Approved: 3-17-98
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 12, 1998 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Robin Kempf, Legislative Research Department
Norman Furse, Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Dr. William Murphy, Wichita
Bob McDaneld, Administrator, EMS Board
Michael Cumley, Lenexa
Jason White, Kansas Emergency Medical Services Association
Pat Johnson, Kansas Board of Nursing

Others attending: See attached list

Announcements

The Chair announced a subcommittee on **HB 2724** with Senator Hardenburger as Chair, and Senators Salmans and Steineger as members. Senator Hardenburger pointed out that there will be a panel consisting of three members representing the dentists and three members representing the dental hygienists. Members of the subcommittee will act as moderators, and the subcommittee will be meeting March 19th.

Hearing on HB 2723 - Use of automatic defibrillators by certain persons

Dr. William Murphy, cardiovascular surgeon from Wichita, testified before the Committee in support of **HB 2723** which would create a new law relating to the use of automatic external defibrillators by persons who have received appropriate training. The AED is used to restart the heart if a person has suffered a cardiac arrest and has no pulse and is not breathing. Dr. Murphy pointed out that with recent breakthroughs in technology, use of AEDs now require minimal training to operate, are easier to use and maintain, and are lower in cost which make it more practical to train individuals. (Attachment 1) It was noted during Committee discussion that a doctor's prescription would be required by those individuals purchasing an AED. Training requirements for individuals using an AED and conditions when an AED should or should not be used were also discussed. A demonstration of an AED was given to the Committee, which was shown to be relatively easy to use, and it was pointed out that all AED machines have to be tested and approved by the FDA before they are put on the market. The cost of one machine is approximately $3,000 to $12,000. The distribution, financing and liability issues with using an AED were also discussed.

Bob McDaneld, Kansas Board of Emergency Medical Services, testified in support of **HB 2723** and noted that the use of automatic external defibrillators would save more lives and help more cardiac victims survive and return to productive lives. (Attachment 2) It was noted during Committee discussion that CPR training would address the issue of proficiency and use of an AED. Mr. McDaneld pointed out that EMS statutes only govern people who are certified attendants, and certified attendants would receive proper training in the use of an AED. In regard to an individual purchasing the device, a physician would determine for whom that device is appropriate.

Pat Johnson, Board of Nursing, noted that some of the issues have been raised during Committee discussion that were of concern to the Board relating to liability and training, as well as when or when not a defibrillator should be used. Ms. Johnson pointed out that there are many unanswered questions about AEDs, and felt the bill should be postponed for a year so that use of automatic external defibrillators may be further studied. (Attachment 3) During Committee discussion it was pointed out that an AED is a vital machine in saving lives for first responders and EMTs.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Jason White, Kansas Emergency Medical Services Association, testified before the Committee in support of the concept of **HB 2723**, but suggested the bill be amended to bring the bill into compliance with national standards. The proposed language would read: "Training and treatment protocols must be consistent with national recommendations and will be authorized by local medical control or local medical authorization; the automated external defibrillator will be maintained consistent with the manufacturer's recommendations; all actual uses of the automated external defibrillator will be reported to the authorizing medical group or individuals" as noted in his written testimony. Mr. White also felt an AED should be made available at the statehouse, as well as having an AED readily available for use in many locations. (Attachment 4)

Michael Cumley, American Heart Association basic life support instructor and owner of a safety consulting company, expressed his support for **HB 2723**. Mr. Cumley noted that the time is here for public access to the life saving AED as outlined in his written testimony. (Attachment 5)

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for March 16, 1998.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 3-12-98

NAME	REPRESENTING
Pat Johnson	Bd of Nsg
Bob McDaniel	Board of EMS
[illegible]	AM Heart Association
Cindee Shaller	American Heart Assoc.
Jamie Bradshaw	American Heart Assoc.
Jerry Cunningham	Phillips County EMS
Michael Cumley	individual
[illegible]	KEMSA
Jason White	KEMSA
Karla [illegible]	KDHA
Tami [illegible]	KOA
Susan Anderson	Hein + Weir
Devon Reid	KSNA
LARRY BUENING	BD OF HEALING ARTS
[illegible]	KTLA

American Heart Association℠
Fighting Heart Disease and Stroke

Kansas Affiliate, Inc.
5375 S.W. 7th Street
Topeka, Kansas 66606
Tel 785 272-7056
Fax 785 272-2425

STATEMENT IN SUPPORT OF HOUSE BILL 2723
BY THE AMERICAN HEART ASSOCIATION
KANSAS AFFILIATE, INC.

