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COUNCIL OF THE CITY OF PHILADELPHIA

3

COMMITTEE ON PUBLIC SAFETY

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Room 400, City Hall
Philadelphia, Pennsylvania
Tuesday, February 21, 2006
1:15 p.m.

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PRESENT:

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COUNCILWOMAN DONNA REED MILLER, CHAIR

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COUNCILMAN JAMES F. KENNEY

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COUNCILMAN JUAN RAMOS

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COUNCILMAN FRANK RIZZO

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RESOLUTION 051158 - Resolution authorizing
City Council's Committee on Public Safety to
conduct Public Hearings to examine ways to
increase the number of people who have been
trained in Cardio-Pulmonary Resuscitation.

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COUNCILWOMAN MILLER: Good

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afternoon to everyone. The Committee on

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Public Safety's public hearing is now in

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session.

6

Will the Clerk please read the

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title of the resolution.

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THE CLERK: Resolution 051158,

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resolution authorizing City Council's

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Committee on Public Safety to conduct

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public hearings to examine ways to

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increase the number of people who have

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been trained in Cardio-Pulmonary

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Resuscitation.

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COUNCILWOMAN MILLER: Thank

16

you. For the record, in attendance

17

today -- I don't need a quorum because

18

we're not voting anything out -- to my

19

left is Councilman Frank Rizzo and to my

20

right is Councilman Juan Ramos and

21

Councilman Jim Kenney, and I am

22

Councilwoman Donna Reed Miller, Chair of

23

the Committee.

24

Before the first witness comes

25

up, I'd like to read an opening

1 2/21/06 - PUBLIC SAFETY - RES. 051158
2 statement.

3 I was first made aware of the
4 problem of the bystander rate in
5 Philadelphia by the Fire Commissioner,
6 Lloyd Ayers. He told me that a large
7 number of people in this City are not
8 prepared. They are not prepared to
9 administer aid to a fellow citizen if
10 they need help in the event of a heart
11 attack.

12 By the time rescue crews
13 arrive, usually irreparable damage has
14 been done. If a bystander has been there
15 to give CPR to a victim of a heart
16 attack, his or her chance of survival
17 would have increased dramatically.

18 Heart attacks don't always just
19 happen on the streets. A large majority
20 of attacks occur in the home. This is
21 even more tragic. Family members may
22 know something needs to be done, but too
23 often they may not know how. This leads
24 to instructions on the telephone more
25 often than not that is not very

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2 effective. A family member is trying to
3 make a call under duress and has to have
4 the state of mind to perform a procedure
5 that they may not be familiar with.

6 This is why we are here today
7 in conjunction with the Fire Department,
8 the American Heart Association and Thomas
9 Jefferson University. We want to bring
10 this problem to the forefront. Each of
11 these organizations here are going to
12 discuss and explore the problem and offer
13 some solutions.

14 Each and every Philadelphian is
15 the first link in the chain of survival.
16 If we can increase the number of citizens
17 who are trained to react to an emergency
18 such as a heart attack, we will be
19 offering victims of heart attacks an
20 increased chance of survival.

21 Would anyone else on the
22 Committee have anything they want to say?

23 (No response.)

24 COUNCILWOMAN MILLER: Okay. We
25 have you sort of in panels. So would

1 2/21/06 - PUBLIC SAFETY - RES. 051158
2 Commissioner Lloyd Ayers and the Fire
3 Department, other persons from the Fire
4 Department, please come to the witness
5 table and identify yourself for the
6 record and proceed with your testimony.

7 Good afternoon.

8 COMMISSIONER AYERS: Good
9 afternoon, Councilwoman. I'm Lloyd
10 Ayers, Fire Commissioner for the City of
11 Philadelphia.

12 CHIEF HALPER: Ralph Halper,
13 Regional Director of Emergency Medical
14 Services.

15 CHIEF BUTTS: George Butts,
16 Director of EMS Training for the
17 Philadelphia Fire Department.

18 COUNCILWOMAN MILLER: So who is
19 going to start first? Commissioner?

20 COMMISSIONER AYERS: I'll
21 begin.

22 To the members of the
23 Committee, I'd like to say good
24 afternoon.

25 COUNCILWOMAN MILLER: Good

1 2/21/06 - PUBLIC SAFETY - RES. 051158
2 afternoon.

3 COMMISSIONER AYERS: I'm Fire
4 Commissioner Lloyd Ayers, and I am here
5 to testify, along with Chiefs Butts and
6 Halper and Captain Touchstone, on the
7 importance of Resolution 051158, which
8 addresses the need to increase the number
9 of our citizens who know and will perform
10 Cardio-Pulmonary Resuscitation, commonly
11 known as CPR, in the event of witnessing
12 a sudden cardiac arrest. Here in
13 Philadelphia too few people know what to
14 do when faced with such an emergency.

15 In order for a person to have
16 the best chance of surviving a sudden
17 cardiac arrest, someone must take
18 immediate action. The actions to take
19 are simple ones: Recognize the
20 emergency, activate the emergency
21 response system, call or have someone
22 dial 9-1-1, and start CPR. The question
23 is, who is that someone going to be?

24 The American Heart Association
25 has identified four links that comprise

1 2/21/06 - PUBLIC SAFETY - RES. 051158
2 the chain of survival: Early access to
3 emergency medical services by calling
4 9-1-1; early CPR; early defibrillation,
5 electrical shock to the heart; and early
6 advanced care. Each link in the chain is
7 dependent upon the others. Remember, the
8 chain is only as strong as its weakest
9 link.

10 The first two links in the
11 chain, early access and early CPR, rest
12 in the hands of the bystander, the
13 average citizen who witnesses a sudden
14 cardiac arrest. The bystander must act
15 before EMS arrives. The bystander is the
16 one who will help a victim of sudden
17 cardiac arrest by recognizing that there
18 is an emergency, calling 9-1-1 and
19 beginning CPR.

20 When a person suffers sudden
21 cardiac arrest, when they collapse
22 because their heart is no longer beating
23 properly, they need help as quickly as
24 possible to increase their chance of
25 survival. Without blood circulating, the

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2 victim will begin to suffer brain damage
3 in as little as four minutes, and will be
4 beyond hope of survival in as little as
5 ten minutes. Bystander CPR provides the
6 circulation needed to keep the blood
7 flowing to the brain and vital organs.
8 This, in effect, slows down the clock and
9 increases the likelihood that a victim of
10 sudden cardiac arrest will have the best
11 chance of survival when professional help
12 arrives.

13 The Fire Department will bring
14 the next link in the chain of survival,
15 early defibrillation, in about four
16 minutes. It's during those four minutes
17 that the bystander must act.

18 Through education and training,
19 by increasing the number of people here
20 in Philadelphia who know what to do when
21 faced with a family member, loved one,
22 co-worker, any citizen of Philadelphia or
23 any visitor suffers sudden cardiac
24 arrest, we can increase the chance for
25 victims to survive the event.

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2 COUNCILWOMAN MILLER: Thank
3 you. We can move on to the next witness.

4 CHIEF HALPER: Sure. Good
5 afternoon, Council President, members of
6 Council. My name is Ralph Halper and I'm
7 here to testify along with Commissioner
8 Ayers and my fellow colleagues on the
9 impact of the proposed Resolution 051158
10 encouraging citizen CPR.

11 A model of success: One model
12 of success in increasing the survival of
13 sudden cardiac arrest is in the west
14 coast city of Seattle, Washington.
15 There, 45 percent of the people who
16 suffer cardiac arrest survive. In
17 Philadelphia, five percent survive.

18 Over the past 30 years, Seattle
19 has trained 19 percent of their
20 population in CPR. In Philadelphia, four
21 percent have been trained. In Seattle,
22 bystanders start CPR 44 percent of the
23 time. In Philadelphia, bystanders start
24 CPR 10 percent of the time.

25 Studies have shown that the

1 2/21/06 - PUBLIC SAFETY - RES. 051158
2 more people trained in bystander CPR, the
3 more citizens are willing to act in an
4 emergency, resulting in a higher rate of
5 patient survival. Here in Philadelphia,
6 too few people know what to do when faced
7 with sudden cardiac arrest.

8 For these reasons, we encourage
9 the passage of Resolution 051158,
10 encouraging the training of citizen CPR.

11 This concludes my testimony.

12 COUNCIL PRESIDENT VERNA: Thank
13 you.

14 CHIEF BUTTS: Good afternoon,
15 members of Council. I am Chief George A.
16 Butts of the Philadelphia Fire
17 Department. I am currently assigned to
18 the Philadelphia Fire Academy as the
19 Emergency Medical Services Training
20 Chief.

21 I am here to testify, along
22 with the Fire Commissioner, Lloyd Ayers,
23 and EMS Battalion Chief Ralph Halper on
24 the merits of 051158. By bringing
25 attention to this critical issue, we hope

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2 to improve the survivability of cardiac
3 arrests involving the citizens and
4 visitors of our City.

5 As illustrated in the testimony
6 preceding mine and the testimony to come,
7 the importance of CPR cannot be
8 understated. The Philadelphia Fire
9 Department's EMS Training Unit certifies
10 and maintains the CPR certification of
11 close to 3,000 City employees. This
12 training touches more than just our
13 members. It touches their families,
14 their neighbors and their friends. It
15 stretches beyond just their employment
16 with the City of Philadelphia.

