

The Legal and Moral Case for a Defibrillator

How would you respond if someone suffers cardiac arrest at church?

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“Public access to defibrillators represents potentially the single greatest advance in the treatment of cardiac arrest since the development of CPR.”

— Tom P. Aufderheide, MD, associate professor of emergency medicine at the Medical College of Wisconsin

The time has come for church leaders to consider the purchase and installation of defibrillators. A defibrillator, or automated external defibrillator (AED), is a small electronic device that uses electric shocks to stop an abnormal heart rhythm—known as ventricular fibrillation (VF)—to restore a normal heart beat. VF is by far the most common cause of sudden cardiac arrest. Without defibrillation, persons who are suffering from VF will die within a few minutes, often before paramedics arrive.

EXAMPLE: Gary, a middle-aged man, clutches his chest and collapses during a worship service. The service is abruptly halted, and the congregation is horrified. Some panic, and most have no idea what to do. One member frantically tries to apply CPR. Another calls 911. Fifteen minutes later paramedics arrive, but all efforts to revive Gary fail. He is pronounced dead on arrival at a local hospital. Gary is survived by his wife and two children, all of whom witnessed the tragedy. In the days that follow, members of the congregation begin asking questions: “Was there anything we could have done to save Gary’s life?” “Would it have mattered if our church had a defibrillator?” “If we did have a defibrillator, would our church have been liable if it was not used properly, or failed to save Gary’s life?” “Could our church be liable for Gary’s death because we don’t have a defibrillator?”

This article will address why it is important for churches to develop a response to cardiac arrest, which responses are most effective, the use of defibrillators, and legal issues associated with having a defibrillator on church premises.

The risk of cardiac arrest

The tragic scenario involving Gary could happen in any church. A publication of the American Heart Association (AHA) states:

Sudden cardiac arrest (SCA) is a leading cause of death in the United States. Each year, emergency medical services (EMS) treats about 383,000 victims of SCA before they reach the hospital. Less than 12 percent of

those victims survive. SCA can happen to anyone at any time SCA is the abrupt loss of heart function in a person who may or may not have heart disease. The time and mode of death are unexpected. SCA occurs instantly or shortly after symptoms appear. Most SCAs are due to abnormal heart rhythms called arrhythmias. A common arrhythmia is ventricular fibrillation, in which the heart's electrical impulses suddenly become chaotic and ineffective. Blood flow to the brain stops abruptly; the victim then collapses and quickly loses consciousness. Death usually follows unless a normal heart rhythm is restored within minutes.

The publication further explains: "Defibrillation is a process in which an electronic device gives an electrical shock to the heart. Defibrillation stops ventricular fibrillation by using an electrical shock and allows the return of a normal heart rhythm. A victim's chance of survival decreases by 7 to 10 percent for every minute that passes without defibrillation."

Beginning in the 1990s, small portable defibrillators (also called "AEDs") became commercially available. As described in another AHA publication:

AEDs are highly accurate, user-friendly computerized devices with voice and audio prompts that guide the user through the critical steps of operation. AEDs were designed for use by lay rescuers and first responders to reduce time to defibrillation for victims of [ventricular fibrillation] sudden cardiac arrest. The rescuer turns the AED on and attaches it to the victim with adhesive electrodes or pads. The AED records and analyzes the victim's cardiac rhythm. If a shock is indicated, the AED charges to the appropriate energy level and prompts the rescuer to deliver a shock. If the device is fully automated and a shock is indicated, the AED can deliver a shock without further action by the rescuer.

In the mid-1990s, the AHA began a national public health initiative to educate the public and lawmakers regarding the significant problem posed by cardiac arrest and to promote increased acquisition and use of AEDs by nonmedical entities. The initiative included the drafting of model "Good Samaritan" AED legislation that would grant legal immunity under specified circumstances to nonmedical entities and individuals who acquired, made available, or used AEDs. The AHA's AED initiative proved very successful. Between 1995 and 2000, all 50 states passed laws and regulations related to lay rescuer AED programs. Since 2000, most states have revisited their initial AED statutes and regulations, seeking to continue to reduce legal impediments to the

voluntary acquisition and use of AEDs and, in some instances, mandating the provision of AEDs in specified settings.

The most recent data from the AHA reveals:

- Over 360,000 Americans experienced out-of-hospital cardiac arrest in 2016.
- Every 2 minutes, an individual in the US goes into cardiac arrest.
- The chance of successfully returning to a normal heart rhythm diminishes by 10 percent each minute following cardiac arrest. After 12 minutes, the chance of survival is 0 to 5 percent.
- 60 percent of all cardiac arrests occur outside the hospital. The average national survival rate for out-of-hospital cardiac arrest is only 5 percent.
- Only 32 percent of cardiac arrest victims receive CPR from a bystander, and only 2 percent receive defibrillation from a bystander using an AED.
- Heart disease is the most common cause of death.
- The risk of cardiac arrest varies with race. African Americans are twice as likely to experience out-of-hospital cardiac arrest as Caucasians.
- The US population is aging. In many church congregations, persons over 60 years of age represent the largest constituency.
- Cardiac arrest is one of the leading causes of death in the United States. Unlike a heart attack, which is the death of a muscle tissue from loss of blood supply, many victims of cardiac arrest have no prior symptoms.
- Unfortunately, two out of every three sudden cardiac deaths occur before a victim can reach a hospital, and more than 95 percent of these cardiac arrest victims will die because of lack of readily available lifesaving medical equipment.

