

EXPAND GOOD SAMARITAN LAW

House Bill 4420 as enrolled
Public Act 173 of 1999
Sponsor: Rep. Gerald Law

House Committee: Health Policy
Senate Committee: Judiciary

Second Analysis (12-13-99)

THE APPARENT PROBLEM:

Public Act 17 of 1963, known as the “Good Samaritan” law, provides immunity from civil liability to certain authorized medical personnel who in good faith render medical aid in emergency situations, except where an act or omission amounts to gross negligence or wilful and wanton misconduct. The act was amended in 1986 to grant immunity from liability to any person who performed cardiopulmonary resuscitation (CPR) in an emergency (regardless of whether the person had any training in the technique), and again in 1987 to grant immunity to physicians who in good faith and without compensation, performed physical examinations on persons to determine their fitness to engage in competitive sports. The 1987 legislation also granted immunity to health care professionals giving emergency care to participants injured during competition, and to registered members of the National Ski Patrol. The reasoning behind such legislation was to encourage bystanders to help accident and heart attack victims and to encourage health professionals to render medical care to nonpatients in an emergency or as volunteers with schools without fear of being sued by the people they attempt to help.

With the development in recent years of automated external defibrillators (AEDs), devices that analyze a heart attack victim’s heart rhythm and automatically deliver the appropriate electric shock necessary to restore a regular rhythm, a medical procedure that was once only in the purview of trained medical professionals and certain emergency personnel such as paramedics can now be performed by the average person. Though the machines have been shown in several studies to increase the survivability of certain types of cardiac arrest, many people have been resistant to the widespread availability and placement of AEDs in police cars and public access areas such as shopping malls, stadiums, and fitness clubs due to fears over liability. To address this concern, legislation has been offered to place language in statute that is similar to the

provision pertaining to laypersons giving CPR and physicians rendering emergency care, thereby extending immunity from civil liability to anyone using an AED on a heart attack victim.

THE CONTENT OF THE BILL:

House Bill 4420 would amend Public Act 17 of 1963, known as the Good Samaritan law, to limit the liability of persons who used an automated external defibrillator (AED) to render emergency service to another person. An individual who had no duty to render emergency service would not be liable for damages in a civil action arising out of the good faith use of an AED to treat another person. Further, the bill would also extend immunity from civil suits to a physician providing medical authorization for use of an AED, an individual who instructed others in the use of an AED, and an individual or entity that owned, occupied, or managed the premises where an AED was located or used. However, in each case, this immunity would not apply where the actions of the individual providing the treatment amounted to gross negligence or willful and wanton misconduct.

The immunity provided by the bill would only apply to civil actions filed or pending on or after the bill’s effective date. (Note: The bill was filed with the Office of Secretary of State on November 16, 1999.)

MCL 691.1504

BACKGROUND INFORMATION:

Ventricular fibrillation (VF) is the most common arrhythmia of the heart leading to sudden cardiac arrest. During VF, the heart is unable to pump blood because the muscles contract chaotically instead of in a coordinated fashion. According to Dr. Myron

Weisfeldt of Columbia-Presbyterian Medical Center in New York City, a speaker at the March, 1998, conference of the American College of Cardiology, VF accounts for approximately 70 percent of the cases of cardiac arrest, with the single most important factor of survival being the timing of electrical cardioversion (a controlled electric shock delivered by a defibrillator that can restart a normal rhythm).

In his remarks, Dr. Weisfeldt related that studies have shown a survival rate of approximately 80 percent if an individual in VF is cardioverted within one to two minutes of the onset of VF. He goes on to report that survival rates drop dramatically with each passing minute (for example, a speaker at the 71st Scientific Sessions of the American Heart Association in November of 1998 reported that survival drops by seven to ten percent for each minute a person is in VF), resulting in approximately a 25 percent chance of survival after five minutes, ten percent after ten minutes, and just five percent after defibrillating 15 minutes after the onset of VF.

