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**Thursday 30 August 2001**

**Journal  
des débats  
(Hansard)**

**Jeudi 30 août 2001**

**Standing committee on  
justice and social policy**

**Comité permanent de la  
justice et des affaires sociales**

Portable Heart  
Defibrillator Act, 2001

Loi de 2001 sur les défibrillateurs  
cardiaques portatifs

Chair: Toby Barrett  
Clerk: Tom Prins

Président : Toby Barrett  
Greffier : Tom Prins

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**STANDING COMMITTEE ON  
JUSTICE AND SOCIAL POLICY**

**COMITÉ PERMANENT DE LA JUSTICE  
ET DES AFFAIRES SOCIALES**

Thursday 30 August 2001

Jeudi 30 août 2001

*The committee met at 0924 in the Ottawa Marriott Hotel, Ottawa.*

**PORTABLE HEART  
DEFIBRILLATOR ACT, 2001**

**LOI DE 2001 SUR LES DÉFIBRILLATEURS  
CARDIAQUES PORTATIFS**

Consideration of Bill 51, An Act to help save the lives of Ontarians who suffer from cardiac arrest by promoting the widespread availability and use of portable heart defibrillators in public places / Projet de loi 51, Loi visant à contribuer à sauver la vie des Ontariens qui souffrent d'un arrêt cardiaque en promouvant la disponibilité et l'usage généralisés de défibrillateurs cardiaques portatifs dans les lieux publics.

**The Chair (Mr Toby Barrett):** Good morning, everyone. Welcome to this regular meeting of the standing committee on justice and social policy for August 30, 2001, in Ottawa. Our agenda today is consideration of Bill 51.

**OTTAWA HEARTSAFE**

**The Chair:** Our first order of business will be to hear a deputation from Ottawa HeartSafe and I would ask representatives of that organization to approach the witness table, please. You can have a seat, sir. We have 20 minutes

**Mr Michael Dumbrell:** I won't need 20 minutes.

**The Chair:** OK. I can give you fair warning that there will be comments and questions from all three parties—

**Mr Richard Patten (Ottawa Centre):** Time permitting.

**The Chair:** Time permitting. I would ask you, sir, if you would identify yourself for the purposes of Hansard and then proceed.

**Mr Dumbrell:** First of all, thank you very much for allowing me to be here. I take a great pleasure in being here. My name is Michael Dumbrell. I'm executive director of an organization called Ottawa HeartSafe. I've got some notes prepared for you, and I'll refer to them in a minute, but I just want to give you a little bit of background. As my day job, I'm a real estate developer. I have a company called Mayfair Developments. Ottawa HeartSafe was formed on a purely volunteer basis. It was

just a need that a group of us saw needed to be met in 1978. That's how we came to be.

I'll read my notes and leave some time at the end. I'm sure there will be a few questions.

In the fall of 1998, it became apparent to me that there was virtually no defibrillation support outside of hospitals and ambulances in the city of Ottawa. As important as it was, and is, for people to be trained in CPR, which we all know, the reality of the matter is that unless a victim of cardiac arrest has their heart rhythm restored immediately after the heart attack, within seven or eight minutes or so, the victim will in fact be dead. A lot of people confuse CPR with the defibrillation act, and of course CPR is a very important first step of what they call a chain of events.

This realization that we needed defibrillation initiated a movement to have automatic external defibrillators installed in public access buildings, so with the help of some of those who will be gathered here later on today, Ottawa HeartSafe was conceived on a volunteer basis with the goal of raising money from the private and public sectors and to provide for the capital cost and staff training of 100 defibrillators. Our goal when we started off on this thing was 100. It seemed like a very lofty goal; however, 100 was a good round number and that's the number we chose. We did it, one at a time.

Like most fundraising activities, the going was very slow in the beginning. There's a lot of competition out there for the benevolent dollar. At no time, however, was it ever suggested that the idea was daft or inappropriate or somehow not something that was desirable. On the contrary, almost everyone I came into contact with knew of someone who had been affected by heart problems, whether it be a relative, close friend or acquaintance. No one needed to be convinced of the value of the program, which offered help to take on such a widespread disease.