A court case involving a church

A church owns and operates a fitness and recreation facility. In 2008, the church purchased four AEDs from an AED seller (the “AED Company”). At least one of these AEDs was placed in the church’s fitness center. The church also purchased, at a cost of \$150 per AED, “Annual Physician Oversight Program Management.” This program included:

- Physician’s prescription for purchase of AEDs
- Medical oversight and written emergency plan, as required by state law
- Evaluation of employee/responder recertification schedules
- Monitoring expiration dates of AED batteries and electrode pads
- Monitoring AED maintenance checks

- Notifications for the expiration dates of responder certifications, batteries, and electrode pads
- Local EMS registration of AED locations
- Post-event review and analysis of ECG data by a physician and reports filed with appropriate government agencies
- 24-hour customer support
- Post-event physician consultation, if requested
- Physician phone consultation regarding any medically specific aspect of the church's programs

The AED Company further agreed to provide the church four complimentary training classes for up to 20 participants per class, with each participant completing a class receiving CPR, AED, and Emergency Oxygen Administration certifications. Two of these classes were held in March 2009, and the third was held in April 2009. Seventeen persons attended these classes. The fourth was scheduled for May 2009, but only one person signed up, so it was canceled. The church did not order additional training services from the AED Company, but instead hired a church member employed as a fire department captain to provide AED training to fitness center personnel.

In January 2011, more than two years after the church purchased the AEDs, a married couple became members of the fitness center. A few months later the husband collapsed while exiting a cycling room in the center. The cycling class instructor went immediately to his location. The instructor, who had received AHA AED training and certification and CPR certification, observed the victim lying on the floor on his side, his body rigid, his eyes open, and his head lifted off the floor. The instructor heard him breathing and saw his chest rising and falling, and after checking his wrist, she determined that he had a pulse.

Based on the victim's physical condition—breathing, eyes open, head lifted off the floor, and body rigid—the instructor assumed that the victim was having a seizure, not a coronary event, and she placed towels beneath his head for support. She decided to wet more towels to cool him, and as she was heading to the water fountain across the room, she encountered two men, both off-duty police personnel, who had just finished a meeting at the fitness center. One of the men asked if the fitness center had an AED, and if so, where it was located. The cycling instructor walked him to the nearest AED, located outside the aerobics room, and after they retrieved it, she returned with him to the victim's location. The man remained with the victim while she continued to the water fountain across the room to wet the towels, and the two men assumed control of the victim's care. When the instructor returned to the victim's location 45 seconds later, one of the men asked for someone to go outside, await the ambulance, and direct the

paramedics to the victim's location, so the instructor did so. Soon thereafter, paramedics arrived, assumed responsibility for the victim's care, and transported him to the hospital, but he died en route.

The victim's widow (the "plaintiff") sued the church and the fitness center director on duty at the time of the victim's collapse. She alleged that the church owed a duty to those using its fitness center (including her husband) to maintain a reasonably safe facility, and this duty obligated the church to ensure that fitness center personnel were properly trained in the use of the AEDs.

The plaintiff further contended that the church owed a duty to use its AED on her husband following his collapse; that it breached this duty; and that this breach caused her husband's death.

The church filed a motion for summary judgment, asking the court to summarily rule in its favor without the need for a trial. The court denied this motion, and the church appealed.

The Tennessee Supreme Court addressed two questions: (1) did the church owe the plaintiff's husband a duty to acquire and make an AED available for use at its fitness center, and (2) did the church have a duty to use the AED it had acquired.

The court noted that to answer these questions "we begin with the well-established principle, that, while individuals have an obligation to refrain from acting in a way that creates an unreasonable risk of harm to others, the law generally does not impose on individuals an affirmative duty to aid or protect others." However, "exceptions have been created for circumstances in which the defendant has a special relationship with either the individual who is the source of the danger or the person who is at risk." One of these "long-recognized special relationships" is that between a business owner and patron. The court explained:

This duty requires a business entity to take reasonable action to protect or aid a patron who sustains injury or becomes ill on business premises [A business entity] is not required to give aid to one whom he has no reason to know to be ill. A business entity will seldom be required to do more than give such first aid as it reasonably can, and take reasonable steps to turn the sick person over to a doctor or to those who will look after him until one can be brought. And business entities are not required to give aid to persons whom they have no reason to know to be ill or injured or whose illness or injury does not appear to be serious or life-threatening. Furthermore, a business entity's duty to render aid does not extend to providing all medical care that a business could

reasonably foresee might be needed by its patrons or to provide the sort of aid that requires special training to administer.

In this case, the plaintiff sought to recover damages based on a theory that the church's duty to render aid to her husband included utilizing an AED. The court agreed that the special relationship exception applied since the plaintiff's husband was a patron of the church's fitness center. However, it noted that no other Tennessee court "has previously considered whether a business entity's duty to aid and protect its patrons requires it to acquire and make an AED available for use or to use an AED that has already been acquired."

The court noted that its own research demonstrated that the law in other states "concerning the duty of business entities to render aid and the acquisition and use of AEDs is still developing," but it concluded that "every state appellate court to consider the issue has held that the common law duty a business entity owes to patrons does not require a business to acquire and make an AED available for use Furthermore, research reveals that a majority of appellate courts . . . have held that even after a business acquires an AED, the business's common law duty to render aid to patrons does not include use of the AED." These decisions are consistent with Tennessee law.

As already emphasized, a business is not required to provide all the medical treatment it could reasonably foresee might be needed by its patrons, nor is it required to provide the sort of aid that requires special training to administer. Not only do Tennessee statutes require special training for AED use, interpreting the common law as imposing a duty on businesses to acquire AEDs and make them available for use would be contrary to Tennessee's AED statutes, which encourage, but do not require acquisition, and indeed, specifically disallow use of AEDs until and unless certain statutory prerequisites are satisfied. Accordingly, we hold that the church had no common law duty to the plaintiff's husband to acquire an AED or to make it available for use, or to use it.

