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White Paper

LEGISLATIVE STRATEGIES FOR MODERNIZING U.S. AED LAWS

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Readiness Systems is the nationally recognized authority on AED program operations, risk management, law, and public policy. Readiness Systems offers a wide array of services to help communities and organizations ensure AED program operational readiness and manage risk. Readiness Systems proprietary SCA Readiness System™ is the most comprehensive and structured AED program development process and operating model and is the only system that follows national SCA Readiness System Guidelines™.

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The Challenge of Sudden Cardiac Arrest

- Sudden cardiac arrest (SCA) strikes approximately 380,000 victims per year in the U.S. (the equivalent of three full jumbo jets per day). More than 90 percent of SCA victims die, even though the condition is treatable with rapid defibrillation.
- Automated external defibrillators (AEDs), which treat SCA by delivering an electric pulse (shock) to the heart, are easy-to-use medical devices that, if widely deployed and rapidly used by bystanders, can save thousands of lives per year.

Current AED Public Policy Impedes Widespread AED Deployment

- Most current AED laws do not protect every AED program participant and all AED program activities that should be protected.
- Current AED laws vary in all 50 states creating a complex quagmire of often conflicting AED program "standards" that serve as a barrier to widespread AED deployment. These laws make it nearly impossible for AED owners or would-be owners and willing bystanders to know whether they have Good Samaritan immunity protection, thus creating a risk they may not buy AEDs or retrieve and use publicly placed AEDs when called upon to do so.
- Contrary to their intended goal, most current AED laws actually increase rather than decrease liability risks facing AED programs.

Modernizing AED Good Samaritan Immunity

- Modernizing AED Good Samaritan immunity laws requires simplification, removal of AED program operational requirements, and offering meaningful coverage to all AED program participants without condition.
- Modernizing AED Good Samaritan laws will reduce liability barriers and encourage more individuals and organizations to more rapidly deploy AEDs.

AED Deployment Mandates

- Legislative AED deployment mandates represent the primary tool policymakers have to directly control the number and location of AEDs placed in non-medical settings.
- Targeted AED deployment mandates, such as those requiring AEDs in schools and health clubs, necessarily offer a very limited overall public health benefit because they result in only a small,

incremental increase in the number of AEDs deployed within a community, cover only a very limited response area, and impact a very small percent of a community's population.

- General mandates, such as those that might require AEDs at all locations with 100 or more persons on site per day, have the potential to significantly increase a community's sudden cardiac arrest survival rates by more rapidly adding a large number of AEDs over a wide area and thus covering a much larger population base.
- Because sudden cardiac arrest is the leading cause of adult death in the U.S., and it is treatable with rapid defibrillation, the subject of general AED mandates is worthy of serious public policy consideration.

It's About the AED Program, Not the AED Laws

- Viewed in context, AED laws are overemphasized in importance and have little to do with whether SCA victims are given a chance of survival at AED program sites. Rather, the people and organizations who buy AEDs, place them in non-medical settings, operate AED programs on a day-to-day basis, and do their best to help save the lives of sudden cardiac arrest victims are the things that matter. Organizations that focus their energies on designing custom-tailored AED programs and achieving AED program operational excellence will never have to worry about the laws or the lawyers.

THE CHALLENGE OF SUDDEN CARDIAC ARREST

Sudden cardiac arrest (SCA), the leading cause of adult death in the U.S., is a vexing public health problem. Over 380,000 people experience SCA each year in the U.S. and over 90 percent – approximately 350,000 – will not survive. SCA impacts people of all ages, including many outwardly healthy individuals with no known heart conditions. Predicting who, when, and where SCA will strike is virtually impossible.

While it is well known that rapid CPR and AED use can significantly increase an SCA victim's chances of surviving, only 32 percent receive bystander CPR and less than 4 percent are treated with a bystander-used AED before emergency medical services (EMS) personnel arrive. Time is the single most critical factor impacting a sudden cardiac arrest victim's chances of surviving. Generally, the sooner defibrillation occurs the more likely an SCA victim will survive. After just 10 minutes, the chances of survival are nearly zero.