As executive director of Ottawa HeartSafe, I received letters from public and private officials commending the work that was being done and wishing us great success. We were asked by service clubs to come and present to them. Commercial landlords requested information on behalf of themselves and other landlord organizations of which they were members. Newspaper and television reporters were anxious to break the news of this wonderful new initiative.

As more and more people became aware of this new technology, more and more interest was generated. But

inevitably the thrust abated and the act of taking the next step, for one reason or other, was set aside, usually the victim of some apparently more pressing fiscal priority. The common claim in a lot of these cases was, "We really should do this, it's a great idea, but we can't really do it this year. Maybe next year's budget will allow it." Of course, next year would come and go and still no program would have been instigated.

Ottawa HeartSafe was able to achieve a satisfactory degree of success in finding donors and placing AEDs in public facilities. We did the YMCAs in Ottawa, we did the Jewish Community Centre, and various community centres and health facilities. But the major turning point in our case came when the city of Ottawa stepped up with an initiative spearheaded by Dr Rob Cushman of the public health office, Graham Nicol and Justin Maloney of the Ottawa General Hospital, and the endorsement of certain municipal leaders in the new city of Ottawa.

At that point, Ottawa really took its place in North America as one of the leading municipalities to address this issue. The placing of some 345 units and the associated training of staff has made Ottawa one of the safest heart cities in North America and probably the world, truly a fine example, showing initiative and sound public health planning on the part of those entrusted to do such things.

#### 0930

Just getting back for a moment to the challenges we faced in the beginning, I think it's really important to stress to this group today that no one considered our work anything but worthy and a prudent step to address a considerable health threat to the general public. After all, we've all heard the statistics of an imminently aging population whose health concerns will indeed become more and more prominent as the boomers of the 1960s move into the second half of their lives en masse. But what I found was that the real challenge lay in convincing others, most notably the decision-makers with many other decisions to make, that this was an issue that needed to be dealt with immediately and not after the horse was down the lane, so to speak; not after cardiac arrest victims were lost at neighbourhood malls or golf courses or movie theatres or performing arts centres or facilities such as the one we're sitting in now. I dare say that this facility probably does not have a defibrillator or a defibrillator system and trained staff.

I routinely receive inquiries from groups who like the idea of installing the defibrillator program but for whatever reason, be it funding or lack of urgency or some other reason, simply do not take the next and critical step of actually doing it. The idea seems to get stuck at the concept stage. Everybody likes the concept but it stalls at the roll-up-your-sleeves-and-get-to-work-and-do-it stage.

The relatively small cost of purchasing and training on a defibrillator should hardly be an obstacle to going ahead. It does not represent a burden to most organizations. After all, we're talking about a cost of approximately \$6,000 for placement, including the training. By the way, when I started off in this we were paying \$7,500 per placement, but because this is starting

to take off now, deals can be made with manufacturers from whom we're purchasing these units at considerably cheaper prices, and there are good packages available for training staff.

The other issue that comes up sometimes when we're talking about this is the issue of liability. It's been raised as a concern but has also been dealt with in law by deeming the act of attempting to revive a cardiac arrest victim as an act of compassion and one which should in no way place the individual or organization attempting to help in any sort of legal vulnerability.

There has also been some concern expressed in not wanting to shock a patient who does not need to be shocked. I think some people are concerned that these defibrillators can do damage to a patient. However, the technology of the machine—and I wish I had brought mine. Usually when I come to these presentations there are about six of them in the audience, so I've stopped bringing them, but unfortunately this morning there's none. I hope you have seen them. There will be some here later on this afternoon. I know who is coming and they will bring their machines. The technology of these machines just removes any kind of critical decision by a human being from the equation. It simply will not administer a shock if the patient's vital signs do not indicate it appropriate. For those who may not be familiar with this machine, it's actually taped on to the chest beside the heart. It monitors the vital signs from there and will not issue a shock if the patient does not warrant one.

The machine virtually walks the operator through each step. It has a mechanical voice in it that dictates each step that should be taken, and which is easily taken, and it will override any possibly human error and is virtually foolproof. A child can be taught the procedure. As a matter of curiosity, children seem to master the process more quickly than adults.