Relevance to church leaders

The Tennessee Supreme Court concluded that church-based fitness centers in that state have no legal duty to acquire AEDs or to use them in cases of cardiac arrest. But this case is nevertheless important for the following reasons:

It demonstrates the risk of cardiac arrest to church members, and the rapid onset of death if an AED is not available or not used. The risk rises with the number of elderly

who attend church services. The plaintiff's husband died because of a failure to halt his cardiac arrest with electric defibrillation. Tragically, this likely was avoidable.

Churches that operate a fitness facility, or that conduct fitness programs on their premises involving vigorous physical activity, are at the greatest risk for not having, or not using, an AED. The law in this area is evolving, and while some courts, like the Tennessee Supreme Court, would not impose a duty on such churches to install AEDs and have trained users immediately available, courts in other states have ruled that fitness centers do have such a duty.

At this time, no court has ruled that churches that do not have a fitness center, and do not conduct exercise classes on their premises, have a legal duty to install an AED, and have persons immediately available who can operate it.

Even if a church has no legal duty to install and staff an AED, an argument can be made that it has a moral duty to do so, based on these factors:

- A substantial percentage of persons attending most churches are older, and at a heightened risk of cardiac arrest. For many churches, it is only a matter of time before a member or visitor collapses with cardiac arrest. In general, the survival rate for such victims decreases by 10 percent per minute. Without an available AED, and persons trained to use it, cardiac arrest in all too many cases becomes a death sentence.
- AEDs are no longer cost prohibitive.
- Newer AEDs are "foolproof," meaning that they do not emit an electric charge unless VF is detected.
- The common fear that "if we have a defibrillator but don't use it properly, we can be sued," is fallacious.
- The common fear that "if we use an AED on a person who has not experienced cardiac arrest, we will make the condition worse," is fallacious.
- Modern AEDs are easy to operate. Many provide verbal instructions to the user.
- Training addressing the use of AEDs is readily and inexpensively available in most communities. Check with your local chapter of the AHA, or a hospital, for information. Ideally, several persons in a church should be certified to use an AED to ensure that at least one is present during every service or activity.

Many states require "places of public accommodation" to have AEDs. It is often unclear whether such laws apply to churches, and especially churches that do not invite the public onto their premises for commercial purposes. Check with legal counsel to clarify this issue.

Quick Facts and Stats About Cardiac Arrest and AEDs

Here are the key points you should know about defibrillators and cardiac arrest:

- Over 300,000 Americans die each year from cardiac arrest. Every 2 minutes an individual in the US goes into cardiac arrest.
- The chance of successfully returning to a normal heart rhythm diminishes by 10 percent each minute following cardiac arrest. After 12 minutes, the chance of survival is 2 to 5 percent.
- While calling 911 is essential in all cases of cardiac arrest, it alone may not be an adequate response. The average response time for paramedics is 12 minutes.
- The vast majority of cases of cardiac arrest are caused by ventricular fibrillation (VF), for which electric defibrillation is the only remedy. CPR is not solely sufficient to restore a normal heart rhythm for a victim of VF.
- About one-fourth of all cases of cardiac arrest occur in public places, such as airports, stadiums, theaters, and churches.
- The US population is aging. In many congregations, persons over 60 years of age represent the largest constituency.
- Defibrillators are designed to not administer a shock until after they have analyzed a victim's heart rhythm and determined that an electric shock is required. This helps make these devices safe and effective, even when used by lay people.
- Defibrillator training courses are provided by the American Red Cross, the AHA, local emergency medical services groups, and other public health and safety institutions.
- The price and weight of AEDs continue to drop. Today, units are available that weigh under five pounds and cost from \$1,000 to \$2,000. Modern units are also easy to operate. Many have voice commands to guide users.
- Every state has enacted a law that provides limited immunity from liability for the use of a defibrillator. Most of these laws protect persons who have received training in the use of defibrillators, even if they have no formal medical training.
- Some courts have found organizations liable for the death of a patron or customer because they did not have a defibrillator. The AHA has noted that "as awareness of the new generation of defibrillators grows, companies and organizations may face greater threat of liability if they aren't properly prepared to respond in a timely manner to a cardiac emergency."

Is CPR the answer?

Cardiopulmonary resuscitation (CPR) is an attempt to use chest compressions and artificial respiration to keep oxygen-rich blood flowing to a person's brain and heart during cardiac arrest. Many church leaders assume that there are members who have received training in CPR, and that these members will be able to respond effectively if someone suffers cardiac arrest on church property. Is this an appropriate response to the risk of cardiac arrest? Unfortunately, the answer is no. It is true that most Americans have received CPR training. But for many, the training occurred years ago and has never been applied. The chances of such a person saving a cardiac arrest victim is remote.

Even more importantly, church leaders should recognize that while CPR can sustain a patient in VF for a short time, only defibrillation can restore a normal rhythm. Without defibrillation, the victim will die. This is borne out by a recent study of cardiac arrest victims. Of every 100 victims treated with CPR alone, 95 died, 2 to 3 survived a few days, and 1 to 2 fully recovered. With defibrillation, the survival rate increases dramatically. According to a recent article in a prominent medical journal, the survival rate jumps to 74 percent for victims of cardiac arrest who are defibrillated within 3 minutes.

Can't we just call 911?

While calling 911 is essential in all cases of cardiac arrest, it alone may not be an adequate response. The chance of successfully returning to a normal heart rhythm diminishes by approximately 10 percent each minute following cardiac arrest. After 12 minutes, the chance of survival is 2 to 5 percent. Many churches are located in crowded urban or suburban areas where traffic congestion may delay the arrival of paramedics for several precious minutes. In many rural areas, the response time for paramedics (if they are available) may be 30 minutes or more.