PURPOSE AND BENEFITS OF AUTOMATED EXTERNAL DEFIBRILLATORS

An automated external defibrillator (AED) is a medical device designed to quickly, safely, and effectively deliver a defibrillation shock to SCA victims. AEDs are easy to use because they offer voice, text, and graphics prompts – even minimally trained or untrained individuals are able to use AEDs to save lives.

To address the public health threat of SCA, many interested groups and organizations actively promote the widespread placement of AEDs in non-medical settings for use by people with minimal or no medical training. As a result, AEDs are now found in many public settings. Examples include airports, shopping malls, schools, health clubs, sports arenas, manufacturing facilities, office buildings, and more. An estimated 1.5 - 2 million AEDs are now located in U.S. public settings. While this number is expected to continue to grow, it is still well below the number needed to have a significant impact on overall SCA survival rates. Depending upon how they craft AED laws, policymakers can encourage or discourage people and organizations from buying and placing more AEDs in non-medical settings.

CURRENT AED PUBLIC POLICY – A COUNTERPRODUCTIVE APPROACH

Generally, Good Samaritan immunity laws are enacted by policymakers to encourage particular types of conduct. For example, the first Good Samaritan law, enacted in California during the 1950s, offered immunity to physicians who voluntarily stopped to render aid to accident victims. The goal of this approach was to encourage physicians to act by reducing the risk of negligence lawsuits.

Similarly, starting in the mid-1990s, legislatures throughout the U.S. began enacting AED-related laws, including Good Samaritan immunity laws, presumably with the intent that such laws would reduce liability risks and therefore encourage more organizations and individuals to buy, place, and use AEDs in public settings. Such laws now exist in every state and vary widely in structure, content, complexity, and scope of coverage.

Unfortunately, for reasons discussed below, many existing AED laws actually increase rather than decrease liability risks facing AED owners and users and act as a barrier to those organizations considering the purchase of AEDs. Further, these laws are misunderstood by many in the AED community. Indeed, persistent myths and misinformation about the true scope and presumed benefits of these laws can be found on the websites of many AED, AED program services, and AED training vendors.

What to Look for in AED Laws

To understand the true nature and limitations of the existing AED public policy framework, one must first know what to look for in AED laws. There are a number of attributes generally included in AED laws that describe the scope of each law's requirements and what, if any, Good Samaritan immunity protection may be available in a particular state. These attributes are described below.

People Who May Qualify for Immunity Protection

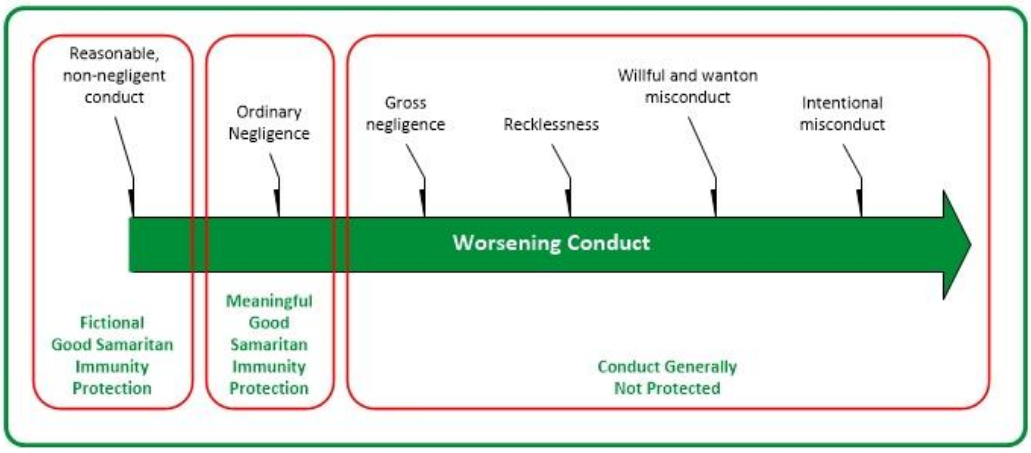
AED program constituents who may be covered by an AED law include (various laws may use differing words to describe these constituents):

- People who own AEDs or are responsible for AED program sites
- AED users, which may include trained and/or untrained users
- AED trainers
- AED program medical directors

Not every law covers every constituent.