Until recently, use of a defibrillator required a trained professional (doctor or paramedic) to interpret the patient's heart rhythm to determine whether defibrillation was appropriate. First introduced in 1979, automatic external defibrillators (AEDs) that accurately analyze cardiac rhythms and/or deliver an electric shock when appropriate have now been streamlined by the medical manufacturing industry into smaller, lighter-weight, lesser expensive, easier to use, voice-prompt models that people other than paramedics and other medical first responders can use.

Placed in public access areas such as airplanes, airports, casinos, shopping malls, arenas, and fitness centers, anecdotal reports show that the new generation of AEDs have had dramatic results in saving the lives of sudden cardiac arrest victims. Perhaps the most statistically-supported beneficial effect has been the placement of AEDs in police cars. In many areas, a police officer is able to respond to an emergency call in less time than an ambulance or other advanced life support service (on average, studies have shown a police-first response time to VF cases of 4.2 minutes vs. 6.3 minutes for EMS-first cases). A look at one study's average interval from the receipt of a 911 call to delivery of the first shock showed a call-to-shock interval of six minutes for police compared to ten minutes for when EMS arrived first (from a talk delivered at the 71st Scientific Sessions of the American Heart Association Conference, November, 1998, by Dr. William Groh of Indiana University.) Patients treated by police had a survival-to-hospital-

discharge rate of 20 percent compared to 2.9 percent of those treated first by EMS.

Despite such dramatic results in survival numbers, it is reported that only 30 percent of first responders (for example, police cars) are currently equipped with AEDs. Apparently, the major reason for placement of AEDs in squad cars and public access places is the concern over lawsuits when persons other than trained life support personnel use AEDs on cardiac arrest victims. Several states have recently adopted laws granting civil immunity (except in cases of gross negligence) to individuals under Good Samaritan Laws. In light of the improved chances of surviving a heart attack caused by VF, a joint American Heart Association/American College of Cardiology task force has recommended the widespread availability of AEDs, especially in remote areas and places where trained medical first responder personnel are not immediately available.

FISCAL IMPLICATIONS:

According to a Senate Fiscal Agency analysis of the bill dated 10-21-99, the bill would have no fiscal impact on state or local government.

ARGUMENTS:

For:

Automated external defibrillators (AEDs) restore a normal heart rhythm for victims of sudden cardiac arrest who have one of the two most frequent heart arrhythmias: ventricular fibrillation and ventricular tachycardia (VF/VT). About 70 percent of cardiac arrest victims have one or the other of these arrhythmias. Research studies have proven that in such cases, survival decreases by about 10 percent for each minute that a person remains in the arrhythmia. Many emergency medical first response systems and advanced life support systems typically need anywhere from four to ten minutes to respond, thereby dramatically decreasing the chances for survival of a cardiac arrest victim. The new generation of AEDs, with clearly marked electrodes that show proper placement; voice prompts that instruct the user to stand back, check for a pulse, administer CPR; and the ability to accurately analyze a heart rhythm and deliver the appropriate shock only when medically necessary, now provides a relatively safe and beneficial means for a layperson to help a cardiac victim until professional emergency medical personnel can arrive. The placement of AEDs in places where people congregate -- office buildings, pools, sports arenas, concert halls,

schools, universities, shopping malls, and so forth -- could play a major role in increasing a person's chance of surviving sudden cardiac arrest. However, with today's litigious climate, it is imperative that laypeople and businesses have the assurance that their good faith efforts to assist in a medical emergency will not result in facing a major lawsuit.

Against:

Several municipal officials and police agencies have expressed a concern regarding protection from civil liability for fire fighters and police officers. The problem appears to center around the issue of having a "duty" to respond. The bill extends immunity to persons who have no duty to respond to an emergency. Since responding to various types of emergencies is well within the job description of fire fighters and police officers, the bill may not extend to them. It would seem, though, that members of these two professions, even volunteer fire fighters and emergency personnel, would be covered under existing governmental immunity laws. However, confusion has arisen regarding the interplay of governmental immunity laws and Part 209 of the Public Health Code, which governs emergency medical services. Under the Health Code, immunity is extended to those providing medical first response services, but only when rendered by licensed medical first responders. Therefore, many are concerned that to continue to receive immunity from civil liability when using AEDs, all fire fighters and police officers may have to become trained and licensed as medical first responders.