So we're left to wonder how to bring about this last step in the generally accepted and apparently prudent decision-making process of whether to install PAD programs in public facilities. In my view, the proposed legislation, Bill 51, the Portable Heart Defibrillator Act, will be the agent that tips the scale in favour of the right thing to do.

Shopping centres and malls have become more than a place to purchase commodities. They are in fact gathering places for different and large sectors of society. Restaurants, theatres, golf courses, community centres, retirement homes, virtually any public-use building would benefit from having a PAD program.

I think the proposed legislation represents an idea whose time has come and demonstrates sound, prudent planning on the part of public health officials. It demonstrates leadership on the part of government in an area with proven need and acts as a beacon for bringing forth legislation that the majority of the public will at some point in their lives, either directly or indirectly, benefit from.

I hope these comments have been helpful to you and of some contribution. Once again, thank you for the opportunity to appear here today.

**The Chair:** Thank you, Mr Dumbrell. This committee did have a demonstration of one of the machines yesterday by the Ministry of Health. I would now ask for questions and comments. We have about two minutes for each party, beginning with the Liberals.

**Mr Mike Colle (Eglinton-Lawrence):** I want to thank you, Michael, for being here, because I was trying to find out essentially why some cities in Canada, like Ottawa, seem to be basically light years ahead. I know Ottawa has about 300 in operation. Toronto has a population of 2.6 million and we've got about 30 or 40. Windsor seems to be the other place. I was desperately trying to find out why Ottawa got going, and I think I found a few of the key players.

I want to congratulate you and HeartSafe for putting in your volunteer time to get the program going here in Ottawa and inspiring the program. Again, on behalf of people who are interested in this initiative, I certainly congratulate volunteers like you for doing this.

You are in commercial real estate, the development business. I guess what we're trying to get at is, what would be the benefit if I'm a landlord—we had someone who had sold the program to the Cadillac Fairview in Toronto—of a shopping mall or a public facility? A golf course may be more obvious, but what would be the benefit of their purchasing or supporting such a program initiative?

**Mr Dumbrell:** These large landlords pride themselves on prudent property management principles. I think the same as they would provide a fire retardant system or the latest in technology in terms of providing smart buildings for people to adapt their computers and Internet use and everything we hear about, the same principle applies here. In fact, in this particular case in building management, especially in the case of office buildings and shopping centres where we have a large concentration of senior citizens, it's very prudent, very timely, very appropriate to have one of these machines and training of security people to be able to react quickly to an incident.

To answer your question directly, I think it's prudence on the part of the landlord.

**Mr Colle:** I just have one more quick question. In terms of getting over the hump, you mentioned here the major turning point in Ottawa, because you had been talking about it. What happened to turn it around?

**Mr Dumbrell:** The horse down the lane is a good scenario to use here. Everyone thinks it's a great idea. There's no one who has said, "Dumbrell, you're crazy. You shouldn't be doing this. You're wasting your time." Everybody said, "That's a great idea. My dad passed away. I wish we would have had one." I get donations from people who have lost relatives, well-known developers, well-known wealthy organizations. It just seems like it's the right thing to do.

The legislation doesn't have the feel that we're ramming anything down anybody's throat. It feels like it's the right thing to do and, "Yeah, OK. Now we need to do it." In my opinion that's probably going to be the reaction from the people who are asked to do this and to

fall into line with this thing. As I say, no one thinks it's a bad idea.

But it's not something that's pressing; it's not an urgent need. There's always something. There's a plumbing issue or a hole in the roof or some other issue that was more pressing that got the money, and, "OK, we'll do that next."

Golf courses is a great example. We have guys 50, 60, 70 years of age, and it's a \$6,000 item. These guys each pay three times that much for initiation on these courses. They are always asking me, "How much can I buy one of these things for?" But they just don't take that last step. I think this will just be a beacon for them. They'll say, "Yes, let's just do it."

**0940**

**Mr Peter Kormos (Niagara Centre):** What is it about the bill that you find attractive? Clearly, the city of Ottawa has this program, the city of Windsor—I don't know what other communities; those are the two we've heard about. In the private sector, the Eaton Centre—Cadillac Fairview uses these. So what about the bill do you find attractive? It's obviously not a liability issue, right? There's no liability issue. What does the bill do?