SENATE PUBLIC HEALTH AND WELFARE
MARCH 12, 1998

Madam Chairperson and members of the Committee........My name is Dr. William Murphy. I am a cardiovascular surgeon in Wichita and I appear on behalf of the American Heart Association, Kansas Affiliate. Thank you for the opportunity to speak in support of House Bill 2723.

Every day nearly 1,000 people in the United States die unnecessarily due to sudden cardiac arrest. More than **90 percent** of these people die because lifesaving defibrillators arrive on the scene too late, if at all. Studies have shown that **250 lives can be saved** each day from sudden cardiac arrest by using Automatic External Defibrillators (AEDs). To accomplish this lifesaving goal, AEDs need to be more widely accessible to the non-medical, minimally trained lay person.

As the concept of expanding access to defibrillation receives more and more attention, the American Heart Association realizes the importance of being a leader in this arena. That is why the AHA has introduced legislation that would enable anyone who completes required training - a Basic Life Support course, including training on AEDs, - to use the device in cardiac emergency. (Any person using an AED would first activate the EMS system, in most communities, calling 911.) This legislation will also provide protection from liability for any person using an AED in an attempt to save a life. The American Heart Association is also developing strategies for implementation of program that will educate as well as make the public, medical and non-medical personnel aware of the importance of AEDs.

Public access to AEDs support the American Heart Association's "Chain of Survival" which refers to the four critical links in the emergency treatment of sudden cardiac arrest. Starting these procedures, which include activation of the EMS system, early CPR, early defibrillation, and early advanced care, may determine whether one lives or dies.

Recent breakthroughs in technology mean AEDs now require minimal training to operate, are easier to use and maintain, and are lower in cost, making it more practical to train individuals. Automatic means that recorded voice prompts the user through the steps of using the AED and computer algorithms identify the abnormal heart rhythms and select the type of defibrillation therapy. However, the term automatic does not mean they are without manual intervention. An operator must still press a "shock" button only after the machine has prompted them to do so. Thus the terms, automated or semi automatic have also been used to describe these machines. As a result, the American Heart Association respectfully asks that you support House Bill 2723 and allow public access to AEDs in the state of Kansas.

Senate Public Health & Welfare
Date: 3-12-98
Attachment No. 1

AHA Medical/Scientific Statement

Task Force Report

Public Access Defibrillation

A Statement for Healthcare Professionals From the American Heart Association Task Force on Automatic External Defibrillation

Myron L. Weisfeldt, MD; Chairman; Richard E. Kerber, MD; R. Pat McGoldrick; Arthur J. Moss, MD; Graham Nichol, MD; Joseph P. Ornato, MD; David G. Palmer, Esq; Barbara Riegel, DNSc; and Sidney C. Smith, Jr, MD

In October 1993 the American Heart Association appointed the Task Force on Automatic External Defibrillation. The task force was charged with conducting a conference on automatic external defibrillation, evaluating research needed for broader community use of automatic external defibrillators, and overseeing evaluation of the feasibility and desirability of their use by healthcare professionals and the lay public.

In December 1994 a conference on public access defibrillation was held in Washington, DC. More than 300 persons attended, representing science, industry, the healthcare professions, law, and the federal government. During the meeting the participants reached a consensus on the general proposition of greater public access to defibrillation and the need for broad-based clinical research, public and professional education, and legislative reform. Following the conference, members of the task force, with input from others in the field of emergency cardiac care, wrote this statement, which was approved by the AHA Board of Directors in June 1995.

Early bystander cardiopulmonary resuscitation (CPR) and rapid defibrillation are the two major contributors to survival of adult victims of sudden cardiac arrest. The AHA supports efforts to provide prompt defibrillation to victims of cardiac arrest. Automatic external defibrillation is one of the most promising methods for achieving rapid defibrillation. In public access defibrillation, the technology of defibrillation and training in its use are accessible to the community. The AHA believes that this is the next step in strengthening the chain of survival. Public access defibrillation will involve considerable societal change and will succeed only through the strong efforts of the AHA and others with a commitment to improving emergency cardiac care.