Degree of Misconduct That May Qualify for Immunity Protection

The degree of misconduct found in the world of negligence law can be characterized along a continuum ranging from non-negligent conduct to intentional misconduct. This continuum is shown in the following chart (different states sometimes use different words but the concept is the same):



By definition, Good Samaritan laws make it more difficult to sue those involved with AED programs by protecting certain levels of misconduct from liability. The level of protection varies widely from state to state. Meaningful immunity laws typically protect misconduct rising at least to the level of ordinary negligence. For example, a law may protect all but "acts of gross negligence or willful or wanton misconduct." Laws that protect negligent misconduct (or worse) offer a layer of risk management protection if all other attributes of the law are met.

> An example of ordinary negligence might be a bystander's failure to use an AED because an SCA victim is wrongly perceived to have a pulse. An example of gross negligence might be the removal of an AED battery because a person nearby is bothered by the device's audible alerts signaling the battery is in need of replacement.

In contrast, some states offer only "fictional" immunity that applies only to those who act "as an ordinary, reasonably prudent person would have acted under the same or similar circumstances." Thus, only reasonable – or non-negligent – conduct is protected in these states. Levels of

misconduct, including ordinary negligence and beyond, are not protected at all. These types of laws create the perception that immunity protection is available, though in reality it is not.

The statutory language in a number of states is unclear creating uncertainty about the degree of misconduct that may qualify for immunity protection. In these states, it will take lawyers, juries, and judges to decide the scope of immunity coverage only after a lawsuit ensues.

AED Program Activities That May Qualify for Immunity Protection

Many activities take place within an AED program long before an AED is ever retrieved for use in an actual SCA emergency. Examples include deciding how many AEDs to buy, putting AEDs in various placement locations, maintaining equipment, training, developing policies, and many more. Some of these activities will influence or impact how an organization responds during SCA events. Yet, most state AED laws appear to cover only actions associated with the use of an AED. Other AED program activities that relate to preparing for and responding to an SCA event do not appear to be covered.

Operational Requirements Specified in AED Laws

Most state AED laws impose operational requirements on AED programs and their constituents. Types of requirements may include:

- Maintenance
- Agency notification
- Training
- Medical direction

Some states require compliance with these operational requirements as a condition of immunity and some do not.

Gaps in Existing AED Law Coverage

Public policy goals associated with existing AED laws are not well-articulated in the statutes themselves or in the current literature surrounding AED public policy. Ostensibly, these laws were originally intended to reduce legal liability risks facing organizations deploying, and bystanders using, AEDs in non-medical settings. It is also widely perceived, and often mischaracterized in online and published materials, that the existing universe of AED laws offers broad liability protection to all AED program participants for all AED program activities. In stark

contrast to these widespread perceptions, most current AED laws **do not** protect the full scope of people and AED program activities that should be protected.

Consider the following selected highlights (because some states apply different attributes to various AED program constituents, the total number of states in some categories add up to more than 51):