**Mr Dumbrell:** I went into the Web site and downloaded it. What I like about it, as I said before—I keep using the example—is it's a beacon. I think it shows the way for some people who may not have addressed this issue. It may not have been a priority with them, so they just haven't become aware it is an important issue.

**Mr Kormos:** OK. You've got your golf club with the \$18,000 entry fee. I come from small-town Ontario. I've got little Ukrainian halls and Croatian halls and those sorts of groups. You get into the Moose Lodge for 50 bucks, I think. They can't afford this equipment. These people are struggling. Property tax increases nailed them big-time. They tend to be elderly. They're cooking perogies there till 3 in the morning just to make a couple of bucks on a Friday.

Should the government be sponsoring a program where organizations like the Ukrainian Cultural Centre in Welland, which hosts huge public events and is of great value to the community—should we taxpayers be providing this machinery if those halls are non-profit and don't have the resources your golf club has?

**Mr Dumbrell:** I'll just go back to my point about prudent management of any kind of public facility where you have those groups of people. I think it's prudent management, the same as you have a fire retardant system, any type of system that accommodates people. I think anyone can justify that system.

**Mr Kormos:** Should funding be available to these organizations that don't have the resources to pay for it out of pocket? They're retirees, poor Ukrainian retirees whose pensions are dwindling under the pressures of—you know the kind of folks I'm talking about.

**Mr Dumbrell:** Absolutely, I do, and I think you have raised a good point. I don't feel qualified—

**Mr Kormos:** Old ladies with arthritic fingers, making perogies till 4 in the morning—

**Mr Dumbrell:** I take your point; however, I don't feel qualified to comment. If you're asking my personal opinion as a taxpayer, I think they'd certainly get my taxes.

**Mr Kormos:** All right. Good. Thank you.

**The Chair:** I'll go to Mr Beaubien.

**Mr Marcel Beaubien (Lambton-Kent-Middlesex):** I'll split my time with Mr Guzzo.

**Mr Garry J. Guzzo (Ottawa West-Nepean):** I just want to say that as someone who has been involved in the development industry in Ottawa over the years, it's interesting to see some of the charitable work that goes on and the leaders from that industry taking the lead. It flies in the face of some of the criticism you've had to take over the years, and I commend you for it. I just want to explain to Mr Colle that I thought he would have recognized the answer to why Ottawa is so far ahead in so many fields. This, again, is related to the St Pat's mafia. I'd have thought you would remember that, having gone to that great institute of higher learning.

The other thing is, I would just correct a few things for Mr Kormos, I think, because I do have occasion to visit Welland and I drive through Thorold to go to a course called Lookout. What does it cost to join Lookout? Oh—

**Mr Kormos:** You won't see any old Ukrainian ladies playing golf at Lookout.

**Mr Guzzo:** And those perogies are very tasty, but we don't have anything in Ottawa to compare to Lookout. I just want you to know that.

**Mr Beaubien:** Just one quick question. You mentioned that in your opinion there is no liability exposure. I have to disagree with you on that. If you look at the bill, and you are a developer, under section 2 it says, "Privately owned buildings to which the public has general access." I would ask you as a developer how you feel about it, and I would also ask you to discuss it with your insurance broker, when you look at the liability wording, as to whether there would be any liability exposure.

**Mr Dumbrell:** I too had a concern at the beginning. When I started, I was concerned about liability, and that was one of the first questions I asked. This program operates under the auspices of various doctors who take it under their wing, so to speak, to operate under their insurance policy. In this particular case, Ottawa Heart-Safe, to use an example, operates under the auspices of Dr Justin Maloney, and the insurance policies that cover the doctor extend to people he includes in this particular program. I can safely assume that same type of arrangement can be made for any building that would incorporate this PAD program.

**The Chair:** Thank you, Mr Dumbrell. We appreciate that report.

**Mr Dumbrell:** My pleasure, gentlemen. Thank you very much.

**The Chair:** The representative of the next delegation, the Lifesaving Society, is feeling under the weather and will not be attending. However, the Canadian Red Cross

is here, and I think they are amenable to coming forward a little early.