Public access defibrillation will include

- Performance of defibrillation by laypersons at home and by firefighters, police, security personnel, and nonphysician care providers in the community
- Exploration of the use of bystander-initiated automatic external defibrillation in rural communities and congested urban areas where resuscitation strategies have had little success

The AHA can also play a major role by

- Increasing public awareness that defibrillation improves the rate of survival from an often fatal condition that each day affects 1000 Americans
- Ensuring that objective, current research data are used to guide implementation of these changes in performance and teaching of CPR
- Working with medical manufacturers, legislators, and governmental agencies to promote safety and efficacy, reduce cost, and update training requirements to facilitate implementation of public access defibrillation. Broader use of automatic external defibrillators should also lead to readiness tests and features that deter both misuse and misapplication.

Meaningful change will occur only with the broad public support that has traditionally characterized the AHA's efforts in the fight against heart disease and stroke.

Acknowledgments

The Public Access Defibrillation Conference was made possible by the financial support of the National Heart, Lung, and Blood Institute; the American College of Cardiology; the American Red Cross; the American Medical Association; the AHA Councils on Clinical Cardiology, Cardiovascular Nursing, Cardiopulmonary and Critical Care, and Cardiovascular Disease in the Young; the Citizens CPR Foundation; and the North American Society of Pacing and Electrophysiology.

A related report is printed in this issue of *Circulation*, beginning on page 2740.

"Public Access Defibrillation" was approved by the American Heart Association Board of Directors in June 1995.

Requests for reprints should be sent to the American Heart Association, Emergency Cardiac Care Department, 7272 Greenville Avenue, Dallas, TX 75231-4596.

(***Circulation*. 1995;92:2763.**)

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KEY WORDS • defibrillation • cardiopulmonary resuscitation • AHA Medical/Scientific Statements

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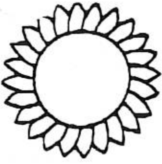

Johnson County
Kansas

January 20, 1998

American Heart Association
Kansas Chapter
Topeka, Kansas

ATTENTION: Ms. Cindee Stratton

Dear Ms. Stratton,

I have been asked to provide a letter of support for the Public Access Defibrillation Program (PAD). In my roles of medical director for Johnson County Med-Act Paramedic Service and Chairman of the of the Emergency Medical Services Committee (EMSC) of the Johnson County Medical Society, I am keenly interested in this therapy being readily available to the general public.

Without question, the rapid application of defibrillation to a cardiac arrest patient in a shockable rhythm currently provides the greatest chance for patient survival. Clearly, nothing else has ever been proven to be more beneficial in either the out-of-hospital or in-hospital venues. It is felt that for every minute following the onset of ventricular fibrillation that the patient remains in cardiac arrest, the potential for success resuscitation decreases by ten percent. Therefore, it is obvious that rapid defibrillation is critical to improving outcomes in sudden cardiac arrests.

On October 14, 1997, the EMSC stated the following position in their minutes:

- Endorsed the concept of early defibrillation for cardiac arrest patients as most beneficial
- Promoted application of AEDs in communities of higher arrest rates to receive emphasis

It is important that areas of need be established, those being communities of greater use potential. Careful involvement of the local EMS providers and hospitals to determine this is important. Ongoing education and quality assurance programs must be in place to assure that knowledge of the device and its applications is retained. Implementation of such devices must come from community need and not from the advocacy of the product vendor.

I commend the efforts of the Kansas Chapter of the American Heart Association for its efforts to improve the health and welfare of the citizens of our state.

Sincerely,

Lester E. Richardson, II, DO, FACEP

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Occupational Health & Safety
AUGUST 1997

Defibrillators Enter the Business Marketplace

An evolving legal trend may ultimately lead to higher risks for businesses that fail to purchase and use AEDs.

Now, a new wave of small, portable defibrillators is being developed....Manufacturers even envision a day when the devices, technically known as automatic external defibrillators and costing $2,500 to $4,000 each, will be as common as fire extinguishers.

The Wall Street Journal
Aug. 5, 1996

In 1990, the American Heart Association challenged the medical device industry to develop a state-of-the-art automated external defibrillator (AED) capable of being used by virtually anyone. As *The Wall Street Journal* noted, the industry responded in a manner leading to significant advances in AED technology. Smaller, lighter, cheaper, easier, sturdier and more effective AEDs are now available. As a result, many businesses are now considering the benefits associated with the purchase of AEDs for use by trained individuals on site.