17 As I sit here before you, I can
18 say with pride that this training has
19 saved lives and that this training has
20 made a difference. But for our great
21 metropolis, these 3,000 are not enough.
22 As previously stated, our great city can
23 and should do more in this area.

24 The question can be asked what
25 can we do. The key to the answer can be

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2 found in education and training. The
3 biggest obstacle of getting involved is
4 often the fear of not knowing what to do.
5 There is no easier fear for knowledge to
6 overcome. So what can we as citizens do?
7 We can take advantage of the available
8 CPR training at hospitals, AHA training
9 centers, the Red Cross and other
10 certified training centers. This
11 training and education will help us to
12 realize that there is nothing to fear in
13 coming to the aid of someone in cardiac
14 arrest. This training and education will
15 help us to realize how easy it is for us
16 to learn CPR.

17 With education and training
18 comes preparation, and with preparation
19 comes comfort, and with comfort comes
20 confidence. The fact is that most
21 cardiac arrests are witnessed by family
22 members, friends and co-workers. I ask
23 as citizens of this great city, you look
24 around and ask yourself if your family
25 member, if your friend, if your co-worker

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2 was in cardiac arrest, would you know
3 what to do.

4 As a city government, we should
5 endeavor to make more learning
6 opportunities available to our citizens.
7 As leaders, we should encourage the
8 public to take CPR classes. We need to
9 commit to making sure that no City worker
10 in any City workplace has ever the need
11 to say the words "if only I knew what to
12 do." We should lead the way in giving
13 our citizens the confidence to get
14 involved in the event of a cardiac
15 arrest.

16 With this in mind, the
17 Philadelphia Fire Department, with the
18 permission of Chief Ayers, commits to
19 training selected members of other City
20 agencies as CPR instructors so they can
21 provide that instruction in their agency.

22 The citizens of Philadelphia
23 should come away from this hearing with
24 the understanding that learning CPR and
25 accepting their responsibility for their

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2 part of the chain of survival yields
3 great returns on the small investment of
4 taking a CPR class. We of the
5 Philadelphia Fire Department will be
6 there for you, but the value lies in
7 raising the response rate of our citizens
8 to cardiac emergencies and, therefore,
9 raising the survival rate of our citizens
10 in cardiac arrest.

11 Remember, you can save a life,
12 and it's easier than you think.

13 I thank you for this
14 opportunity to address Council.

15 COUNCILWOMAN MILLER: Thank
16 you. Thank you all for your testimony.

17 I have a few questions, and I
18 know Councilman Rizzo also has a
19 question.

20 What are the signs of cardiac
21 arrest? If someone is having a heart
22 attack, I don't know that I would know
23 that. What are the signs? Anyone can
24 answer that.

25 CHIEF BUTTS: The signs and

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2 symptoms of a heart attack vary, but
3 usually it's chest discomfort radiating
4 into the neck or down the left arm,
5 sweating. There can be dizziness,
6 nausea. Very often sometimes when these
7 symptoms are minor, they're overlooked as
8 flu-like symptoms, but recognition is
9 extremely important.

10 COUNCILWOMAN MILLER: So I
11 guess if someone had those symptoms and
12 then they began to pass out, I guess
13 that's what would help you understand
14 that they're having a heart attack.

15 CHIEF BUTTS: Well, even before
16 that happens, it's a good idea to start
17 your part of the chain of survival and
18 get help for that person. You don't need
19 to wait until they pass out. If someone
20 says, I have chest pain and I'm having
21 trouble breathing, it's time to get
22 started.

23 COUNCILWOMAN MILLER: Okay.

24 CHIEF BUTTS: The clock starts
25 ticking then.

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2 COUNCILWOMAN MILLER: Thank
3 you.

4 Councilman Rizzo. I have other
5 questions, but you can go on.

6 COUNCILMAN RIZZO: That's okay.
7 Do you want me to go?

8 COUNCILWOMAN MILLER: Go ahead.

9 COUNCILMAN RIZZO:
10 Commissioner, the big utility companies
11 like PGW, Exelon, Comcast, SEPTA, I would
12 hope that -- and I look back to when I
13 worked for a utility, that that was a
14 very important part of corporate policy,
15 that all employees, not just the ones
16 that were working in an environment
17 that -- as you can imagine, knowing CPR
18 when you're working in a crew on
19 energized electrical wires. I mean,
20 that's an absolute requirement. But it
21 didn't stop there. It worked its way
22 through the entire company, where even
23 the people that worked in the office were
24 well trained in the area of CPR.

25 Maybe it wouldn't be a bad idea

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2 to send a letter to the Presidents of the
3 various corporations to get -- I mean,
4 can you imagine if you had every SEPTA
5 driver -- and I don't know whether SEPTA
6 drivers know how to administer CPR -- if
7 a person on their bus would become ill.
8 I don't know if all the PGW employees
9 that work on the street are trained. You
10 would think so, because, again, of the
11 environment that they work in.

12 I know PECO, Exelon, all of
13 their employees are well trained, for
14 obvious reasons. Comcast, what a
15 presence they have.

16 So, again, I guess our numbers
17 are skewed a bit because we really don't
18 know how many of the people that I just
19 mentioned are out there to be able to
20 respond. And as far as I know, I've
21 never heard any executive ever say, Don't
22 get involved. Just the opposite, Do what
23 you can do to help. Same with our
24 Sanitation workers. I have no clue
25 whether they could come to the aid of a

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2 fallen citizen.

3 So maybe the best place if we
4 want to bump these numbers would be to go
5 where we could get the most response
6 almost immediately and have a plea for
7 the big corporations to step forward and
8 make sure that that training hasn't
9 fallen between the cracks.

10 To be real candid, what effect
11 do you think it has -- because I've had
12 people tell me that they probably
13 wouldn't respond or want to know, be
14 trained, because they're afraid of
15 getting sick with some communicable
16 disease.

17 Candidly, do you think that
18 that has had an effect on the numbers?

19 COMMISSIONER AYERS: Well, I
20 believe that there are many factors that
21 feed into this, why our rate is so low,
22 but I also believe that education as to
23 how to properly do CPR and also that
24 coupled with the research, the great
25 research that's been done by doctors, not

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2 only here in the United States but around
3 the world, that are telling us that even
4 people who are shy that way, who may not
5 normally intervene with compressions and
6 mouth-to-mouth resuscitation, that we
7 have other ways that we can get people to
8 do mouth-to-mouth. But more especially,
9 the research says that as long as the
10 chest compressions are going, that's
11 something, that you have circulation in
12 the body, that you have whatever
13 remaining oxygen is in the blood that is
14 going to the brain and other vital organs
15 so that this person has a chance so that
16 when we get there, they're in a state
17 that they're more shockable as far as the
18 AEDs, all of those things that we have to
19 bring to bear upon their survival, that
20 these things are the things that we have
21 to educate people to.

22 Also, we have to educate people
23 that it's important to get involved, that
24 just because you touch a person doesn't
25 mean that you're going to get some

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2 communicable disease. So the more you
3 educate the population, the more readily
4 they'll intervene and be intervening with
5 education, understanding what they're
6 doing and how important it is.

7 COUNCILMAN RIZZO: The first
8 part of my suggestion on the big
9 companies.

10 COMMISSIONER AYERS: I think
11 that that's a real key piece, that we
12 plan on doing that, that that's part of
13 what we want to look at as far as going
14 forward.

15 CHIEF HALPER: Council, sir, I
16 believe some of the major CPR agencies in
17 our City, such as the American Red Cross
18 and the American Heart Association, might
19 have some work in that area. And the
20 American Heart Association is here. They
21 may be able to address that later on as
22 far as CPR in the private sector.

23 COUNCILWOMAN MILLER: And one
24 of the things that we're going to do
25 after these hearings is put together a

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2 task force to figure out -- we talked
3 about this already -- to figure out the
4 outreach and education efforts that we're
5 going to take moving forward.

6 So that's a very good
7 suggestion.

8 COUNCILMAN RIZZIO: Thank you.

9 COUNCILWOMAN MILLER: I have a
10 question. What is Seattle doing
11 different? I mean, do you know what
12 they've done different, because they have
13 so many people trained? I mean, have
14 they had an outreach program to
15 corporations? What are they doing?

16 CHIEF BUTTS: Seattle had a
17 very public effort to, and a concentrated
18 effort, to train a large number of their
19 citizens in CPR. For Seattle, this has
20 been an ongoing event for about 30 years.
21 This didn't just happen for them. It
22 involved all facets of the city, the
23 private companies, the city itself. They
24 had billboards. They had an entire
25 advertising campaign to get people

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2 interested and on board.

3 COUNCILWOMAN MILLER: Sounds
4 like it worked.

5 CHIEF BUTTS: It did.

6 COUNCILWOMAN MILLER: What
7 about the issue of getting sued if
8 someone administers CPR, the issue of
9 being sued?

10 CHIEF BUTTS: There are what
11 are called good samaritan laws, which say
12 if you go in to help someone and you're
13 trying to help them, that you are exempt
14 from any legal action.