- **15 states (29%) do not offer immunity protection to AED trainers or AED program medical directors and 5 states (10%) do not protect AED owners or those responsible for AED program sites:** All states appear to offer immunity protection to AED users, though 2 states cover only trained AED users (assuming other requirements of the laws are met).
- **43 states (84%) limit immunity protection only to AED use-related activities – other AED program design and operational activities are not protected:** Strikingly, 43 states appear to protect only AED use-related activities (the statutes in 2 other states are unclear on this issue). This means only the actions of AED responders occurring at the time of an SCA event get immunity protection (and by extension, their employers). AED program decisions and actions taken in advance of an SCA event are not protected. For example, decisions and actions regarding how many AEDs to buy, where to place them, who can use them, who is told about them, how people are trained, and others, are not protected. Only 16 states (32%) protect a broad range of AED program activities.
- **6 states (12%) offer only "fictional" immunity protection to one or more AED program constituents and the laws in 9 other states (18%) are unclear – meaning no immunity protection is or may be available at all:** For some AED program constituents, 6 states do not protect at least ordinary negligence and thus offer no meaningful immunity protection at all. The statutory language in another 9 states is unclear on this issue. Forty-one states (90%) do protect at least ordinary negligence for some AED program constituents.
- **22 states (43%) states offer immunity protection only if statutory operational requirements contained in AED laws are met**, regardless of whether meeting or not meeting these operational requirements has anything to do with an SCA response or outcome.

- **When considering all AED law attributes, only 4 states (8%) offer meaningful Good Samaritan immunity protection because they:**
    - Cover all AED program constituents;
    - Cover a broad scope of operational activities;
    - Provide protection for at least ordinary negligence; and
    - Do not condition immunity protection upon compliance with any statutory operational conditions.

  [Data as of March 2013]

While well intentioned, current AED laws are not well crafted. As a result, significant gaps now exist in the scope of AED Good Samaritan coverage across the U.S.

Current AED Laws Increase Rather Than Decrease Liability Risk

Contrary to their perceived purpose, many existing AED laws generally increase rather than decrease liability risks for AED programs and their constituents. This is because the laws pursue two distinct AED program objectives, only one of which is appropriately addressed through legislation. The first objective, clearly within the province of legislatures, is to offer qualified immunity protection to certain AED program constituents with the goal of encouraging widespread AED deployment. The second objective is to incorporate AED program design and operational requirements, some as conditions of immunity. Unfortunately, including this second objective increases liability risks facing organizations with AEDs and is an ill-suited method for creating effective AED programs.

Regarding the first legislative objective (immunity), it is widely perceived, and often mischaracterized online and in published materials, that the existing universe of AED Good Samaritan laws offers broad liability protection to all AED program participants for all activities. In stark contrast to these widespread misperceptions, many current AED Good Samaritan laws do not protect everyone involved in AED programs nor, with some exceptions, do they protect AED program activities beyond AED emergency use.

Regarding the second legislative objective (operational requirements), many existing AED laws incorporate numerous AED program design and operational requirements, some as conditions of

immunity. Examples include maintenance, agency notification, training, medical oversight, and others. While these are important AED program components, they represent only a subset of all factors to be considered in designing and operating an effective AED program (see, for example, *SCA Readiness System Guidelines™: A Framework for the Placement, Retrieval, and Use of AEDs in Non-Medical Settings* available at www.readisys.com). Further, states impose a widely varying mix of AED program operational requirements reflecting differing internally and externally influenced priorities. Finally, some states impose operational requirements that are virtually impossible to comply with.

Factors defining what constitutes a "reasonable" AED program are still emerging and AED program standards of care will be quite fluid for years to come. Notwithstanding significant complexities associated with AED program design and operations, requirements embedded within AED laws impose mandatory "standards" and operational burdens on every AED program site regardless of size, scope, or unique characteristics. This unusual mix of often conflicting laws, and the unrealistic one-size-fits-all approach, creates significant risk that AED immunity law requirements will be viewed as establishing a "standard of care" resulting in increased rather than decreased liability exposure for organizations with AEDs.

Put another way, the inherent and realized risk of the current approach is that immunity protection will be lost because an organization is unable to understand what constitutes compliance, and thus fails to fully act in accordance with an AED law's terms. An organization might also lose immunity protection by failing to comply with stated operational requirements having no impact on an SCA incident or outcome. These risks are now materializing in AED-related litigation.