**Mr Kormos:** Chair, while they're coming forward—this whole issue about liability—and I appreciate the issue and concern. My dilemma, and this is what I put to research, is that clearly there are 100 units out here in Ottawa in private places, among other things, and similarly in Windsor, in both private and certain public places, and the liability issue didn't rear its head in those two conversations. Yet I appreciate there is some concern. I wonder—and I don't know what direction; that's why research is research. Could they perhaps do some investigation into what in fact is going on, how the insurers of these properties in Ottawa or Windsor have responded to the presence of these machines in there, just to clear it up, because it is a murky area. I'd appreciate that.

**The Chair:** Thanks, Mr Kormos.

#### CANADIAN RED CROSS

**The Chair:** Good morning. Welcome to our committee. You have 20 minutes. We ask you to identify yourself for purposes of the Hansard record.

**Ms Tracey Braun:** My name is Tracey Braun. I'm proud to be able to be here to speak on behalf of the Canadian Red Cross to tell you how highly supportive we are of Bill 51, the Portable Heart Defibrillator Act. We believe it's a critical step in improving the survival rate of people in Ontario who suffer cardiac arrests.

I'm here today representing the Canadian Red Cross, but I am not a doctor, a medical professional, nor a researcher. In my past, I have worked with the ambulance. My role is that I am a Red Cross first aid and AED instructor. For close to 20 years, I have had the pleasure of teaching other people how to save lives. Over the course of my teaching career, I have seen great advances in the research and theory behind basic life support and vast improvements in instructional techniques and teaching materials. I have also seen the Canadian Red Cross and other national training agencies remove significant barriers to access and place valuable life-saving training where it is needed most: in the hands of ordinary people. The results of these efforts have been more people trained to react in the case of cardiovascular emergencies and more lives saved.

If we think back, not long ago if you were to suffer a cardiac arrest, a heart attack, outside a hospital environment, your chances of survival were slim. It wasn't until 1960 that medical researchers discovered that chest compressions helped circulate blood through a person's body when the heart had stopped. This idea, believe it or not, led to a radical new procedure, CPR: C for cardio, the heart; P for pulmonary, the lungs; and R for resuscitation, which literally translates "to give back life."

For some time, this awesome power to restore life was restricted to the medical community. Then, in the mid-70s, the American Heart Association and the Canadian Heart Association, now known as the Heart and Stroke

Foundation of Canada, recommended that CPR training be extended to the general public.

At the time, in spite of dire warnings—I don't know if you remember the newspaper articles of the time but there were dire warnings that this "highly advanced medical skill" in the hands of lay people would create unbelievable havoc. But CPR soon became commonplace, and ordinary people started saving lives.

When I first became a CPR instructor in 1982, people were shocked at the idea of a high school student teaching CPR. I was only 17. At the time, almost all CPR instructors were from the medical field. They were doctors, nurses or ambulance attendants, wondering what right I had to be there. Today, Red Cross first aid and CPR instructors come from all walks of life, including university students, computer specialists, accountants and young mothers.

**0950**

The Canadian Red Cross has over 50 years of experience in teaching first aid to Canadians.

We agree with the Heart and Stroke Foundation that the key to improving the health of Canadians lies within the strength and application of each link of the chain of survival. I'm sure you've gone through that. I think the Heart and Stroke presented that yesterday in Toronto. If any link is weak or missing, the chance of survival is lessened. Recognizing that first aid and CPR are not separate ideas but are both part of the chain of survival, the Canadian Red Cross incorporated CPR into all of our first aid programs at all levels in 1994.

In 1997, the Canadian Red Cross developed the first national training program for public access to defibrillation in order to address the defibrillation link in the chain of survival. We believe that early access to defibrillation is the single most important factor in life or death, increasing the chances of survival of someone suffering a cardiac arrest.

In January 2001, the Canadian Red Cross released the second edition of our first aid program, the Vital Link. In addition to the first aid and CPR content, all of our first aid and CPR courses—all—now include information on how an AED works. This new addition to our program follows one of the major recommendations of the new ECC-CPR International Guidelines released in the fall of 2000.