15 One of the problems that has
16 plagued the situation is that people for
17 those reasons will stand by and do
18 nothing, and that is far worse than
19 attempting to do something. As the
20 Commissioner pointed out, research has
21 shown that just the compressions, without
22 even getting involved in the
23 mouth-to-mouth, just the compressions
24 greatly improve a person's chance of
25 survival. And connected to that, 80

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2 percent, studies have shown, 80 percent
3 of the cardiac arrests that occur occur
4 with a family member or a friend. And
5 I'd like to believe that I think most of
6 my family and most of my friends will
7 probably do mouth-to-mouth on me if I
8 collapsed.

9 COUNCILWOMAN MILLER: Well, at
10 least if they hit your chest. See, I
11 just learned something. I didn't know
12 that that's the important part, to keep
13 that blood flowing. That's real
14 important.

15 CHIEF HALPER: Just to
16 understand that and how that works is
17 that in our atmospheric air now, we have
18 approximately 20 percent of oxygen in the
19 100 percent of air that we're breathing.
20 So when you breathe in, you're getting 20
21 percent oxygen. Then when you exhale,
22 you're exhaling yet another 16 percent or
23 maybe 15 percent. So your body is
24 utilizing four to five percent of the
25 oxygen. And then when you exhale it,

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2 you're exhaling 15 percent of that.

3 So the theory is is that if you
4 do chest compressions without the
5 mouth-to-mouth airway breathing, that
6 you're still circulating that 15 percent
7 of oxygen in the person's body. And the
8 American Heart Association will address
9 later the science of CPR and explain
10 that, of how that still benefits the
11 patient.

12 COUNCILWOMAN MILLER: All
13 right. Any other members have any
14 questions?

15 Councilman Rizzo.

16 COUNCILMAN RIZZO:
17 Commissioner, I don't want to get off
18 track, but could you describe the
19 difference between the advanced life
20 support versus the basic in the response
21 of the person who is having a heart
22 attack? Describe, if you could, the
23 difference in the two responses.

24 COMMISSIONER AYERS: Okay. The
25 difference in the responses as related to

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2 a basic life support unit, which has two
3 emergency medical technicians on board
4 who are trained, emergency medical
5 technicians, they're licensed by the
6 State of Pennsylvania and that they are
7 authorized to do all of those things that
8 an emergency medical technician would do.
9 They would come to the scene. They would
10 assess the scene. They would immediately
11 begin CPR or take the CPR operation over
12 if bystander CPR has started. They would
13 begin to give oxygen to that person,
14 along with the compressions and breaths
15 or whatever has been done. And that
16 oxygen, just the oxygen and the
17 continuation of the compressions is
18 something that would help that
19 individual, because, one, if the
20 compressions were taking place, they
21 would have hopefully adequate blood
22 pressure in the system to keep that
23 oxygen going to the vital organs. The
24 supplement of the oxygen is going to
25 raise that for that patient.

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2 They would start to package
3 that patient, put that patient in the
4 medic unit and do the next best thing for
5 that patient, and, that is, get them to
6 the area hospital.

7 An ALS unit coming up on the
8 same type of a heart attack situation,
9 they would assess the scene. They would
10 begin to take over where the bystander
11 CPR had started. They would look at that
12 patient. They would give that patient
13 oxygen or possibly intubate that patient,
14 which would be the difference, where the
15 oxygen would be going by tube into the
16 lung versus by bag into the lungs. But
17 the most important thing is, they will
18 continue those chest compressions,
19 package that person and get them on the
20 way.

21 Other things that an advanced
22 life support paramedic would be able to
23 do would be to begin to start to take an
24 intervention into the body by way of
25 tubes, needles, tubes, starting a drip,

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2 things like that. They can do those
3 types of things. Also, they have the
4 ability to put other drugs and chemicals
5 in the system that would hopefully assist
6 in helping that patient.

7 The one thing that both of them
8 would do if that heart had started that I
9 didn't mention was, they would apply the
10 defibrillator. They would take a
11 reading, see where it is at and they will
12 shock that patient. So both of them
13 would do almost the exact same things.

14 COUNCILMAN RIZZO:
15 Commissioner, is there any question that
16 if a constituent is having a heart
17 attack, that response is important but
18 advanced life support is obviously the
19 best care a person experiencing a heart
20 attack can have?

21 COMMISSIONER AYERS: Well, the
22 materials that I have been reading and
23 the report out from doctors, a consortium
24 of doctors from around the world, tells
25 us that an advanced life support

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2 intervention is not the end-all to that
3 patient, that the advanced life
4 support -- of course, I would want to
5 have the better advanced life support,
6 but the most important thing is the
7 oxygen, the compressions and the handling
8 of that patient, making sure that your
9 link is handled properly, which is
10 getting that person to the higher level
11 of care. That is the most important.

12 COUNCILMAN RIZZO: Both are
13 doing that, but I'll use the word the
14 stepped-up care comes from -- if you're
15 having a serious heart attack, the
16 advanced life support can provide more
17 care than obviously it says. Advanced is
18 one level of service, basic is another.
19 And I'm not going to go where you think
20 I'm going. I just want to understand.

21 COMMISSIONER AYERS: No. I
22 understand. I would like to say that I
23 would have to understand that more, I
24 believe, the American Heart Association
25 understands some of those comments and

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2 some of those conclusions that doctors
3 came to. They did not say that advanced
4 life support was no good, but some of the
5 things that we thought in the past,
6 before 2002, in the early '90s, that we
7 would have this great advancement in
8 cardiac care just by having two EMTs, I
9 don't think that they have the same
10 percentage of thought that what advanced
11 life support brings to the game when you
12 start talking about advanced life
13 support, emergency medical technicians
14 and the difference.

15 I believe that there is a
16 difference. I believe that if you can
17 have advanced life care, that is what
18 would be good, but I believe that an
19 emergency medical technician, two
20 emergency medical technicians and two
21 paramedics on the scene taking care of a
22 patient, getting that patient packaged
23 and to the hospital will give that person
24 the opportunity to survive. I believe
25 that.

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2 COUNCILMAN RIZZO: Thank you.

3 Thank you, Madam Chair.

4 COUNCILWOMAN MILLER:

5 Councilman Kenney.

6 COUNCILMAN KENNEY: Thank you.

7 Commissioner, isn't the main
8 difference between the advanced life and
9 the basic life the intravenous
10 administration of drugs? Isn't that
11 really the basic difference, that they're
12 able to administer intravenously certain
13 drugs that are critical in the care?

14 COMMISSIONER AYERS: That's one
15 of the differences. Another difference
16 is that they can read the strips on the
17 monitor a little bit better.

18 COUNCILMAN KENNEY: EKG.

19 COMMISSIONER AYERS: Exactly.
20 And be able to forewarn the hospital
21 during the hay system that we have a
22 person, this is what their rhythm is
23 looking like, and it gives some more
24 advanced warning to the receiving
25 hospital on what they need to do.

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2 COUNCILMAN KENNEY: How many
3 runs a year, both basic and advanced,
4 does the Department respond to a year?

5 COMMISSIONER AYERS: Gosh,
6 207,000, something like that last year.

7 COUNCILMAN KENNEY: Of the 207
8 or so thousand, how many of those are
9 severe cardiac arrests? Have you been
10 able to break them down into need for
11 transport to the hospital?

12 I understand there's a wide
13 range of stories throughout the City and
14 throughout the history of the Department
15 as to the use of EMT and ALS units by the
16 public, ranging from severe cardiac
17 arrest and death to, I have a doctor's
18 appointment, and anywhere in between.

19 Have we been able to break down
20 what people call the Fire Department for
21 on the medical side?

22 COMMISSIONER AYERS: Yes, we
23 have. We have. And one of the things
24 that we have found is that for advanced
25 life support, they're about 20 percent of

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2 our calls. They average around 20 to 25
3 percent.

4 COUNCILMAN KENNEY: And
5 advanced life support would be what
6 categories of illness or injury?

7 COMMISSIONER AYERS: A category
8 where you would absolutely be looking at
9 this patient as in trouble, in dire need
10 of medical attention, and that we need to
11 get them to a hospital right away.

12 COUNCILMAN KENNEY: So the
13 person would die without medical
14 attention potentially.

15 COMMISSIONER AYERS: The person
16 could die without medical attention.

17 COUNCILMAN KENNEY: That's the
18 20 --

19 COMMISSIONER AYERS: And that
20 could be everything from heart attack to
21 sometimes with auto accidents, it's the
22 same thing.

23 COUNCILMAN KENNEY: But all of
24 those serious cases are about 20 percent
25 of the 200,000?

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2 COMMISSIONER AYERS: About 20
3 percent.

4 COUNCILMAN KENNEY: And the
5 rest of them fall into what kind of
6 categories?

7 COMMISSIONER AYERS: Basic life
8 support.

9 COUNCILMAN KENNEY: Give me an
10 example. A bicycle accident? A dog
11 bite?

12 Part of the whole -- and this
13 is a little bit off the subject, but part
14 of this whole debate on ALS versus basic
15 is the types of injuries or types of
16 medical conditions that your people are
17 dealing with and in what ratio and in
18 what frequency they are.