Efforts by policymakers (and those influencing them) to use AED laws as a tool to design AED programs has led to significantly increased confusion and legal liability risk. Current laws vary in all 50 states, meaning in effect that program design and operational standards vary in all 50 states. This AED law quagmire often makes it difficult for organizations potentially interested in deploying AEDs to implement AED programs since the implementation process frequently leads to increased confusion, burdens, and risk. The current state of U.S. AED laws also creates a situation in which it is nearly impossible for AED owners and willing bystanders to know whether they have Good Samaritan immunity protection, and thus they might not buy AEDs, or retrieve and use publicly placed AEDs when called upon to do so.

MODERN APPROACH TO AED GOOD SAMARITAN IMMUNITY

The primary public policy goal of AED Good Samaritan immunity laws should be to simply and meaningfully offer qualified liability protection to all AED program constituents with the objective of encouraging more organizations to buy, and more people to feel comfortable using, AEDs. AED program operational requirements should be addressed outside of the legislative arena. This is similar to the approach used for cardiopulmonary resuscitation (CPR). Occupational Health and Safety Administration (OSHA) laws requiring CPR training typically do not incorporate CPR training requirements directly into, or as conditions to, general Good Samaritan immunity laws. Rather, they rely upon CPR training guidelines published by third-party organizations. AED immunity laws can better encourage widespread AED deployment and reduce liability risk by following this model.

Model AED Good Samaritan Immunity Law

The model AED Good Samaritan immunity law (Model AED Law) provided below is founded on the following principles:

- Positively influence behavior: The law must effectively reduce liability risk in order to encourage more organizations to acquire, and more people to use, AEDs.
- Be understandable: The law must be easy to read and understand.
- Provide broad coverage: The law must protect all AED program constituents.
- Provide meaningful liability protection: The law must meaningfully protect all but grossly negligent or willful or wanton misconduct.
- Eliminate burdensome and complex immunity conditions: The law must not include AED program design or operational requirements, and should certainly not condition immunity upon compliance with any such requirements.
- Achieve uniformity: When widely adopted, the law must make AED Good Samaritan immunity standards uniform throughout the U.S.

Model AED Good Samaritan Immunity Law

(AED Good Samaritan Immunity Modernization Act)

An act to repeal [insert statutory references] and enact new provisions relating to AED Good Samaritan immunity.

Section 1. [Insert statutory references] are hereby repealed and replaced with the following:

Section 2. The following persons and entities are immune from civil liability for damages arising out of acts or omissions that relate to preparing for and responding to suspected sudden cardiac arrest emergencies absent gross negligence or willful or wanton misconduct:

(a) Any person or entity that acquires an automated external defibrillator;

(b) Any person or entity that owns, manages, or is otherwise responsible for the premises on which an automated external defibrillator is located;

(c) Any person who retrieves an automated external defibrillator in response to a perceived sudden cardiac arrest emergency;

(d) Any person who uses, attempts to use, or fails to use an automated external defibrillator in response to a perceived sudden cardiac arrest emergency;

(e) Any physician or other authorized person who issues a prescription for the purchase of an automated external defibrillator;

(f) Any person or entity that is involved with the design, management, or operation of an AED program; and

(g) Any person or entity that provides instruction in the use of an automated external defibrillator.

Selected Model AED Law Commentary

The following commentary highlights the goals and objectives of this modern legislative approach. It also reviews selected operational requirements commonly found in existing AED laws and the reasons these requirements are omitted from the Model AED Law. Only the most prevalent operational requirements are discussed, though others exist.

Understandability: The Model AED Law is purposefully crafted to be easy to read and easy to understand. This approach will help organizations with, or considering the purchase of, AEDs to clearly recognize the benefits and scope of available immunity coverage hopefully leading to more rapid and widespread deployment of AEDs.

Scope of coverage: The Model AED Law offers immunity protection to each person and entity involved with AED programs and for all activities.

Scope of liability protection: The Model AED Law offers immunity protection for all but grossly negligent or willful or wanton misconduct.