An AED is not a substitute for calling 911. Whenever a person suffers cardiac arrest in a church, 911 should be called immediately. But, since it may take paramedics several minutes to arrive, it is important for a trained person within the congregation to begin defibrillation immediately.

The case for defibrillators

What is a defibrillator? Most cardiac arrests are caused by abnormal heart rhythms (VF). VF occurs when the heart's electrical system malfunctions, causing a chaotic rhythm in the main pumping chamber of the heart that prevents the heart from pumping oxygen to the victim's brain and body. AEDs are medical devices that can effectively restart a

heart that has stopped. Defibrillators are subject to FDA approval, and can only be sold with a prescription by a licensed individual. AEDs have been shown to be safe and effective, even when used by lay people, since the devices are designed to not administer a shock until after it has analyzed a victim's heart rhythm and determined that an electric shock is required. AED training courses are provided by the American Red Cross, the AHA, local emergency medical services groups, and other public health and safety institutions.

How effective are defibrillators? Defibrillators are very effective in saving the lives of persons who experience sudden cardiac arrest. Consider the following statistics: 80 percent of cardiac arrests are caused by VF, for which defibrillation is the only effective treatment.

- 60 percent of all cardiac arrests occur outside the hospital. The average national survival rate for out-of-hospital cardiac arrest is only 5 percent.
- Organizations that have established and implemented defibrillation programs have achieved average survival rates for cardiac arrest as high as 50 percent.
- According to the AHA, wide use of defibrillators could save as many as 50,000 lives nationally each year.
- Studies show that defibrillators are successful up to 90 percent of the time in detecting VF that should be defibrillated, and are successful up to 99 percent of the time in not sending electric shocks when VF are not detected.

How much do they cost? When defibrillators were first introduced, they weighed more than 100 pounds and cost several thousands of dollars. Today, units are available that are under 5 pounds and cost from \$1,000 to \$2,000.

The experience of other charities and organizations

About 25 percent of cardiac arrest cases occur in places where people congregate, and so it is easy to see why more churches, charities, malls, airports, and fitness centers are acquiring AEDs. And, as the size and cost of AEDs continues to decrease, and they become easier to use, more organizations are considering their use.

Are AEDs a substitute for CPR? Most medical authorities agree that defibrillators are not a substitute for CPR. While CPR is generally ineffective in cases of cardiac arrest caused by VF, it may sustain life for a few precious minutes until defibrillation can be applied. CPR provides a small amount of blood to the brain and heart and keeps these organs alive until defibrillation can shock the heart into a normal rhythm.

The AHA recommends that defibrillator users be trained in both CPR and defibrillator use: “Early CPR is an integral part of providing lifesaving aid to people suffering sudden cardiac arrest. The ventilation and compression skills learned in a CPR class help to circulate oxygen-rich blood to the brain. After delivering a series of three electric shocks, the typical defibrillator will prompt the operator to continue CPR while the device continues to analyze the patient.” In other words, training in both CPR and defibrillator use is essential.

A recent issue of the Journal of the American Medical Association contains the following statement:

Compared with standard care for ventricular fibrillation, CPR first prior to defibrillation offered no advantage in improving outcomes for this entire study population or for patients with ambulance response times shorter than 5 minutes. However, the patients with ventricular fibrillation and ambulance response intervals longer than 5 minutes had better outcomes with CPR first before defibrillation was attempted. These results require confirmation in additional randomized trials.

A small number of cases of sudden cardiac arrest are not caused by VF, and in these cases CPR may be the best response.

Key point. Many medical professionals recommend using the “Cardiac Chain of Survival” in responding to victims of sudden cardiac arrest. The first step in the chain is to call 911. The second step is to provide early CPR to the victim. The third step is to provide early defibrillation, and the fourth step is early advanced life support, which includes care by paramedics and transport to a hospital. The chain recognizes the value of CPR in conjunction with defibrillators.

Legal issues

There are a number of legal issues associated with the use of defibrillators, including the following:

What if an AED is used on a person who is not experiencing cardiac arrest? You see the need for having a defibrillator in your church. But you are still reluctant to purchase one because of a concern that using a defibrillator on a person who is not suffering from VF could make the person worse. This problem has largely been solved by computer technology. Most modern defibrillators will not emit electric impulses until they analyze a victim’s heart rhythm and determine that an electric shock is required. Their

built-in computer uses a sophisticated algorithm to detect if a shock is necessary and if it is, selects the preprogrammed amount of energy. If your church purchases a defibrillator, be sure that it has this “failsafe” feature (to receive FDA approval, this feature is required).

EXAMPLE A man slumps over in his seat during a worship service. A church member who has received training in operating a defibrillator immediately retrieves a defibrillator maintained by the church, connects it to the victim, and turns it on. The man was not experiencing cardiac arrest. He merely “blacked out.” The defibrillator determines that the victim is not experiencing abnormal heart rhythms, and does not emit a shock. The man regains consciousness a few moments later.

What if a defibrillator is used, but does not save a person’s life? Defibrillators are no guaranty that a victim of cardiac arrest will be resuscitated. A defibrillator may be used too late; it may be used by a person who has received no training in its proper use; it may malfunction; or the batteries may be drained. What if a church purchases a defibrillator, but is unable to save the life of a person suffering from cardiac arrest because of one or more of these problems? There are a number of responses to this concern.

Reducing the risk

These risks can be reduced by: having several members trained in the proper use of a defibrillator; proper placement of the defibrillator on church premises (often this will be prescribed by state law); and proper maintenance of the defibrillator (again, often prescribed by law).