19 So I think it's important for
20 the public to understand that every EMT
21 call or every 9-1-1 call for medical
22 treatment is not a cardiac arrest where
23 someone is potentially dying. It's about
24 20 percent of those calls. So the rest
25 of them have to fall into other

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2 categories that are less

3 life-threatening, I would assume.

4 COMMISSIONER AYERS: That's

5 correct, Councilman.

6 COUNCILMAN KENNEY: And that

7 that would be appropriate for EMT or even

8 first-responder. We still do

9 first-responder?

10 CHIEF HALPER: Yes, we do.

11 COMMISSIONER AYERS: Yes.

12 COUNCILMAN KENNEY: So we have

13 the engine company, the ladder company go

14 out to a potential medical call and then

15 they assess the situation and call

16 whether they need an EMT or an advanced

17 life support system.

18 COMMISSIONER AYERS: Well, they

19 may communicate it to that incoming unit,

20 but along with every first-responder run,

21 we do send a medic unit. There are

22 times --

23 COUNCILMAN KENNEY: So the

24 medic unit and the first-responders go at

25 the same time?

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2 COMMISSIONER AYERS: That's
3 correct.

4 COUNCILMAN KENNEY: What
5 determines whether it's an advanced life
6 support system or a basic life support
7 system?

8 COMMISSIONER AYERS: What they
9 are presented with. They'll make an
10 assessment, they'll look. It could be a
11 situation where there's a problem with
12 the person's airway, a problem with the
13 person's circulation or open bleeding, a
14 problem with circulation like the heart
15 or a problem with their circulation like
16 open bleeding. So they would assess
17 that.

18 COUNCILMAN KENNEY: For this
19 discussion and I guess more for a future
20 discussion, I'd be interested in knowing
21 of the 200 or so thousand calls, the 20
22 percent and what the 80 percent entail
23 just in general terms, what types of
24 response, whether it's anecdotal or
25 whether it's actually -- I'm sure you

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2 guys have reports that are filed as a
3 result of any kind of contact with the
4 public so we would know what those other
5 type of medical events are, I assume.

6 CHIEF HALPER: In the broadest
7 term, in the most general terms, the way
8 I usually explain it is that basic life
9 support provides external treatment and
10 care. Advanced life support provides
11 invasive procedure into the person's
12 body, as the Commissioner said, with a
13 tube or a medicine or a reading of EKG,
14 things of that nature.

15 So if you're talking about the
16 BLS classification of calls, they could
17 go from a fracture to a bruise to a cut
18 to a child delivery, things of that
19 nature that can be handled on the outside
20 of the patient.

21 COUNCILMAN KENNEY: Is part of
22 the 20 percent also gun-related shootings
23 and those kind of things?

24 CHIEF HALPER: That is correct.

25 COUNCILMAN KENNEY: So it's

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2 cardiac arrests, shootings, serious --

3 CHIEF HALPER: Trauma.

4 COUNCILMAN KENNEY: -- trauma?

5 CHIEF HALPER: Penetrating
6 trauma. The serious would be the upper
7 thorax of a knife or a bullet wound.

8 COUNCILMAN KENNEY: And that
9 amounts to 20 percent of our 200,000?

10 CHIEF HALPER: That's about 10
11 percent. That's an advanced life support
12 case, but the whole advanced life support
13 bracket would be 10 and 10, maybe 10
14 medical and 10 trauma.

15 COUNCILMAN KENNEY: Okay. All
16 right. Fine.

17 The other question I have
18 relative to the administration of CPR, I
19 remember when I was much younger, before
20 I was in Council, my dad as a Battalion
21 Chief was an instructor at the Fire
22 Academy, and I remember having all these
23 pieces of equipment, the bresusciani (ph)
24 and the doll and the thoracic section.
25 We'd all learn how to do that stuff and

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2 were all taught how to do it properly.

3 Are there times when it
4 shouldn't be administered? And the
5 reason I ask this question is, in order
6 for a person to determine the need for
7 it, does the heart need to have stopped
8 or is the heart in just -- and people
9 from the Heart Association could also
10 kind of respond to this question.

11 Is the heart in a weird rhythm?
12 Is it proper to do it then? Is it proper
13 to do it only when the heart has stopped?
14 Are there times when people are in
15 distress where it's administered and
16 they're worse off for having CPR
17 administered to them? I mean, I know
18 that might not be a large number of
19 cases, but I'm just curious as to trying
20 to educate people as to when it's
21 appropriate to do it, because I know
22 people, it would be the first thing they
23 did. I don't know whether or not that's
24 a good thing either.

25 So can you respond, and then

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2 maybe the Heart Association people could
3 respond.

4 COMMISSIONER AYERS: I'd like
5 to say that I believe that we have many
6 experts in this room that will be able to
7 answer those questions. Of course, I've
8 tried to do the best that I could with
9 the limited knowledge that I have in
10 those areas. So I would suggest that we
11 have the opportunity to bring some of the
12 experts to the -- is that okay?

13 COUNCILMAN KENNEY: That's
14 fine.

15 COUNCILWOMAN MILLER: The Heart
16 Association is coming on next. That's
17 the next panel.

18 COUNCILMAN KENNEY: That's
19 fine. Thank you.

20 COUNCILWOMAN MILLER:
21 Councilman Rizzo.

22 COUNCILMAN RIZZO: Thank you.

23 Commissioner, in reference to
24 advanced life support and basic -- for
25 lack of a better word, I'll use the word

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2 creative dispatch. Will we send an
3 advanced life support unit for something
4 that we know doesn't require advanced
5 life support? Are they just in the
6 rotation? If it's where they're
7 stationed and there's someone that fell
8 off a bike, will we tie up an advanced
9 life support unit or could we send the
10 closest basic and keep that advanced life
11 support unit available when we really
12 need them? Because I hear one of our
13 problems is that sometimes we've got the
14 advanced life support tied up on issues
15 that don't require advanced life support.

16 COMMISSIONER AYERS: Yes, we
17 can, and we do try to make those
18 distinctions and do that type of a
19 dispatch. But one of the things that we
20 find is the amount of demand that is
21 placed on the system, for the most part,
22 it precludes that opportunity. And we
23 have a staged response that we've set up.
24 So that advanced life support unit may
25 very well have to take the next case,

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2 which would be a basic life support type
3 of an event, even though the dispatcher
4 knows that. There may not be another
5 available unit for some distance.

6 So those are some of the things
7 that we are in the process of improving
8 in the Fire Department, both with
9 technology as well as with experience,
10 having people who can actually hear the
11 call, be able to, if you will, decipher
12 the call and give the best response to
13 the AED fire communications worker, that
14 dispatcher, in that dispatch.

15 So we are working on those
16 things, and that is available, but,
17 again, the demand on the system sometimes
18 precludes that type of an opportunity.

19 COUNCILMAN RIZZO: Thank you,
20 Madam Chair.

21 COUNCILWOMAN MILLER: Thank
22 you.

23 Thank you, Commissioner.

24 Are there any other questions
25 of these witnesses?

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2 (No response.)

3 COUNCILWOMAN MILLER: Thank
4 you. Thank you, Fire Department.

5 Our next group of people will
6 be from the American Heart Association,
7 Dr. Charles Bridges.

8 DR. BRIDGES: Thank you.
9 Councilwoman Miller and members of the
10 Committee on Public Safety, my name is
11 Dr. Charles Bridges. I am Chief of
12 Cardiothoracic Surgery at Pennsylvania
13 Hospital and Associate Professor of
14 Surgery at the University of Pennsylvania
15 Health System. I'm a former member of
16 the American Heart Association's
17 Southeast Pennsylvania Region Board of
18 Directors.

19 Joining me today to my right is
20 Ed Stapleton, an Associate Professor of
21 Emergency Medicine and Director of
22 Pre-Hospital Education in the Department
23 of Emergency Medicine at the State
24 University of New York-Stoney Brook.

25 On behalf of the American Heart

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2 Association, thank you for holding a
3 hearing to raise awareness of this
4 important issue and to discuss ways to
5 teach more Philadelphians
6 Cardio-Pulmonary Resuscitation, commonly
7 referred to as CPR. Also, thank you for
8 providing the American Heart Association
9 with this opportunity to testify today.

10 We would like to thank the
11 members of the Philadelphia Fire
12 Department and its emergency medical
13 services for all the outstanding work
14 that they do. Their testimony here
15 clearly outlined the issues facing
16 Philadelphia.

17 We hope that this hearing
18 serves as a catalyst to raise awareness
19 of why it's important that as many
20 Philadelphians as possible learn CPR, and
21 brings us together to find ways to get
22 Philadelphians that training. All of
23 this will help to save many lives.

24 The American Heart Association
25 would also like to take this time to

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2 discuss what CPR is, offer a national
3 perspective and some best practices, and
4 discuss some options available to
5 increase the bystander rate.

6 CPR is a combination of
7 breathing, known as ventilation, and
8 pushing on the chest, known as
9 compressions, delivered to victims
10 thought to be in cardiac arrest. Cardiac
11 arrest is often caused by an abnormal
12 heart rhythm called ventricular
13 fibrillation. That is when the heart
14 quivers, but does not pump any blood.
15 The victim in ventricular fibrillation
16 cardiac arrest needs CPR, which can
17 support a small amount of blood flow to
18 the heart and brain to buy time until
19 normal heart function is restored.