Training: The Model AED Law omits any reference to training as an operational requirement or as a condition of AED Good Samaritan immunity. For the following reasons, there is no longer a supportable public policy rationale for including training requirements in AED laws:

- The ease-of-use characteristics of modern AEDs: AEDs are now widely recognized as very easy to use. Even untrained 6th graders guided by voice, text, and graphics prompts were shown to be able to use AEDs nearly as rapidly as trained paramedics. In effect, AEDs offer real-time training to users.
- The successful use of AEDs by untrained bystanders: A published Chicago O'Hare Airport study documented that over 60 percent of AED users who successfully saved SCA victims were untrained. Since that study was published, many other examples of the successful use of AEDs by untrained bystanders have been documented.
- The critical need to encourage rapid AED use: Because SCA is 100 percent fatal unless quickly treated, every willing rescuer should be empowered and encouraged to respond to SCA emergencies, regardless of formal training

status. AEDs can only help SCA victims. AEDs cannot harm a victim since safety features incorporated into the devices allow the delivery of a defibrillation shock only when medically warranted.

While the Model AED Law does not include a training requirement, individuals and organizations may still independently choose to obtain formal AED training and may be encouraged to do so.

Emergency 911 notification: Many states require that "AED users must activate the EMS system as soon as possible," though most such laws don't specify as soon as possible from when. In some laws, the failure of the AED user to call 911 may lead to the loss of immunity protection. The Model AED Law omits this requirement. This is because bystanders volunteering to help SCA victims may or may not immediately call 911 when faced with an actual emergency. Indeed, they may be focused exclusively on helping the victim. While someone calling 911 is important, those willing to help SCA victims should not be at risk for the loss of Good Samaritan immunity protection based on a technical failure to comply with this superfluous administrative requirement.

Administrative AED placement notification: Many states require that AED owners report the presence and location of AEDs to a state or local agency, sometimes as a condition of immunity. The Model AED Law omits this requirement. This is because almost no agencies use this information for any purpose whatsoever. For example, less than a handful of the approximately 6,000 911 dispatch agencies in the U.S. enter AED location information into computerized dispatch systems. Thus, despite the widespread notification requirement, an estimated less than 1 percent of 911 dispatchers have the ability to tell callers where nearby AEDs are located. AED laws containing these requirements therefore create a burden without a benefit and can result in the loss of immunity protection. In one striking example, a court in a recent case ruled that American Airlines lost AED Good Samaritan immunity protection because it failed to comply with an Illinois requirement that AED owners notify a local hospital and 911 dispatch agency of AEDs **on its airplanes** that sometimes visit Chicago O'Hare Airport. This ruling occurred despite the fact the failure to notify had no bearing on the response to or outcome of the SCA event.

AED PLACEMENT MANDATES – AN OVERVIEW

This AED placement mandate overview is provided as general information for policymakers. The issue of mandates can be politically challenging and often involves many competing interests and perspectives. The following discussion offers a framework for policymakers considering this type of public policy initiative.

Generally, individuals and organizations buy AEDs for the following three reasons:

- Voluntary choice: Individual choice often driven by an organizational champion based on growing awareness, a life saved, or a potentially preventable death.
- Coerced voluntary choice: Fear that the failure to have AEDs may create the risk of a negligence lawsuit based on a violation of a perceived standard of care (court imposed standard of care).
- Statutory mandate: A mandatory duty to deploy AEDs imposed by legislative policymakers (legislatively imposed standard of care).

Only legislative mandates directly control the number and location of AEDs placed in public settings. Otherwise, AED acquisition and placement is left to voluntary organizational or individual choice. Mandates have the potential to more rapidly increase the number of AEDs in a community while voluntary deployment results in a much slower, ad hoc AED adoption rate.

Legislative AED mandates can take two forms. They can be targeted at specific locations or industries (targeted mandates) or they can apply more broadly based on general site parameters or characteristics (general mandates). To date, legislative AED deployment mandates have been of the targeted variety focusing on such locations as airlines (the only federal AED mandate), schools, health clubs, large occupancy buildings, government buildings, law enforcement vehicles, and places of public assembly. Broad-spectrum general mandates (e.g., those that might require AEDs at all locations with 100 or more persons on site per day) have not yet been embraced.