Court cases

It is interesting to review actual court cases addressing liability based on ineffective use of a defibrillator. Consider the following summary of one of the leading cases.

CASE STUDY 1 A man suffered a cardiac arrest. An ambulance was called and paramedics provided emergency medical services. The paramedics attempted to restart the victim’s heart using a defibrillator. The machine did not function, and so another ambulance was summoned. By the time it arrived, the man had died. The man’s wife sued the ambulance company, claiming that it was grossly negligent in failing to test and maintain the defibrillator.

A Michigan appeals court dismissed the lawsuit. It noted that state law provides immunity for persons who use defibrillators unless their actions constitute gross negligence or willful misconduct. State law defines gross negligence as conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results. The court concluded that “a jury could not conclude that the alleged negligence of failing to conduct daily tests of the equipment was so reckless as to demonstrate a substantial lack of concern for whether an injury results where the machine was subject to some degree of inspection and had never malfunctioned in the past.” *Young v. Houghton Lake Ambulance Service*, 2002 WL 31928476 (Mich. App. 2002).

State immunity laws

Every state has enacted a law that provides limited immunity from liability for the use of an AED. Most of these laws protect persons who have received training in the use of an AED, even if they have no formal medical training.

The federal Cardiac Arrest Survival Act

Congress enacted the federal Cardiac Arrest Survival Act in 2000 that provides limited immunity from liability for the use of a defibrillator. This “Good Samaritan” provision specifies that “any person who uses or attempts to use an automated external defibrillator device on a victim of a perceived medical emergency is immune from civil liability for any harm resulting from the use or attempted use of such device.”

The Act defines a defibrillator as a device that is (1) distributed in accordance with FDA guidelines; (2) is capable of recognizing the presence or absence of VF, and is capable of determining, without intervention by the user of the device, whether defibrillation should be performed; (3) upon determining that defibrillation should be performed, is able to deliver an electrical shock to an individual; and (4) in the case of a defibrillator device that may be operated in either an automated or a manual mode, is set to operate in the automated mode.

The Act also provides immunity to “acquirers” of defibrillators, such as churches and other places of public accommodation, so long as any harm resulting from the use of the defibrillator was not due to a failure of the acquirer:

- to notify local emergency response personnel or other appropriate entities of the most recent placement of the device within a reasonable period of time after the device was placed;
- to properly maintain and test the device; or

- to provide appropriate training in the use of the device to an employee or agent of the acquirer when the employee or agent was the person who used the device on the victim, except that such requirement of training does not apply if
- the employee or agent was not an employee or agent who would have been reasonably expected to use the device; or
- the period of time elapsing between the engagement of the person as an employee or agent and the occurrence of the harm (or between the acquisition of the device and the occurrence of the harm, in any case in which the device was acquired after such engagement of the person) was not a reasonably sufficient period in which to provide the training.
- Immunity from liability, for either users or acquirers, does not apply if the harm resulting from the use of an AED was caused by “willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the victim who was harmed.”

The Act clarifies that “with respect to a class of persons for which this section provides immunity from civil liability, this section supersedes the law of a state only to the extent that the state has no statute or regulations that provide persons in such class with immunity for civil liability arising from the use by such persons of automated external defibrillator devices in emergency situations (within the meaning of the state law or regulation involved).”

Can our church be liable for not having a defibrillator?

Can a church be liable for the death of a church member because it did not have a defibrillator available that would have saved the victim’s life? No court has addressed this issue in a case involving the death of a person in a church service. However, a number of courts have addressed this issue in other contexts. Here is a summary of the leading cases:

No liability for not having a defibrillator

CASE STUDY 2 A 64-year-old man (“Terry”) with a history of heart problems (including a prior heart attack and bypass surgery) suffered a stroke while playing tennis at a tennis club. Within a minute of his collapse, two tennis club members administered CPR and called for an ambulance. Approximately ten minutes later, emergency medical technicians arrived and administered a series of defibrillation shocks and transported Terry to a hospital. Although he survived the incident, Terry sustained severe and permanent injuries, and is no longer able to think or concentrate

and requires assistance in virtually every aspect of his life. Terry and his wife sued the tennis club, claiming that if it had possessed a defibrillator and used it promptly, Terry's injuries would have been significantly less. The Pennsylvania Supreme Court concluded that the tennis club had no legal duty to purchase and install a defibrillator, and therefore it was not liable for not having one. It rejected the argument that a state law providing immunity from liability for untrained persons who use a defibrillator in an emergency imposed a duty on the tennis club to obtain one. The court concluded, "The existence of a civil immunity provision for Good Samaritans who use a defibrillator in an emergency situation cannot impose a duty on a business establishment to acquire, maintain, and use such a device on its premises." *Atcovitz v. Gulph Mills Tennis Club, Inc.*, 812 A.2d 1218 (Pa. 2002).

CASE STUDY 3 A 47-year-old man was playing in a tournament at a racquetball club. He was an experienced racquetball player, regularly playing two to three times a week. During the tournament, the man collapsed. CPR was immediately performed by a bystander and a doctor who was participating in the tournament. Emergency medical services were called and the victim was taken to a local hospital. All attempts to revive him were unsuccessful. The cause of his tragic death was determined to be cardiac arrest, as a consequence of atherosclerotic heart disease. The victim's estate sued the racquetball club, alleging that its negligence in failing to have a defibrillator on its premises caused the victim's death. A New York appeals court dismissed the lawsuit. It concluded, "It is well-settled law that voluntary participants in sporting events assume the risk of injuries normally associated with the sport. A participant in a sporting event can be held to have consented to those injury-causing events which are known, apparent or reasonably foreseeable consequences of participation Moreover, relieving an owner or operator of a sporting facility from liability for the inherent risk of engaging in sports is justified when the consenting participant is aware of the risk, has appreciation of the nature of the risks and voluntarily assumes the risk. Furthermore, where the injured party had previously participated in the sports activity on numerous occasions it is not unreasonable to conclude that he or she assumed the obvious risk of injury in participating in that activity. Decedent was an experienced amateur racquetball player who was known to play two to three games a week, with each game lasting approximately 45 minutes. Further, decedent had participated in tournaments such as the one in question, and indeed was aware of the physical strain the games placed upon him. Clearly, the risk of cardiac failure is inherent when participating in a sport of such intensity and given decedent's experience and background, we conclude that decedent assumed this risk. A reasonable person of decedent's age and experience must be expected to know that there is an apparent and foreseeable risk of cardiac arrest while participating in the strenuous sport of racquetball. Moreover, it is uncontroverted that the entire staff at the club was trained in CPR, that emergency 911