20 Just last year, the American
21 Heart Association, continuing its
22 practice of science-based research,
23 issued new guidelines for CPR. This
24 revision was based on the most
25 comprehensive review of resuscitation

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2 literature ever published and
3 incorporated the input of 281
4 international resuscitation experts over
5 a 36-month period. The new guidelines,
6 simply put: Rescuers should push hard,
7 push fast, allow full chest recoil,
8 minimize interruptions in compressions
9 and provide a shock to the heart called
10 defibrillation promptly when appropriate.
11 Defibrillation eliminates the abnormal
12 heart rhythm and allows the normal heart
13 rhythm to resume.

14 Decades of research have shown
15 that more people can survive sudden
16 cardiac arrest when CPR is performed
17 within a particular sequence of rapid
18 events. This sequence is, one,
19 recognizing early warning signs of a
20 medical emergency; two, activating the
21 emergency medical system; three,
22 performing basic CPR; four, providing
23 defibrillation; and, five, accessing
24 early advanced care such as oxygen and
25 medications. The common term for this

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2 sequence by EMS and the medical community
3 is the chain of survival. While
4 specialized programs are necessary to
5 develop strength in each individual link,
6 all of the links must be connected.
7 Weakness in any link lessens the chance
8 of survival for a victim of cardiac
9 arrest.

10 We mention the chain of
11 survival because as we focus on one
12 particular link, CPR, we cannot ignore
13 the critical actions preceding CPR and
14 following CPR.

15 The chain of survival begins
16 when a medical emergency is recognized
17 and the EMS system is activated by
18 calling 9-1-1. This can be done either
19 by a witness or by the person who
20 actually is experiencing the symptoms.
21 This link can be strengthened through
22 public education and awareness.

23 For a number of years, the
24 American Heart Association has offered
25 educational and public service programs,

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2 print materials and websites designed to
3 make the public aware of what to do when
4 a cardiac arrest occurs. Participants in
5 classes on CPR and American Heart
6 Association-sponsored school site and
7 work site training programs learn the
8 warning signs of heart attack, how to
9 recognize a person in cardiac arrest and
10 to quickly call the EMS system when a
11 person collapses.

12 Performing CPR immediately
13 after recognizing cardiac arrest is the
14 next critical step. CPR should coincide
15 with the efforts to activate the EMS
16 system. As I said earlier, CPR buys time
17 for a cardiac arrest victim until a
18 trained responder can arrive with a
19 defibrillator, other proper medical
20 equipment and transport the victim to
21 advanced care.

22 Effective bystander CPR
23 provided immediately after cardiac arrest
24 can double a victim's chance of survival.
25 We are here today because in order to

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2 strengthen this link, we should rely on
3 trained citizens, bystanders or witnesses
4 to the medical emergency, rather than
5 emergency responders to begin performing
6 CPR, because with rare exceptions, too
7 much time has passed to wait for
8 emergency personnel to begin CPR.
9 Studies show that if bystander CPR is not
10 provided, a sudden cardiac arrest
11 victim's chances of survival fall
12 approximately 10 percent for every minute
13 of delay until defibrillation. Few
14 attempts at resuscitation are successful
15 if CPR and defibrillation are not
16 provided within minutes.

17 There are several ways to
18 ensure that bystanders initiate basic CPR
19 before emergency responders arrive. The
20 most widely advocated is citizen CPR
21 training. Community-based CPR training
22 programs endorsed and conducted by the
23 American Heart Association have trained
24 laypersons in CPR in training centers,
25 work sites and school sites across the

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2 City. These courses are offered
3 throughout the City through a training
4 center network. A number of
5 representatives from these centers are
6 with us today.

7 These courses are taught under
8 the supervision of a certified
9 instructor. The courses teach students
10 how to recognize that an emergency
11 exists, recognizing the signs of heart
12 attack and stroke, how to check the
13 victim for signs of circulation,
14 emphasize the core skills of CPR; that
15 is, pushing on the chest and breathing
16 for the victim, calling 9-1-1 and child
17 and infant CPR. These comprehensive
18 courses generally require three to four
19 hours to complete, often involve a test,
20 and the participant, upon successful
21 completion, receives a certification
22 card.

23 These courses are the mainstay
24 of American Heart Association's efforts
25 to train citizens to help save a life.

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2 However, we realized that we were not
3 reaching as many people as possible.

4 There are a number of barriers to
5 consider and address when designing a CPR
6 training program. Cost, ability to find
7 instructor volunteers or lack of
8 awareness of the importance of knowing
9 CPR skills are just a few of the
10 barriers. Many people are also
11 embarrassed to practice CPR skills in
12 public or are afraid of failure or think
13 that they are physically unable to
14 perform the skills.

15 I would like to turn it over to
16 Ed Stapleton. Mr. Stapleton is a widely
17 recognized expert in his field and has
18 worked extensively with the American
19 Heart Association's Emergency Cardiac
20 Care program for a number of years.
21 Mr. Stapleton will discuss some advances
22 in tools and techniques to train large
23 numbers of people CPR quickly.

24 Mr. Stapleton.

25 MR. STAPLETON: Thank you.

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2 First of all, it's an absolute pleasure
3 to be here, because certainly we
4 recognize the importance of this
5 initiative in terms of really having an
6 impact.

7 What I'd like to do is go over
8 some statistics of importance on this
9 issue. And this an interesting video.
10 This is the actual original performance
11 of CPR 40 years ago by the inventor of
12 CPR. CPR hasn't been around for that
13 long, but he found that with simple
14 mouth-to-mouth breathing and chest
15 compressions, you could in fact perfuse
16 vital organs such as the brain and extend
17 the time in cardiac arrest where a person
18 could be saved.

19 As was mentioned, American
20 Heart Association publishes guidelines
21 about every five years that analyzes the
22 science to show progression. There's
23 been very innovative things that I'll
24 talk about later in these new guidelines
25 that give us great hope for improving

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2 what is right now a dismal national
3 survival rate of about five to ten
4 percent.

5 So heart disease is the number
6 one cause of death, and there are about
7 340,000 pre-hospital deaths a year from
8 sudden cardiac arrest. Think about that
9 for a second. That's almost a thousand a
10 day. When we think of the magnitude of
11 terrorism and all these things, you'll
12 never see numbers of this magnitude. So
13 it is an enormous problem and, to a great
14 extent, these people could be saved with
15 proper care.

16 And it is a very interesting
17 thing, that sudden cardiac arrest is.
18 It's mainly propagated by an abnormal
19 heart rhythm called ventricular
20 fibrillation, which can happen in the
21 absence or presence of a heart attack.
22 Someone can go into ventricular
23 fibrillation spontaneously, and the only
24 effective treatment of this rhythm is
25 early defibrillation. What CPR does is

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2 keep the vital organs perfused until such
3 time that defibrillation can occur, and
4 extends the period of time that people
5 can be resuscitated from cardiac arrest.

6 And as was mentioned, with each
7 minute that passes -- this is another
8 powerful statistic -- the chance of
9 survival decreases by about 10 percent.
10 There have been numerous studies that
11 have validated this particular statistic.
12 So that's an extremely sensitive time
13 frame.

14 A good example of that was at
15 O'Hare Airport, which is one of the most
16 successful defibrillation programs in the
17 United States, where they were able to
18 save about 60 to 70 percent of sudden
19 cardiac arrest victims as compared to
20 five percent nationally by having a good
21 CPR defibrillation program at the
22 airport. And what they did that was so
23 brilliant was to put defibrillators every
24 minute of a brisk walk. So that you have
25 about two minutes round trip to a

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2 defibrillator any point in the airport.
3 It was a very strategic and interesting
4 program. So they had an enormously
5 successful survival rate because they
6 thoughtfully put together a program that
7 involved both CPR and defibrillation.

8 This is a fellow who was a
9 benefit of a program we did in Long
10 Island. His name is Muhammad Shaw, and
11 he's 13 years old. And he sort of
12 illustrates what can be done with a good
13 CPR program and defibrillation program.

14 Muhammad Shaw had a cardiac
15 condition where he collapsed suddenly at
16 school, and CPR was started immediately
17 because they had trained rescuers in the
18 school. They also had an AED in the
19 school, and Muhammad Shaw was shocked by
20 a teacher at the school and, in fact,
21 converted to a normal rhythm almost
22 spontaneously, and the interesting case
23 is, CPR was started immediately.
24 Muhammad was shocked in three minutes.
25 The ambulance in Long Island arrived in

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2 14 minutes.

3 So having the community care
4 there was the critical element of his
5 survival. No doubt about it. Nobody
6 would argue that. And in most EMS
7 systems, you really can't rely in terms
8 of sudden cardiac death on EMS as the
9 main factor for this. That's very
10 important to realize.

11 Now, I'm also from a big city,
12 New York City, and I was head of the CPR
13 Certification Program for many years, and
14 we said, How are we going to get more
15 people? You have the same challenge.
16 You have a million and a half people.
17 How do we get a critical mass of people?
18 Because the interesting thing is, having
19 these large companies is a very important
20 strategy, but 70 to 80 percent of cardiac
21 arrests occur at home. So unless you
22 train a critical mass of population,
23 people will not be subject to receiving
24 CPR. You can't rely on the public to do
25 it necessarily, except each individual in

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2 their own home.