Despite technological progress, tort liability fears create impediments to the widespread deployment and use of these life-saving machines within the commercial business environment. In other words, before AEDs can become "as common as fire extinguishers," legal concerns must be acknowledged, understood, and addressed.

AEDs in the Land of Torts

One significant obstacle to large-scale AED distribution in the business world is fear of exposure to negligence liability lawsuits. Would-be AED purchasers appear to perceive heightened legal risk flowing from the acquisition, deployment, and use of the device.

Prudent businesses must certainly analyze relative risks and benefits when considering whether to adopt or not adopt AED programs. In this context, two recent jury verdicts suggest an evolving legal trend that may ultimately lead to higher risks for businesses that *fail* to purchase and use AEDs. A basic negligence primer helps explain why.

In order for a plaintiff to successfully sue an AED purchaser or user, four essential elements must be proven. These include duty, breach of duty, causation of injury, and legally recognized damages. The failure to prove any one of these elements is fatal to a plaintiff's case. The element of greatest import in the AED context is that of duty.

Duty in negligence law is defined as "an obligation, to which the law will give recognition and effect, to conform to a particular standard of conduct toward another." In the absence of a legal duty, no liability can be imposed. In other words, one cannot be successfully sued for failing to perform an act in the absence of a legally mandated obligation to perform the act in the first place.

In the context of duty, businesses contemplating the purchase of AEDs must consider whether a legal obligation to render medical aid to patrons exists and, if so, the scope of the obligation. In effect, this constitutes an analysis of legal risk.

While bystanders generally have no legal obligation to provide affirmative medical aid to ill or injured persons, the existence of certain relationships between a victim and one in a position to render aid may create a duty to provide assistance. Business sectors including common carriers (airlines, passenger rail lines, cruise ship lines, etc.), innkeepers (hotels, motels, etc.), and commercial business establishments open to the public (most other businesses) may be compelled by law to render a minimum level of first aid care and to timely summon outside emergency medical assistance. The scope of this duty is generally defined by appellate court case law, trial courts and juries.

By RICHARD A. LAZAR

Historically, appellate courts have been generally resistant to requiring common carriers, innkeepers, and commercial businesses faced with ill or injured patrons to do more than summon an ambulance. Two recent trial court verdicts, however, suggest an evolving trend toward higher standards requiring the protection of customer health and safety in the commercial business environment.

In June 1996, a Florida jury found Busch Gardens negligent for not properly training its employees to provide emergency care and for failing to have essential medical equipment, including a defibrillator, on the premises. The jury awarded the plaintiff $500,000 in damages for the resulting death of her 13-year-old daughter.

In another recent case, a federal judge found Lufthansa Airlines negligent for failing to timely provide treatment for a passenger suffering a cardiac emergency and awarded $2.7 million in damages. In light of this case and a variety of other factors, the Federal Aviation Administration is currently considering the mandatory deployment of AEDs on all commercial aircraft.

While it is unclear whether the Busch Gardens and Lufthansa verdicts will survive court appeals, modern advances in AED technology coupled with low cost and the proven ability of these devices to save lives may persuade more and more trial and appellate courts to sanction businesses that fail to adopt AED programs. Prudent businesses can avoid this legal risk by purchasing AEDs and training employees in their use.

Balancing Risks and Benefits

Legal risks associated with adoption and implementation of business-based AED

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Occupational Health & Safety
AUGUST 1997

DEFIBRILLATORS ENTER THE BUSINESS MARKETPLACE

programs, while not zero, appear quite negligible. At least one industry believes greater risks flow from the failure to adopt such programs.

Airline industry observers also say they expect other U.S. airlines to follow American Airlines' footsteps (American has announced a plan to equip all its foreign and domestic aircraft with portable defibrillators by the end of 1998) in hopes of avoiding potential lawsuits for negligence that might arise from a failure to provide appropriate medicines and equipment needed to treat a sick passenger in flight.

The following factors highlight why business-based AED programs generally constitute a low-risk endeavor:

- No lawsuits, verdicts, or appellate cases are identified involving the use of a defibrillator in the business environment to help a victim of sudden cardiac arrest (SCA).
- SCA victims are, in effect, already dead. Use of an AED can only help, it cannot hurt.
- Many if not most businesses carry liability insurance coverage protecting the business in the event of an AED related lawsuit.
- Many states have laws limiting the types and scope of negligence lawsuits permissible against lay individuals rendering emergency medical care (tort limitation, Good Samaritan, and a variety of immunity laws).