was called shortly after decedent collapsed and that a rescue squad arrived at the facility within five minutes. Plaintiffs' contention that the club was negligent in failing to have a defibrillator present during the tournament for immediate use lacks merit. Under the circumstances the decedent, as a matter of law, assumed the risks associated with playing racquetball and the club performed its respective duties in a reasonable manner." *Rutnik v. Colonie Center Court Club, Inc.*, 672 N.Y.S.2d 451 (N.Y. Sup. Ct. 1998).

Potential liability for not having a defibrillator

CASE STUDY 4 A 28-year-old man and his wife were on a Frontier Airlines flight from Boston to San Francisco for a vacation. The man was an NCAA record holder in swimming. During the flight, the man suffered a cardiac rhythm disturbance that resulted in cardiac arrest. His wife immediately alerted a flight attendant who requested the assistance of any qualified medical personnel on board, and a physician and an emergency medical technician, who were passengers on the flight, promptly attended to the man. The physician requested a defibrillator, but the plane's emergency medical kit did not contain one. Despite the extraordinary efforts of the physician and emergency medical technician, the man died. The widow sued the airline, claiming that it was on notice of the wide use and effectiveness of defibrillators for in-flight cardiac arrests. A federal court in Massachusetts ruled that the widow could sue the airline for negligence, and that her lawsuit was not preempted by the federal Airline Deregulation Act. *Stone v. Frontier Airlines, Inc.*, 2002 WL 32077859 (D. Mass. 2002).

CASE STUDY 5 A 55-year-old man ("Charles") was attending a "charity ball" at a convention center owned by a university in Louisiana, when he collapsed while seated at a table. At 2:05 a.m., a nurse employed by the university received an emergency call of a "man down." She arrived at the scene two minutes later, and called an ambulance. Charles died while en route to the hospital. His widow sued the university, claiming that the nurse had been negligent in failing to have a defibrillator with her when she responded to the emergency. The widow noted that the nurse had been specially trained in Advanced Cardiac Life Support (ACLS), and had a defibrillator available but failed to bring it with her. A trial court concluded that the nurse had been negligent in failing to bring a defibrillator with her in responding to the emergency call, and awarded damages of \$800,000 against the university. A Louisiana state appeals court affirmed the jury verdict against the university. It noted that the nurse had only brought a wheelchair with her in responding to the call, rather than a defibrillator that was in her office, and that the wheelchair was useless in assisting a person suffering from cardiac arrest. The court observed, "It does not take a medical expert to understand that it is difficult to envision a situation wherein a wheelchair would be of immediate value

in a true emergency, but that it would be easy to envision an emergency wherein the defibrillator could be of value. Even a layman would consider a cardiac event as one of the likely causes when someone collapses under circumstances such as existed in the instant case. In other words, common sense would tell one that 'man down' could mean a cardiac event. Common sense would also tell one that if 'man down' turned out to be a true emergency, which any responder would know is a reasonable possibility, that the defibrillator could be of immediate value whereas the wheelchair would not. For example, if it turned out that the decedent had had a stroke or swallowed something that blocked his windpipe, other likely possibilities in a party setting, the wheelchair could serve no crisis value." The court based its conclusion in part on the testimony of a cardiologist at the trial who stated that "the movement in this country and elsewhere to have defibrillators in most public places is because the best chance that anyone can have to survive a sudden cardiac arrest is if that person is defibrillated promptly." *Madison v. Ernest N. Morial Convention Center*, 834 So.2d 578 (La. App. 2002).

CASE STUDY 6 A man suffered a cardiac arrest and died while traveling from Boston to San Francisco aboard a United Airlines flight. The victim's wife sued the airline, claiming that it was responsible for her husband's death because it failed to equip its aircraft with defibrillators. She claimed that her husband would have survived if the in-flight emergency medical kit had contained such equipment. A federal court in Massachusetts ruled that the widow could pursue a negligence claim against the airline, and that her claim was not precluded by the federal Airline Deregulation Act. *Somes v. United Airlines, Inc.*, 33 F.Supp.2d 78 (D. Mass. 1999).

CASE STUDY 7 A husband and wife were passengers on a 4-hour TWA flight from Seattle to St. Louis. The husband was a chain smoker with a long history of breathing difficulties. Shortly after the plane left Seattle, the husband reported to a flight attendant that he was having difficulty breathing. The flight attendant retrieved a portable bottle of oxygen and placed an oxygen mask over the husband's face. When the husband's condition deteriorated, the flight attendant asked if there was a doctor on board. A neurosurgeon responded, and after a cursory examination, he determined that the husband would be fine and so there was no need to divert the plane. Several minutes later, the doctor again examined the husband, and seeing a further decline in his condition, started CPR. The doctor continued CPR until the plane landed in St. Louis 45 minutes later. The husband was pronounced dead by paramedics who were waiting for the plane at the St. Louis airport. The victim's wife sued the airline, claiming that it was negligent in not having a defibrillator on board which would have saved her husband's life. A federal court in Georgia rejected the airline's motion to dismiss the case, and concluded that there was a legitimate question of whether the airline was negligent in

not having a defibrillator on board. *Ferguson v. Trans World Airlines*, 135 F.Supp.2d 1304 (N.D. Ga. 2000).