3 So we decided to do a video and
4 see if people can learn CPR just from the
5 video alone with the mannequin
6 instruction. We published this in a New
7 York state journal, and basically what we
8 found is, the video had some effect, but
9 really people need mannequin practice to
10 learn CPR. It's a psychomotor skill. At
11 the end of the day, that's what you have
12 to know to be successful.

13 Well, an introverted person
14 named Alan Braslow worked with a big
15 company many years ago where he developed
16 a video self-instruction system. It took
17 22 minutes to take, and he had people --
18 it was video self-instruction where they
19 watched the video and learned CPR as they
20 were watching the video, and it took 22
21 minutes. And several studies have been
22 published since then that have shown not
23 only this 22-minute video -- this is the
24 irony of it. Listen very carefully --
25 was equal or better than three hours of

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2 traditional CPR instruction. You say,
3 Well, why would that occur? Twenty-two
4 minutes of self-instruction was better
5 than three hours of traditional
6 instruction. Well, the truth was, people
7 during those 22 minutes did CPR and
8 practiced and reenforced and learned CPR.
9 So it was a very -- the original one was
10 32 minutes. The more recent ones are 22
11 minutes. And what it is, is a kit as you
12 saw previously on the screen, you see on
13 the desk there, where each individual
14 gets a mannequin, a video and a book, and
15 they can actually take it home and learn
16 CPR at home with their family and train
17 their other family members.

18 One of the most successful
19 strategies for implementing this has been
20 in schools. I did a study where I went
21 to Minnesota and I trained 96 students in
22 three classes. It took me two hours.
23 Those students went home and trained 288
24 people. For my efforts for two hours in
25 a classroom, 384 people were trained in

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2 CPR. Had I used the traditional approach
3 for teaching CPR, I would have trained
4 six to eight people.

5 So this is the new paradigm.
6 This is the new invasion that allows us
7 to train large numbers of people very
8 quickly. Well, guess what? Somebody did
9 a lot better than I did. In Denmark,
10 they did a National First Aid Week where
11 they had seventh graders in Denmark, 35
12 students, learn through this
13 self-instructional methodology, who in
14 turn went home and trained their family
15 members, and in three weeks, trained
16 100,000 people in CPR. That is a
17 powerful multiplier.

18 That's the beauty of this
19 particular strategy. It's a strategy
20 that allows you to train a large number
21 of people.

22 Thank you very much.

23 DR. BRIDGES: Thank you,
24 Mr. Stapleton.

25 Let me point out that in the

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2 time it took for us to testify, you, your
3 staff, a family, a mother, a classroom, a
4 group of seniors, a faith-based group or
5 a group of neighbors could have learned
6 CPR core skills using the CPR Anytime
7 program and be ready to help save a life.

8 The American Heart Association
9 appreciates this opportunity to testify.
10 We would like to present each member of
11 the Committee, as well as each member of
12 City Council, a CPR Anytime program so
13 that you can train your staff, yourself
14 and people in your community how to
15 perform CPR.

16 We stand ready to work with the
17 City of Philadelphia, the Philadelphia
18 Fire Department, Jefferson and other
19 stakeholders to increase the bystander
20 CPR rate in Philadelphia.

21 We would be happy to answer any
22 questions.

23 COUNCILWOMAN MILLER: Okay.
24 Councilman Rizzo.

25 COUNCILMAN RIZZO: Doctor,

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2 thank you. When a person is in the state
3 of fibrillation, ventricular
4 fibrillation, at any time is there a
5 situation when a person that has a heart
6 attack that is not in that state and if
7 you gave them the shock, you could hurt
8 that patient? How do you know whether to
9 use the shocking devices or not, or
10 doesn't it hurt if a person isn't
11 experiencing ventricular fibrillation?

12 DR. BRIDGES: Let me answer all
13 of your questions. First of all, in
14 terms of does it hurt, the vast majority
15 of times the answer is no. If a person
16 is actually not in ventricular
17 fibrillation and happens to be in, let's
18 say, a normal heart rhythm, other than it
19 being a little bit uncomfortable, the
20 vast majority of times the heart is still
21 going to maintain its normal rhythm in
22 the presence of a shock.

23 The other thing is -- so that
24 there's very little downside to shocking
25 someone in a situation when they don't

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2 actually have ventricular fibrillation.

3 The other question is, how do
4 you know that they have ventricular
5 fibrillation. The vast majority of time
6 when people do have a heart attack, there
7 are some other symptoms, such as chest
8 pain that was alluded to. But female
9 patients, for example, are less likely to
10 have chest pain, are more often to have
11 nausea, vomiting and GI symptoms as signs
12 of a heart attack. So chest pain is not
13 necessary, although it is often a clue.

14 And when your heart arrests --
15 cardiac arrest means that the heart stops
16 pumping blood effectively -- you will
17 pass out within a short period of time.
18 You won't maintain consciousness if you
19 in fact have cardiac arrest. So it's
20 usually fairly clear that this kind of
21 emergency has occurred and it's not often
22 difficult to recognize. And, like I
23 said, if you're wrong, there's really
24 very little downside to it.

25 COUNCILMAN RIZZIO: Doctor, just

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2 one final question. Are you aware,
3 either of you, of any hesitation on the
4 part of government? I'm hearing that
5 there are organizations that have an
6 interest in providing the defibrillators
7 to various government agencies to, as an
8 example, a recreation department to put
9 them at various locations.

10 Why would anyone in government,
11 a decision-maker, resist having those
12 devices on their premises?

13 MR. STAPLETON: I'll be able to
14 answer that. I don't know why, but as a
15 practical measure, people will talk about
16 a cost ratio benefit of defibrillators,
17 meaning if you had three people in an
18 office, would it be appropriate to
19 purchase a defibrillator, being the
20 probability of cardiac arrest was so low
21 in that office, that when you thought
22 about it in the long haul, this would not
23 be the place to put a defibrillator.

24 In a building such as this, I
25 would hope you have a defibrillator in

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2 this building, and if you don't, you're a
3 little bit behind the curve, very
4 frankly, because typically a building
5 like this in New York state -- for
6 example, all government buildings have
7 defibrillators on the premises, so do all
8 health clubs. It's a requirement by law.
9 And, in fact, New York state has
10 defibrillators in every single school in
11 the whole state.

12 So where there's a large
13 probability of cardiac arrest or a large
14 concentration of people, you should have
15 a defibrillator on the premise.

16 COUNCILMAN RIZZO: I'll give
17 you an example. What about a recreation
18 center that has basketball courts, tennis
19 courts? Perfect place, obviously, to
20 have those devices.

21 MR. STAPLETON: In New York
22 state, it's legislated, for example, in
23 health clubs you have to have a device.
24 So in places where there is relative high
25 risk, not so much -- basketball center,

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2 if it's a young audience, it may not
3 be -- it could be arguably not a great
4 place, but in health clubs, for example,
5 where there are people like me running on
6 treadmills, you'd probably need a
7 defibrillator.

8 COUNCILMAN RIZZ0: We're going
9 to be -- and, again, not for today, but
10 we're going to be talking about this in
11 the future. So if we could impose
12 possibly to have you back to talk about
13 this.

14 MR. STAPLETON: Sure.

15 COUNCILMAN RIZZ0: Because I
16 think we have a long way to go here.

17 COUNCILWOMAN MILLER: We do.

18 We actually have a young man
19 that died on a basketball court, and his
20 family wants to donate defibrillators to
21 recreation centers, and one of the issues
22 that the City states is the liability
23 issue and the fact that defibrillators, I
24 think, maybe years ago, batteries failed,
25 who is liable, those kinds of issues.

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2 MR. STAPLETON: Well, the truth
3 is -- well, let's take it from two points
4 of view. These defibrillators in terms
5 of recognizing cardiac arrest,
6 recognizing ventricular fibrillation are
7 highly reliable, in the 99 plus
8 percentile. That's how reliable they
9 are. I would gladly put one on and run
10 around the block if you'd like me to.
11 That's how reliable they are.

12 As far as the maintenance of
13 the defibrillator, that's true. It's not
14 very difficult maintenance, but that
15 should be one of the things you consider
16 in setting up programs, is how well you
17 define maintenance and what the
18 responsibilities of the users are. You
19 have to check the batteries. You have to
20 check the expiration of the pads. These
21 are not very difficult things to do. The
22 batteries now have a life of about five
23 years. In the past, they had a life of
24 about two years.

25 So somebody on the premises has

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2 to take responsibility for that, but it's
3 not a big deal. It's just that people do
4 it -- they put a defibrillator on the
5 wall, but they don't put a defibrillator
6 program in their facility. That's the
7 big difference.

8 COUNCILWOMAN MILLER: Right.

9 COUNCILMAN RIZZO: Thank you.

10 COUNCILWOMAN MILLER: Okay.

11 COUNCILMAN RIZZO: We'll be
12 talking.

13 COUNCILWOMAN MILLER: In
14 preparing for these hearings and you're
15 talking about heart attacks all the time,
16 and I guess at my age, I know lots of
17 people that are dying from heart failure,
18 and it makes you real conscious all the
19 time. So yesterday I was at the gym
20 walking around the track and I'm looking
21 all around to see, well, what's the
22 emergency system here, because I also
23 need a defibrillator.

