of medicolegal insurance in Canada deals exclusively with physicians' liability. The commonsense stance that a person who is unresponsive, without a pulse, and not breathing is clinically dead and, therefore, could not be harmed further was apparently beyond their understanding.

In the school setting, there was never a cardiac arrest in either the student or the adult population. Additionally, once a year for 3 days, the school hosts one of the largest rowing regattas in North America, with a combined student and adult attendance of around 1500. Similarly, no arrests occurred during these sporting events.

It seems fair to say that this outlined "real-time" practical experience has been broad enough to provide support for Dr. Brown's contention that the actual need for AED availability has been much exaggerated and could not be supported by what physicians are recommended to practice, namely evidence-based medicine.

Those who would wish to pursue the proposed mandatory in-school AED will likely provide some evidence to support their view. Unfortunately, there is no mandate that evidence need be good: that development would indeed be a step forward.

K.M. Laycock, MB ChB(Edin), Dip Sport Med (CASM)
PO 190, Mill Bay BC V0R 2P0
kmldoc@brentwood.bc.ca

Reference

1. Brown L. Mandating automated external defibrillators in schools: Fire, ready, aim! Can J Emerg Med 2004;6(6):431-3.

The decay of CTAS

To the Editor: The *Canadian Emergency Department Triage and Acuity Scale* (CTAS),[1] when it first was developed, served as a very useful tool by which patients could be triaged both in the hospital and pre-hospital setting. I applauded its arrival and have used it to great advantage in our community emergency department. Unfortunately,

https://doi.org/10.1017/S1481803500013002 Published online by Cambridge University Press