CASE STUDY 8 A 20-year-old male (“Aaron”) was a member of his college’s lacrosse team. During an afternoon practice session, Aaron fell to the ground. Fellow team members and the two coaches were alarmed, especially when Aaron’s whole body began turning blue. The head coach acted in accordance with the school’s emergency plan by first assessing Aaron’s condition, then dispatching players to get a trainer and call for an ambulance. Within minutes a trainer arrived and began performing CPR until two ambulances arrived several minutes later and Aaron was defibrillated. Despite repeated resuscitation efforts, Aaron could not be revived, and he was pronounced dead. While there was some dispute as to how quickly the ambulances arrived, it was at least 10 minutes after Aaron collapsed, and perhaps as long as 25 minutes. Prior to his collapse, Aaron had no medical history of heart problems. He had been examined by a college physician before he was allowed to join the lacrosse team, who found him to be in excellent health. An autopsy later disclosed that Aaron died of cardiac arrest after a fatal attack of cardiac arrhythmia. Aaron’s parents sued the college, claiming its failure to have a defibrillator available caused their son’s death. A federal district court in Pennsylvania dismissed the case, but a federal appeals court ruled that the college could be liable on the basis of negligence for failing to have adequate medical equipment readily available and it sent the case to the district court for trial. *Kleinknecht v. Gettysburg College*, 989 F.2d 1360 (3d Cir. 1992).

Can our church be liable for defibrillating a person without his or her consent?

One court has addressed this question, as noted in the following summary:

CASE STUDY 9 While being treated for cardiac arrest at a hospital, a man was resuscitated with a defibrillator. The man lived and later sued the hospital for damages he allegedly incurred as a result of being alive. These damages included battery, “great pain, suffering, emotional distress and disability” as well as medical and other financial expenses associated with a paralyzing stroke that he later suffered. An Ohio appeals court concluded that the victim signed a document at the hospital refusing treatment in any “code blue” situation. When he suffered cardiac arrest at the hospital, this could be construed as a code blue situation, and as a result the hospital did not have the victim’s consent to resuscitate him with the defibrillator. Performing medical treatment without consent constitutes a battery for which damages may be awarded. But, could monetary damages be awarded for saving a person’s life? The victim claimed that his life was prolonged by the defibrillation, but that life “was, for him, not worth living.” He therefore sought damages for “wrongful living.” The court ruled that life itself is “not a

compensable harm; therefore, there is no cause of action for wrongful living.” Anderson v. St. Francis-St. George Hospital, 614 N.E.2d 841 (Ohio App. 1992).

Factors to consider in deciding whether or not to purchase a defibrillator

Church leaders should consider several factors in deciding whether or not to purchase a defibrillator:

- size of congregation
- frequency of use of premises
- use of premises for strenuous activities (fitness classes, work days, and so on)
- presence of medical professionals (physicians, nurses, paramedics) in the congregation
- distance to nearest hospital or paramedics facility
- response time for 911 calls
- willingness of members to receive training in operating a defibrillator
- cost
- compliance with legal requirements mandated by state law (these may include the placement of defibrillators, maintenance, physician oversight, and reporting all uses)
- value of human life
- state and federal limitations on liability of church members who use a defibrillator
- the use of defibrillators by other places of public accommodation
- Legal restrictions on the use of AEDs

Federal law

AEDs are prescription devices and must be labeled with a prescription statement required by law. A physician who oversees a defibrillation program at a facility must write a prescription for the device in order for the facility to purchase it.

State law

Check your state law regarding the purchase and use of a defibrillator, since laws in all 50 states impose various restrictions on the use of these devices. Many states have laws that contain some or all of the following restrictions:

- only persons who have received training in CPR and defibrillator use through a course approved by the Red Cross or some other designated agency are permitted to use a defibrillator
- defibrillators must be maintained and tested according to the manufacturer's operational guidelines, and written records must be maintained that document this maintenance and testing
- a licensed physician oversees defibrillator training, placement, and maintenance
- there are written plans in place concerning:
 - placement of defibrillators
 - training of personnel
 - preplanned coordination with the emergency medical services system
 - medical oversight
 - defibrillator maintenance
 - identification of those authorized to use defibrillators
 - reporting of defibrillator use to a designated state agency
 - utilization, which has been reviewed and approved by a licensed physician
 - any person who renders emergency care or treatment to a person in cardiac arrest by using a defibrillator must call 911 as soon as possible and report any clinical use of the defibrillator to the licensed physician who oversees the program
 - any entity acquiring a defibrillator shall notify an agent of the applicable emergency communications or vehicle dispatch center of the existence, location, and type of defibrillator

Caution: If your church decides to obtain a defibrillator, you cannot just go out and buy one. Not only are there strict legal regulations that apply to the acquisition and use of defibrillators, but just as importantly, the limited immunity from legal liability that state laws extend to owners and users of defibrillators only applies if these legal requirements are satisfied. Using a defibrillator without strictly complying with applicable laws exposes a church, as well as persons who use the defibrillator, to significant legal risk.