24 But basically you did say that
25 in New York -- you're from New York,

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2 correct?

3 MR. STAPLETON: Correct.

4 COUNCILWOMAN MILLER: That all
5 health clubs and gyms have to have
6 defibrillators. What about rec centers,
7 public playgrounds?

8 MR. STAPLETON: I don't know
9 the margins of that recommendation. I
10 know it specifically targeted health
11 clubs. I would see rec centers to be a
12 lesser risk, let's say, than a health
13 club, because a health club obviously is
14 going to have an age factor associated
15 with that.

16 I don't know -- I don't think
17 rec centers, but every school is required
18 to have a defibrillator on the premises,
19 every single school.

20 COUNCILWOMAN MILLER: I don't
21 know what that is here in Philadelphia,
22 whether that's a requirement or not. I
23 don't ever remember seeing one. I do
24 think we do have some here in
25 Philadelphia.

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2 MR. STAPLETON: I'll let you
3 know, that was an unfunded mandate by the
4 Governor and that schools were expected
5 to buy their own defibrillators.

6 COUNCILWOMAN MILLER: I believe
7 we do have one or two here in City
8 Council. We had an emergency a few years
9 ago, and after that, they wanted to know
10 how many staff were trained, I think, in
11 CPR and able to use a defibrillator. But
12 if something happened right now, I really
13 would not know who to call.

14 Would you?

15 COUNCILMAN RIZZO: No. Well,
16 we call 9-1-1.

17 COUNCILWOMAN MILLER: Well,
18 other than 9-1-1, but I'm talking about
19 somebody right here.

20 COUNCILMAN RIZZO: Because this
21 is a very complicated building, no
22 disrespect, but the response time of this
23 building, it's not an easy building, once
24 you get through traffic, once you get
25 here, to respond to --

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2 MR. STAPLETON: Urban EMS.

3 That's always a difficulty. I worked New
4 York City EMS system for 25 years, and
5 you have vertical times and you have the
6 complexity of that. There are real
7 challenges for EMS in a city like this.
8 But the key thing for cardiac arrest is
9 to have people trained in CPR, which you
10 can do in 22 minutes, and have a
11 defibrillator on the premise when it's
12 appropriate, such as a building like
13 this. Those are the two variables.

14 COUNCILWOMAN MILLER: Those are
15 exactly our goals, to make sure that we
16 have more people trained, not just in
17 Philadelphia but in these buildings also.

18 MR. STAPLETON: Right.

19 COUNCILWOMAN MILLER: Any other
20 questions for the American Heart
21 Association?

22 (No response.)

23 COUNCILWOMAN MILLER: Okay. Is
24 there anybody else to testify?

25 COUNCILMAN KENNEY: Just on the

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2 issue I had raised earlier. I know it
3 may be somewhat far-fetched and not
4 necessarily a high percentage issue, but
5 are there times when it shouldn't be
6 administered, or is it safer to
7 administer it when you think it's
8 necessary?

9 I understand the defibrillators
10 are designed in such a way that they can
11 monitor what the shock intensity is
12 needed and administer it, but when an
13 individual is actually compressing the
14 chest, are there any times when it's not
15 advisable?

16 DR. BRIDGES: Again, those are
17 the extremely rare circumstances when it
18 would potentially be injurious to someone
19 who has a chest injury, for example, to
20 give CPR, but, I mean, those
21 situations --

22 COUNCILMAN KENNEY: People pass
23 out for other reasons other than cardiac
24 arrest or defibrillation. I mean, if
25 somebody goes down on the sidewalk, the

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2 first instinct would be for somebody to
3 start to administer CPR.

4 Is there an issue relative to
5 that being dangerous to a person or is it
6 better to err on the side of safety?

7 DR. BRIDGES: Number one, it's
8 better to err on the side of safety.
9 Number two, those are the kinds of issues
10 that the training programs will deal
11 with, is training you how to recognize
12 appropriate circumstances when you should
13 be using CPR. But having said that,
14 there is, again, almost no downside, and
15 the upside is far greater. Rather than
16 waiting to be sure that this is in fact
17 cardiac arrest, you're much better off
18 using CPR, even if it's occasionally
19 inappropriate.

20 COUNCILMAN KENNEY: Thank you.

21 COUNCILMAN RAMOS: Thank you
22 for your testimony. We'll ask for Thomas
23 Jefferson -- is Thomas Jefferson Hospital
24 here? Please come forward.

25 Good afternoon.

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2 MR. KLEINDIENST: Good
3 afternoon.

4 COUNCILMAN RAMOS: Please
5 proceed with your testimony. Please
6 state your name before the testimony.

7 MR. KLEINDIENST: My name is
8 Rick Kleindienst from Thomas Jefferson
9 University Hospital. Good afternoon,
10 members of the Council. I want to thank
11 Councilwoman Miller and the other City
12 Councilmembers for allowing me the
13 opportunity to testify on the resolution
14 to increase the number of people trained
15 in CPR in the City of Philadelphia. This
16 is an important initiative that will help
17 save lives of those who work and live
18 here. This resolution has the
19 possibility of impacting lives greatly.

20 My name is Rick Kleindienst. I
21 have been a paramedic for 12 years. I
22 have also been an educator in emergency
23 medical services for ten years. I'm
24 currently the manager of the American
25 Heart Association Training Center at

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2 Thomas Jefferson University Hospital,
3 also known as JeffSTAT EMS Training
4 Center. Our Training Center offers
5 formal training programs in
6 Cardio-Pulmonary Resuscitation, also
7 known as CPR, and the use of automatic
8 external defibrillators to over 2,000
9 people annually. Our instructors provide
10 training to all different groups of
11 participants, including laypeople from
12 the community, healthcare professionals
13 such as doctors and nurses. Our
14 instructional staff is well versed in the
15 benefits of CPR. Quite simply, the more
16 people we train, the more lives we save.

17 This afternoon I'm going to
18 review some of the different types of CPR
19 training options available to community
20 members. CPR is easier to learn than
21 many people think.

22 I am also going to briefly
23 review the curriculum of the American
24 Heart Association's CPR program and
25 provide you with an overview of how CPR

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2 programs are conducted, including a
3 possible hands-on demonstration, which
4 you saw in the tape.

5 Last, I will provide some
6 guidance for making a CPR training
7 referendum a reality.

8 There are many types of CPR
9 training programs. Most people attend a
10 formal training program in the classroom
11 course. Here an American Heart
12 Association's certified instructor
13 reviews the importance of the chain of
14 survival and teaches the layperson how to
15 recognize the signs and symptoms of a
16 stroke and a heart attack. This is
17 followed by a review of steps on how to
18 resuscitate a victim that has collapsed
19 from sudden cardiac arrest. The
20 instructor then discusses and
21 demonstrates the steps in CPR and how to
22 use an automatic external defibrillator.

23 The last and most important
24 portion of the course is, the hands-on
25 practical training then begins. Course

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2 participants are given the opportunity to
3 practice skills, such as ventilation and
4 compressions, under the guidance of a CPR
5 instructor. It takes approximately three
6 to seven hours to complete a training
7 program, depending on the type of course
8 that they choose.

9 For one, the Heartsaver AED
10 course will be the most effective program
11 for this initiative. This course is
12 three hours in length and teaches
13 participants how to perform adult CPR,
14 relieve a foreign body from a choking
15 victim and initiate rescue breathing
16 using a barrier device. It also provides
17 instruction on the operation of an
18 automated external defibrillator. The
19 AED has proven to be a life-saving device
20 when used in conjunction with CPR.
21 Course participants will receive a
22 certification card that provides them
23 proof of being trained in CPR or the AED
24 or both. This will be valid for a period
25 of two years.

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2 The American Heart Association
3 recently developed a new CPR training
4 program called CPR Anytime. With CPR
5 Anytime, the participants receive
6 convenient training in their homes via a
7 22-minute DVD. The training kit comes
8 with an inflatable mannequin which can be
9 used to practice breathing and
10 compressions.

11 There is no instructor to
12 oversee performance or answer questions
13 that the participant may have. However,
14 this type of self-learning training
15 program can be effective for some people
16 and is certainly a convenient form of
17 education.

18 Now I'd like to provide you
19 with a brief demonstration, which you saw
20 in the videotape, so we'll just continue
21 with the testimony.

22 I would also like to take a few
23 minutes to demonstrate a portion of the
24 CPR Anytime program, which, again, you
25 saw before, so we'll move on to

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2 continuing with the testimony.

3 One organization cannot handle
4 the amount of training that is required
5 in order for the resolution to be
6 successful. We will need to get many
7 agencies to work together to provide
8 training to the citizens of Philadelphia.
9 This includes Philadelphia Fire
10 Department, American Heart Association,
11 the American Red Cross, the Emergency
12 Medical Services Training Centers in the
13 area, hospitals and perhaps even
14 individual instructors who exist in the
15 Philadelphia community.

16 There are potentially hundreds
17 of thousands of people who need training,
18 and the City will need to reach out to
19 each and every instructor to get them
20 involved. Councilwoman Miller will need
21 to appoint an administrative oversight
22 committee to coordinate these
23 initiatives.