In sum, increased liability risk, if any, associated with adoption of a business-based AED program is quite minimal. In contrast to limited risk, the benefits of AED program adoption are quite remarkable.

For example, published medical research suggests that persons suffering certain forms of SCA who are defibrillated in less than one minute have a 90 percent chance of surviving. For each minute of continued SCA, the likelihood of successful conversion decreases by approximately 10 percent. Thus, from a public health perspective, businesses adopting AED programs can actually increase the likelihood of saving lives.

From a public relations perspective, AED programs offer businesses the opportunity to distinguish themselves in the marketplace. American Airlines, emphasizing passenger welfare benefits, received significant positive media attention following its AED announcement.

Overall, the benefits of AED program adoption in the commercial business arena far outweigh any risks. As these benefits become better understood and disseminated within the business community, it is highly likely AEDs will, indeed, become as common as fire extinguishers. OHS

Richard A. Lazar, a lawyer, is a consultant to the emergency medical services and AED industries from his home base in Portland, Ore.

References

1. Cobb, LA, et al. Report of the American Heart Association Task Force on the Future of Cardiopulmonary Resuscitation. *Circulation*. 1992;85:2346-2355.
2. W. Page Keeton et al., Prosser and Keeton on the Law of Torts§ 53, at 356 (5th ed. 1984).
3. Restatement (Second) of Torts § 314A.
4. "Finally, The Right Tools to Save Lives in the Air." *Chicago Tribune*. Dec. 22, 1996. Discussing American Airlines' plan to equip all its foreign and domestic aircraft with portable defibrillators by the end of 1998.

New York Exchange Faces Reality of Heart Attacks

By Bloomberg News

One morning last March, Patrick Grieve, a 48-year-old clerk, complained to a colleague on the New York Stock Exchange floor of tingling in the bottom of his feet. Just after the opening bell, Mr. Grieve collapsed and died of a heart attack.

"It's become legendary that this ZIP code is the heart attack capital of New York," said Ellen Karasik, an assistant vice president at New York University Downtown Hospital, the nearest medical center.

Nowhere is this more true than on the trading floor of the exchange, where the workers are largely middle-aged men suffering from poor diet, lack of exercise and stressful, frenetic jobs.

The heart attack death rate during business hours for the 5,000 people who work at the exchange is 60 percent higher than the national rate for men between 18 and 65, according to the National Center for Health Statistics.

Five heart attacks occur on the exchange floor in a typical year, and usually two of them are fatal, according to Dr. Ira Schulman, director of cardiology at N.Y.U. Downtown Hospital, formerly Beekman Downtown Hospital. When someone collapses, he said, "I don't think they stop trading."

The New York Stock Exchange is facing this reality. On the perimeter of the trading floor, next to a bank of phones used by brokerage clerks to take orders from their offices, stands a green box with a word etched across the front: Defibrillator. Inside is an electroshock machine used to revive heart attack victims.

The exchange is among the first employers to install a defibrillator, said Michael G. Mullen, an analyst at Cowen & Company in Boston who covers heart technology. Although the exchange is just five to seven minutes away from N.Y.U. Downtown Hospital by ambulance in weekday traffic, a defibrillator can save a patient's life within the first few minutes of an attack.

Defibrillators can restart the heart by applying an electric shock that restores a normal rhythm. Unlike the ones on television shows with big paddles, applied with shouts of "Clear!" the portable version has little pads that are taped to the patient, and a computer that administers treatment..

The exchange would not comment on its defibrillator or say if it has ever been used.

Jason Blatt, a clerk at the exchange, said he wished there had been a defibrillator there two years ago when his friend, William Weyier, collapsed at his feet. "We started doing everything we could, but he died right there; it was terrible," said Mr. Blatt, who works for Einhorn & Company, a specialist firm that matches buyers and sellers at the exchange.

The Big Board has an average of five coronaries a year on the trading floor.

Grand Central Terminal in Manhattan bought a defibrillator this summer for $4,000, and medics used it days later to save a commuting attorney's life. It was made by **Heartstream** Inc., which is being acquired by the **Hewlett-Packard** Company.

The exchange is taking other steps to keep its people alive, including a required annual physical exam, maintaining a medical unit with three physicians on-site and having workers on the floor who are trained in cardiopulmonary resuscitation and so identified by badges on their jackets.