Policymakers considering mandated AED deployment should recognize that targeted mandates such as those focused on health clubs or schools will necessarily result in a very limited overall

public health benefit. This is because targeted mandates result in only a small, incremental increase in the number of AEDs deployed within a community, cover only a very limited response area, and impact a very small percent of a community's population. In contrast, general mandates have the potential to significantly increase a community's sudden cardiac arrest survival rates by more rapidly adding a large number of AEDs over a wide area and thus covering a much larger population base.

Though the specific time, place, and victims of sudden cardiac arrest are impossible to forecast with any precision, the generalized risk of SCA at any particular location is based on the number of people per day visiting the location, age demographics and, to some extent, activities engaged in. When viewed from the context of SCA risk, AED mandates enacted to date run a wide gamut. The two most publicized types of AED mandates relate to health clubs (12 states) and schools (16 states). Health clubs are perceived to fall on the higher end of the risk continuum based on research suggesting those engaged in vigorous physical exercise face a statistically higher chance of experiencing SCA (though to put this risk in context, an individual health club location can expect one SCA event every 12-15 years on average). In contrast, schools are perceived to fall on the lower end of the risk continuum based on population and age demographics. Yet, due to their political appeal, both of these location types face a growing number of targeted AED mandates. To date, the vast majority of the population base remains unprotected.

It is true that general AED mandates would require that public and private entities incur significant costs associated with the purchase of large numbers of AEDs and related program expenses. However, when viewed in comparison with other areas of public safety such as fire protection, these costs appear quite reasonable in relation to the benefits obtained.

Approximately 6,000 people in the U.S. die in fires each year. Over the last few decades, public and private entities have been required to spend about $37 billion dollars on fire suppression systems to address this risk. In contrast, SCA strikes 380,000 victims per year in the U.S. representing a public health threat orders of magnitude greater than fires (6,000 SCA victims die approximately every 6 days). Sudden cardiac arrest is the leading cause of adult death in the U.S. The condition is treatable with rapid defibrillation. The cost of equipping buildings with AEDs is far less than the cost of fire suppression systems and will result in the saving of thousands more lives. From a public health and public policy perspective, general AED mandates would appear

to be reasonable. In sum, the subject of general AED mandates is worthy of serious public policy consideration.

IT'S NOT ABOUT THE LAWS

AED laws and their perceived meaning and impact are much written and talked about in and around the public access defibrillation community. It is true that the current generation of AED laws are complicated and confusing. But, to put this issue in perspective, AED laws are often overemphasized in importance and have little to do with how an organization responds to an SCA emergency and whether SCA victims are given a meaningful chance at survival. Rather, the people and organizations who buy AEDs, place them in non-medical settings, operate AED programs on a day-to-day basis, and do their best to help save the lives of sudden cardiac arrest victims are the things that matter. Organizations are typically better off focusing their energies on designing AED programs that fit their needs and striving for AED program operational excellence rather than worrying about the laws and the lawyers. In a nutshell, it's about the AED program, not the laws.

ABOUT THE AUTHOR

Richard A. Lazar is the founder and President of Readiness Systems. Richard has been at the forefront of AED program operations, risk management, legal, and public policy issues for the past 20+ years. He has served as a public speaker, AED program operations and risk management consultant, and expert witness to a variety of clients nationwide. Richard is often quoted as an expert on operational, risk management, and legal matters surrounding AEDs and has authored numerous articles appearing in a variety of publications. Richard's deep understanding of AED program operations and risk management has led him to testify before the U.S. Congress (Sudden Cardiac Arrest Survival Act), FDA (AED over the counter issues), and state legislatures (AED public policy issues and immunity laws). He has also served as a board member of the Sudden Cardiac Arrest Foundation and advisory board member of the National Center for Early Defibrillation.

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