24 We will need to develop a
25 campaign to get community members to

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2 attend these training programs. We will
3 need to clearly communicate the benefit
4 of them personally, their families,
5 friends and community at large. We will
6 need to offer training programs at
7 convenient times and locations in the
8 community and make it as easy as possible
9 for everyone to participate. Hopefully
10 the local media can help us publicize
11 this information and help us get the
12 community involved.

13 We will also need to identify
14 ways to fund such a large project. This
15 may include grants, private donations,
16 in-kind donations and fundraising drives.
17 Corporate sponsorships could help the
18 resolution be successful also. Companies
19 like Home Depot, K-Mart, Wal-Mart and
20 other large businesses may make
21 considerable donations to the cause,
22 especially because of the fact that
23 everyone in the community benefits from
24 CPR training.

25 Training more people in CPR

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2 will save lives. Other cities such as
3 Seattle, Washington, who have worked
4 aggressively to train their community
5 members in CPR, have reaped the benefits.
6 We can make this a reality in
7 Philadelphia, too.

8 I would be happy to answer any
9 questions that you have regarding CPR
10 training. Thank you.

11 COUNCILWOMAN MILLER: In your
12 testimony, you answered one of my
13 questions, and that was just how long the
14 training actually -- before you had to be
15 retrained, how long the certificate
16 actually lasts. So it's two years. So
17 every two years you have to do it again?

18 MR. KLEINDIENST: Yes.

19 COUNCILWOMAN MILLER: Do you
20 have any questions?

21 COUNCILMAN RAMOS: No.

22 COUNCILWOMAN MILLER: I don't
23 have any more questions.

24 Did the other person from
25 Jefferson testify?

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2 SPEAKER: I'm not going to
3 testify. Thank you.

4 COUNCILWOMAN MILLER: You're
5 just here to be supportive. Okay.

6 All right. I want to thank
7 everyone for coming in today. I think
8 that this is a very important issue.
9 Other public safety issues have been
10 given a lot of attention over the past
11 year actually, and we wanted to make sure
12 that this was brought to the attention.
13 And we plan to put the oversight
14 committee, or whatever we want to call
15 it, a task force, et cetera, together so
16 we can all start working on ways to
17 educate and outreach to our citizens.

18 Is there anyone else here to
19 testify on this resolution?

20 Come up to the table and tell
21 us your name and anything else you want
22 us to know about you.

23 MS. CASSIDY: Thank you. My
24 name is Kathleen Cassidy and I'm from the
25 American Red Cross. I wasn't prepared to

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2 testify today. I just wanted to identify
3 myself and just to say as part of this
4 committee that goes on past this hearing,
5 we'd like to be involved in it.

6 COUNCILWOMAN MILLER: Okay.
7 That's great. We'll reach out to you.

8 MS. CASSIDY: Thank you.

9 COUNCILWOMAN MILLER: Thank
10 you. Red Cross is everywhere.

11 Anyone else want to testify on
12 this resolution?

13 Come on up.

14 CAPTAIN TOUCHSTONE: My name is
15 Mike Touchstone. I'm the Deputy Director
16 of the Philadelphia Fire Department
17 Emergency Medical Services Training
18 Institute, and I'm also American Heart
19 Association Training Center faculty for
20 the City of Philadelphia Training Center.

21 Having listened to the
22 testimony, I thought I could provide a
23 couple of points of clarification. There
24 were questions about heart attack and
25 questions about cardiac arrest, and it

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2 seems that we haven't differentiated
3 between the two.

4 When we're talking about CPR
5 and citizen CPR, we're talking about
6 addressing the issue of cardiac arrest.
7 The education component that all of these
8 agencies that here testified to is the
9 part that we can bring to allow the
10 citizens, the bystanders, the people that
11 own the first two pieces of the chain of
12 survival, to actually take the action
13 that's needed.

14 Heart attack is a different
15 issue, and there are issues connected to
16 education of the public that could
17 address understanding of what a heart
18 attack is.

19 Cardiac arrest and the issues
20 of using the AED are related to specific
21 cardiac rhythms. One of the
22 Councilmembers asked what's the
23 difference and how do you know if it's V
24 fib. The machine knows. There will not
25 be shocks delivered to somebody who has a

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2 perfusing rhythm based on the machine's
3 ability to differentiate between those
4 rhythms. So the risks in that sense are
5 very low. There's only one rhythm that
6 could be presented as a problem, and it's
7 a perfusing rhythm of ventricular
8 tachycardia, which is relatively rare.
9 The treatment for that in fact is
10 delivering energy. It's just a different
11 way of delivering it.

12 We really need to get the issue
13 to the public so that the people at home,
14 where most of the cardiac arrests occur,
15 that's where the action needs to happen,
16 and we need to take it to them. All of
17 the other pieces of the chain of survival
18 belong to us as the Fire Department,
19 early defibrillation, early advanced life
20 support.

21 The resolution, as I understand
22 it, is about taking education to the
23 people that live here so that the people
24 that live here and are visitors have a
25 greater chance to survive.

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2 The distinction is clear that
3 CPR done early is what's going to make
4 the difference. The Fire Department will
5 arrive generally within four to six
6 minutes and will bring the other pieces.
7 If we don't have those first two pieces
8 of the chain of survival, then the rest
9 of the chain doesn't exist.

10 I really have nothing else to
11 add, but I'd be willing to entertain any
12 questions if you have any.

13 COUNCILWOMAN MILLER: Officer
14 Touchstone, I guess the education has to
15 be very basic where we start from,
16 because people have to clearly understand
17 the difference between a heart attack and
18 cardiac arrest. Is that what you're
19 saying?

20 CAPTAIN TOUCHSTONE:
21 Absolutely. And they also have to be
22 educated as to the low potential of risk,
23 both liability and, as someone mentioned,
24 the issues of communicable diseases. The
25 risk to a person that's willing to act is

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2 very, very low in both of those realms.

3 You're not going to get a disease

4 generally doing CPR and you're not going

5 to be held liable for a bad outcome.

6 Essentially, by the time you're doing

7 Cardio-Pulmonary Resuscitation, the

8 person is already on the last step

9 towards death, and you can't do any harm

10 to a dead person. You can only help and

11 possibly increase their ability to

12 survive the event.

13 So the education component will

14 remove the fear and hopefully train

15 people to be comfortable to take the

16 action, because it's not hard. It's easy

17 for a person to save a life.

18 COUNCILWOMAN MILLER: Okay.

19 CAPTAIN TOUCHSTONE: Thank you

20 for the opportunity to speak.

21 COUNCILWOMAN MILLER: Thank

22 you. Thank you for coming in.

23 Come on up.

24 MR. MOONEY: My name is Mike

25 Mooney. I'm the Regional Manager of

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2 Emergency Cardiovascular Care programs
3 for the American Heart Association. I've
4 been asked just to make a point of
5 clarification.

6 We recognize that the situation
7 that has come about as a result of the
8 dismal survival rate of cardiac arrest in
9 the City has taken place over a long
10 period of time. It's a complex issue
11 that requires a complex solution. We at
12 the American Heart Association have a
13 variety of programs, as well as
14 commitment of the organization to making
15 sure that we can help address all links
16 in the chain of survival.

17 Our CPR Anytime program is the
18 most recent program. It was referred to
19 earlier, the 22-minute video-based
20 self-learning program, and we also offer
21 other classroom-type programs which are
22 what we call traditional programs, all
23 the way up through the advanced cardiac
24 and advanced pediatric life support
25 programs provided to the physicians and

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2 nurses and paramedics in the City.

3 We join our colleagues here in
4 support of a good overall addressing of
5 all the different issues that are at hand
6 here and understand that this is not a
7 simple solution.

8 COUNCILWOMAN MILLER: I really
9 think the CPR Anytime program is
10 really -- I'm sure it works, because if
11 it didn't work, you wouldn't be
12 advertising it, but it's really a good --
13 I've signed up for CPR, but then I
14 couldn't figure out where I was going to
15 carve out a half a day to go to training.
16 It sounds like the CPR Anytime program is
17 a program that can work for me and people
18 that have heavy schedules, because I've
19 always wanted to learn CPR, but I've
20 never actually taken a class. So I look
21 forward to learning more as we go along.

22 MR. MOONEY: And when you look,
23 as Ed pointed out earlier, 80 percent of
24 all cardiac arrests happen in the home.
25 And you can imagine how difficult it is

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2 for the common person to place priority
3 on this issue and carve out, as you say,
4 a half a day for training, where we can
5 actually get to them, get them the basic
6 skills of CPR and recognition necessary
7 to provide help in only 22 minutes. So
8 we agree fully.

9 COUNCILWOMAN MILLER: Okay.
10 Thank you.

11 MR. MOONEY: Thank you.

12 COUNCILWOMAN MILLER: Any other
13 questions?

14 (No response.)

15 COUNCILWOMAN MILLER: Anyone
16 else to testify on this resolution?

17 (No response.)

18 COUNCILWOMAN MILLER: Seeing
19 none, this Committee is in recess to the
20 call of the Chair. Thank you.

21 (Committee on Public Safety
22 adjourned at 2:40 p.m.)

23 - - -

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