N.Y.U. Downtown Hospital opened a special chest pain emergency room two and a half years ago. The unit was paid for, in part, with a $1.3 million gift from the New York and American Stock Exchanges, the Henry Goldman Foundation and the Salomon Foundation.

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STATE OF KANSAS
BOARD OF EMERGENCY MEDICAL SERVICES

109 S.W. 6TH STREET, TOPEKA, KS 66603-3826
OFFICE (913) 296-7296 FAX (913) 296-6212 TDD (913) 296-6237

Bob McDaneld
Administrator

Bill Graves
Governor

DATE: March 12, 1998

TO: Senate Public Health and Welfare Committee

FROM: Bob McDaneld

SUBJECT: Testimony in support of HB 2723

The Board of Emergency Medical Services is the state agency which regulates out-of-hospital emergency medical services. Agency responsibilities include the permitting of ambulance services, the licensing of vehicles, and the training, examination and certification of ambulance attendants and instructors. The board also provides an emergency radio communications system in 51 counties, supports the EMS portion of the 800 Mhz communications system and supports and monitors four regional EMS councils.

The Board of Emergency Medical Services supports HB 2723 and requests that the committee report it favorably. Automated external defibrillation can be a life saving technique; its widespread use will help more cardiac arrest victims survive and return to productive lives.

RM/st

C Board Members

Senate Public Health & Welfare
Date: 3-12-98
Attachment No. 2

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1230
913-296-4929
FAX 913-296-3929

Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-5752

To: The Honorable Senator Sandy Praeger, Chairperson
and Members of the Public Health & Welfare Committee

From: Patsy L. Johnson, M.N., R.N., A.R.N.P.
Executive Administrator
Kansas State Board of Nursing

Date: March 12, 1998

Re: HB 2723

Thank you for allowing me to testify on HB 2723 on behalf of the Board of Nursing.

The Board became aware of automatic external defibrillators (AED's) several months ago. A nurse requested continuing education hours for teaching a class that included use of the AED. The Board members were concerned that courses were being presented to individuals with no medical or nursing education. Because defibrillation is considered a medical procedure, the Board of Nursing referred the issue to the Board of Healing Arts.

With the introduction of HB 2723, the Board of Nursing still has concerns and asks these questions:

1. Since the AED is considered a physician prescription device by the Federal Drug Administration (FDA), is the physician who prescribes it responsible that the person(s) using the equipment has had a cardiopulmonary resuscitation course and instruction in the use of the AED?
2. Is the lay person competent to assess fainting, seizures, or other types of unconsciousness for which defibrillation should not be used?

Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Patricia McKillip, R.N., Ph.D.
Education Specialist
296-3782

Diane Glynr
Practice
296-

Senate Public Health and Welfare
Date: 3-12-98
Attachment No. 3

3. The AED is supposed to be automatic, but different models of the equipment have manual overrides. Can a person be defibrillated using the manual controls?

4. Has the equipment been perfected so other types of cardiac arrhythmias (irregularities) do not trigger the defibrillator to discharge?

5. If there is no oversight of who may use the equipment, how will the equipment be maintained over time?

The Board of Nursing believes there are many unanswered questions about AED's. Appropriately educated health care personnel following medical direction or protocols may utilize new equipment such as the AED. This can be done without a change in statutes. Expanding such practices to the general population who have limited education may endanger the public more than protect them.

The Board asks the Committee not pass HB 2723 or at least postponed it a year so that use of the automatic external defibrillator may be further studied.

Thank you.

c/o Clay County EMS
603 Fourth Street
Clay Center, Kansas 67432

(913) 632-2166 • Fax (913) 632-6050

Testimony to
The Senate Public Health and Welfare Committee

RE: HB 2723

The Kansas Emergency Medical Services Association (KEMSA) represents Emergency Medical Technicians, Paramedics, First Responders, EMS Educators and Administrators from throughout Kansas.

We support of the concept of Public Access Defibrillation. Our intent is to make sure all the links in the "Chain of Life" fit together easily and work to improve survival from sudden cardiac arrest.

Dr. Richard O. Cummins, Senior Science Editor for the American Heart Association ECC (Emergency Cardiac Care) Programs, recently posted a letter to the mailing list for Emergency Medical Services Educators that outlines some essential elements for model legislation in Public Access Defibrillation. The AHA ECC Committees are preparing a Medical-Scientific Statement, to be published in CIRCULATION entitled "State Legislation to Enable Public Access Defibrillation: Essential Elements and Suggested Strategies."