Additional considerations in the use of a defibrillator

Placement State laws may specify the placement of defibrillators in any place of public accommodation, including a church. If state law does not prescribe the placement of defibrillators in places of public accommodation, then consult with local public health officials. They will be more than willing to assist you. A good rule to follow is the "3-minute response time" adopted by the AHA. This rule recommends that a

defibrillator in the hands of a trained user will be available within 3 minutes. This is a good benchmark for judging the number of defibrillators, and their location, in any place of public accommodation. In larger churches, more than one defibrillator may be needed to satisfy this rule.

Response procedures State law may specify how to respond to a suspected case of cardiac arrest and the use of a defibrillator. If not, consult with public health officials.

Here are some response procedures that should be considered:

- Have several persons in your church take CPR and defibrillator training. Each of these persons should carry a cell phone whenever they are on church premises.
- A defibrillator should be stored in a locked box. Trained users should have a key to the box, and should bring their key whenever they are on church premises. Here are key points to keep in mind:
 - Locked boxes are preferable to unlocked, due to the risk of theft.
 - Locked boxes means that trained users with keys must be available for the AED to be accessible.
 - The main risk is during worship services due to the number of people. There should be at least one trained AED user present with a key.
 - For smaller, midweek groups, there may be no trained AED users present. That's fine. Churches are not required to have a user with a key present 24/7.
 - Trained users should be instructed in the optimal response to a suspected case of cardiac arrest. One approach is to have two trained users retrieve the defibrillator and assess the victim, while another trained user immediately calls 911 on his or her cell phone and waits at the entrance to the church to escort emergency personnel directly to the victim.
- Security

Consider the following illustration: A 45-year-old man collapses during a worship service. The church has acquired an AED that is hanging on the back wall of the sanctuary. Four members of the church have received CPR and defibrillator training, and two of them immediately retrieve the defibrillator and activate it. To their horror, they discover that the batteries have been removed from the device. Someone calls 911, but an ambulance does not arrive for 15 minutes. The victim is pronounced dead on arrival at a local hospital. It is later discovered that two adolescent boys removed the batteries a few weeks before as a "practical joke."

Such a scenario could happen in any church. As a result, it is absolutely essential to store a defibrillator in a locked box, with every trained defibrillator user having a key.

First responders

A defibrillator is useless without a trained user, especially if only trained users have keys to access the defibrillator. The presence of a trained user is not something that should be left to chance. One response is to have a “first responder” designated for every church service or function. The first responder is responsible for being at the service or function, and making sure that at least one additional trained user will be present along with a third person (ideally, a third trained user) who will be responsible for calling 911 and meeting the paramedics at the church entrance and directing them to the victim.

Maintenance Several state laws prescribe maintenance procedures that must be followed. These usually include periodic system and battery checks. It is imperative that these requirements be strictly met, since noncompliance can subject a church to liability for deaths caused by a malfunctioning device that was not properly maintained.

Extra batteries Be sure to keep an extra battery in your locked defibrillator case. Also, only purchase a defibrillator in which the battery can be “hot swapped.” That is, if the battery dies while the defibrillator is being used, you can switch batteries without losing power. Your extra battery should be tested for capacity, and replaced periodically.

Warranty card Fill out and send in the warranty card that comes with your defibrillator. This will allow you to be contacted in the event of a product recall.

Useful life Do not exceed the useful life of your defibrillator. Future advances in technology will make defibrillators even more effective, compact, and inexpensive.

After using a defibrillator State laws often require a report to be made to the overseeing physician or a state agency whenever a defibrillator is used. In addition, the AHA recommends that after a defibrillator is used, you should (1) return the AED to a state of readiness; (2) replace the pads, pocket mask, and other peripheral supplies that were used; (3) transmit data to the physician; and (4) review the case with the overseeing physician and emergency medical personnel who responded to the incident.

Training

Some have asked, “If defibrillators are so easy to use, why do people have to be trained to use them?” The AHA responds to this question as follows: “A defibrillator operator must know how to recognize the signs of a sudden cardiac arrest, when to call 911, and how to perform CPR. It’s also important to receive formal training on the defibrillator that will be used. That way, the user becomes comfortable with the device and can successfully operate it in an emergency. Training also teaches the user how to avoid potentially hazardous situations.”

Key point. AHA has developed a “Heartsaver” defibrillator course that integrates both CPR and defibrillator training. The course is four hours long. To find out the nearest location where this course is offered, go to the AHA website at cpr-ecc.org, call the AHA customer support center at 1-800-242-8721, or check your local telephone directory for the nearest AHA office.

Conclusion

The AHA has noted that “as awareness of the new generation of defibrillators grows, companies and organizations may face greater threat of liability if they aren’t properly prepared to respond in a timely manner to a cardiac emergency. This trend can be seen in [recent] cases in which lawsuits were filed against companies that weren’t prepared.”

The risk of liability is a powerful motivation for acquiring a defibrillator. But church leaders should be guided by a higher and even more compelling motivation: the protection and preservation of those whom the Bible declares are made in the image of God.

Selecting a Defibrillator There are several models on the market, and choosing the right one for your church can be a bewildering task. If you have a physician or nurse in your congregation, he or she will be able to assist you. The bottom line is that you want reliability and ease of use. Here are some features you should consider in any unit:

- opening the lid readies it for use (no time is wasted looking for the “on” switch)
- portability
- clear and concise voice prompts that guide users through every step of the rescue process
- one-button operation eliminates rescuer confusion and uncertainty
- status of the machine is easily determined by a red or green light
- powered by an extended-life lithium battery

- a warning light and audible noise announce the battery is low
- automatic self-tests ensure that the unit can deliver full energy
- unit delivers shocks only when appropriate, based on abnormal heart rhythm
- unit can be used on persons with implanted cardioverter defibrillators (ICDs) or pacemakers
- batteries can be “hot swapped” (replaced without turning off the unit)
- illuminated control panel (easily visible in dim light)