Response:

This concern is unfounded. Police officers and fire fighters are trained in basic first aid and CPR. Many squad cars carry oxygen and first aid kits to assist in medical emergencies. Assisting in medical emergencies must not be confused with rendering the statutory level of care that would make an agency a medical first response service or an individual officer a medical first responder. The new generation of AEDs are so simple to use, that use of one would be on a level similar to administering CPR. Just as training in CPR and being sent to assist in cardiac arrest cases has not made police and fire fighters medical first response services, neither should the routine placement of AEDs in squad cars and fire engines.

Further, in a letter sent in December 1998, by the director of the Emergency Medical Services Division of the Department of Consumer and Industry Services to medical control authorities (which supervise emergency medical services within an emergency medical services system, typically a county), the director addressed the question of whether the use of AEDs by law

enforcement agencies and personnel made them medical first responders. The director wrote that the Public Health Code's definition of medical first response service "excludes a law enforcement agency from having to meet the medical first response service requirements *if it does not hold itself out as providing this level of care.*" The director further wrote that "[t]ypically, a law enforcement officer is not dispatched to provide life support at the level of care of a medical first responder and is therefore not required by Part 209 to be trained and qualified as a medical first responder." It would be reasonable to assume that the above argument would apply to all municipal employees. In light of the information regarding the quicker response time of police officers and other first responders as compared with medical first responders, it is imperative that police officers be equipped with AEDs, especially in rural areas. Reportedly, two rural services in Kalamazoo County saved three individuals in 1997 with the use of an AED. Widespread availability of these devices would save even more lives.

Against:

Several states restrict immunity from civil liability to those who have been trained and licensed as emergency medical services personnel. The state of New York requires that individuals have 40 hours of training at the emergency medical technician level. The bill as introduced would have required at least four hours of training by the American Red Cross, American Heart Association, or other approved training program. Some amount of training in the use of AEDs should be restored to ensure that even laypersons have some basic knowledge of how to safely operate the devices. Further, without proper training, people could assume that learning CPR is not necessary, or they could rely too much in the benefits of an AED and fail to call 911 to summon trained emergency personnel.

Response:

The New York law cited above pertains to licensed individuals. Though many states, including Michigan, require licensed emergency personnel to receive a specified amount of training before using defibrillators, it does not make it unlawful for laypersons to use AEDs. The bill merely extends immunity from civil lawsuits to corporations and businesses that have AEDs available in their buildings and facilities, and protects individuals who respond in an emergency to save the life of a heart attack victim. Reportedly, about 20 states have recently extended immunity to laypersons using AEDs, with legislation pending in several other states.

The majority of the supporters of the bill agree that it is only a first step in increasing the chances of survival for victims of cardiac arrest. The next big hurdle will be disseminating appropriate educational materials to the public. An AED does not replace or remove the need to know CPR. Often, CPR may need to be started before using an AED in order to clear the airway, or to keep oxygen in the victim's system while someone else retrieves the AED. Further, it should never be assumed that use of AEDs by laypersons would ever minimize the need for trained emergency medical personnel, as victims of cardiac arrest still need medical care, possibly even surgery, to ensure survival. Quick use of an AED to restore a normal heart rhythm dramatically increases a victim's chance of survival, basically by keeping him or her alive until appropriately trained medical personnel can arrive. As to the issue of training, all people should be trained in the use of an AED, just as all people should be trained in first aid and CPR. However, the Good Samaritan Law provides protection from lawsuits to persons administering CPR whether they have received training or not. The immunity for using an AED should be the same as for those administering CPR.

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■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.