According to Dr. Cummins' letter, the statement presents the perspective that "model" legislation should:

- *provide "limited" immunity (not just immunity) to four groups (prescribing physicians, premises owners, trainers, rescuers*

IF THEY MEET CERTAIN CONDITIONS:

- *receive training specifically in CPR combined with AED use*
- *training and treatment protocols should be consistent with national recommendations, and should be authorized by local medical control or local medical authorization*
- *attempt to rescue is rendered consistent with Good Samaritan concept, i.e. in good faith, sincere effort to help, within the scope of the training (not gross negligence) and gratuitously*
- *the device is registered with EMS-911 system*
- *device is maintained consistent with the manufacturer's recommendations*
- *rescuer reports any actual clinical use to authorizing medical group/individual*

It is unfortunate that the legislation for Public Access Defibrillation has been pushed through so quickly, the science behind the concept has not been allowed to catch up with it.

In our testimony before the House Health & Human Services Committee, KEMSA addressed our main concern that EMS Directors around the state feel strongly they should know the location AED's before walking in on a critical event. This provides an avenue of communication and smoother transition between citizens using the AED and the local EMS System who will assume care of this patient.

√ It is KEMSA's proposal that HB 2723 be amended with the attached language to bring it into compliance with national standards. We feel this can only enhance the benefit of this lifesaving effort for the citizens of Kansas.

President:
Connie McAdam
P.O. Box 2522
Shawnee Mission,
KS 66201-2522
(913) 867-2202

Vice President
John Dudte
Hutchinson Community College
1809 Essex Road
Hutchinson, KS 67501
(316) 665-4911

Secretary:
Pam Kemp
Clay County EMS
603 Fourth Street
Clay Center, KS 67432
(913) 632-2166

Treasurer:
Duane Billinger

Senate Public Health & Welfare
Date: 3-12-98
Attachment No. 4

KEMSA recommended changes in HB 2723

Change all words "automatic " to automated. There are no automatic's made anymore.

In (2) change the word "encouraged " to "required"

Change (3) to be (6)

New (3) "training and treatment protocols must be consistent with national recommendations and will be authorized by local medical control or local medical authorization"

New (4) "the automated external defibrillator will be maintained consistent with the manufacturer's recommendations"

New (5) "all actual uses of the automated external defibrillator will be reported to the authorizing medical group or individual"

Senator Praeger and members of the Committee.

Thank you for hearing me today. My name is Michael Cumley, and I am here today in a three-fold capacity.

Firstly, I am here as an independent American Heart Association Basic Life Support Instructor. Of the 36,000 plus individuals trained as Healthcare Providers (1n 1996). I personally was responsible for only a small percentage. My students in these classes represented a gamut of certification and licensure in the healthcare industry, from M.D. to dental hygienist; occupational therapist to nurse's aid. In each class, when the students were told of the causes of fibrillation and explained the effects of defibrillation, the question most asked is "Why cant I?" Senators, the healthcare industry is apparently primed for this opportunity; and seemingly eager to acquire the tools and training.
In classes given to the community at large (church groups, athletic coaches, etc.), during explanation of the "Chain of Survival" concept, the question of public access is consistently asked. Recent media coverage of the success of AED operation (i.e. Good Morning America, Reader's Digest, etc.) has raised public awareness to the extent that I must invariably answer the question "Why can't I?."

Secondly, I am here as the owner of a safety consulting company. As a Federal Dept. of Labor, Occupational Safety and Health Administration (OSHA) Outreach Trainer, I inform companies of various sizes and industries of compliance standards; offer and advise different strategies and implementation procedures. While OSHA does not have a specific standard covering defibrillation, standard 29CFR 1910.151 does cover CPR. Also, to be considered is the "General Duty Clause" which states that each employer "shall furnish… a place of employment, which is free from recognized hazards that are causing or are likely to cause death or seriously physical harm to the employees." Once again, media coverage of successful rescucitation caused by AED use brings up the question "Why can't I?."

Lastly, I am here as a citizen, Good Samaritan, and the son of a cardiac arrest victim. My father had a history of heart problems. He died in his home of sudden cardiac arrest. Could an AED have saved him? Sadly, we will never know. My question to you today is simply this, "Why can't I?."

I respectfully ask that you support House Bill 2723.

Senate Public Health & Welfare
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Attachment No. 5