With the introduction of Bill 51, we now have the opportunity to strengthen the chain of survival even further in Ontario by placing lifesaving AEDs into the hands of ordinary people who can use them and save even more lives. We believe that AEDs should be readily accessible and available where they can do the most good.

I won't bother to go through this next section because I believe yesterday you heard about Casino Windsor, so I'll leave that information. The key point when we're talking about Casino Windsor is decreasing the time. Decreasing the time appears to be the most cost-effective when applied by a public access program. Let's face it,

when we're talking about government, we're talking about cost-effective.

Adding more professional responders to an existing emergency medical system to decrease the collapse-to-first-shock time is economically unattractive. Ensuring easy access to AEDs will be the essence to the success of Bill 51.

Chicago's O'Hare Airport, which I believe you heard about yesterday too, so we won't go into details on that, is a classic example of true public access, and that's what we need to talk about. When we talk about public access, their AED machines are not tucked behind counters or out of sight of the general public, as were Casino Windsor's—their machines were provided by a trained group of rescuers. Rather, at O'Hare, they are mounted on the wall in full view of public access. They have approximately 35 machines throughout their terminals. No matter what direction you walk in a terminal in Chicago, an AED is no further than one minute away. Members of the public can access, and have accessed, the AEDs to save lives. I believe it was Memorial Day of 1999 when there had been five collapses, five saves, and four of the people had not used an AED before.

As another example, Kimberley MacMillan, an authorized provider of the Red Cross, was on duty at Canada Day in London this year as the event's first aid provider. She was accompanied by one of her employees, Cheryl Murray, who is also a trained first aid instructor with the Red Cross. They received an urgent call, and found a man slumped over in his van, barely breathing. They removed him from his van and discovered that his pulse had stopped. Luckily at that time, a fellow came along, Frank Cornelius, who happened to be a first responder for Oneida First Nations. Frank started CPR and shortly after that they attached the automated external defibrillator. The first reading that registered on the AED advised the responders to shock the victim. Immediately after the first shock was delivered, the man's cardiac rhythm and breathing resumed. Using the AED, MacMillan continued to monitor the casualty and no more shocks were required. Emergency Medical Services arrived within minutes to transport the patient to hospital. From the time of the first shock and subsequent restoration of his heart function, the patient maintained a near-normal heart rate and did not suffer further cardiac arrest.

Imagine all of the lives that could be saved if people were trained to use AEDs just like many of us are trained to perform CPR.

We recognize that AEDs are not without risk. Effective guidelines for maintenance, training and support are required. However, these guidelines should not be restrictive but should support the principle of easy access to defibrillation.

An AED is safe to use by anyone who is trained to operate it. Studies have shown the devices to be 90% effective—in other words, able 90% of the time to detect a rhythm that should be defibrillated—and 99% effective to recommend not shocking when defibrillation is not

indicated, far higher than what people can do with CPR and their effectiveness in determining a pulse. Because of the wide variety of situations in which it will typically be used, the AED is designed with multiple safeguards and warnings before the energy is released.

Minimal training is required for the AED. I believe you heard about the study in Seattle where they trained the grade 6 students, so I won't go into that either. Let's face it, we all know that grade 6ers can do VCRs and we still can't.

It's easy to learn how to use an AED, and Bill 51 will contribute to accessibility. However, one barrier to the full potential of AEDs remains: AED is still a medically delegated act in most provinces in Canada, including Ontario. Before using an AED, you need to find a doctor who will license you under his or her licence. Let's not forget that CPR was once also a medically delegated act. Like CPR, AED is an easy, teachable skill, and can be put in the hands of the people who can do the most good with it: again, the members of the community.

The Red Cross is a member of the Emergency Cardiac Care Coalition of Canada, along with Heart and Stroke, St John Ambulance and Lifesaving, who also provide AED programs. We are all well positioned to promote public access to AED. All national training agencies and members of the ECC provide CPR training in an effort to minimize death and disability due to cardiovascular disease. ECC has established medically sound treatment protocols that are accepted as the standard of care that bystanders, paramedics, nurses and physicians follow. Training at the bystander level is simple and the Canadian Red Cross, as well as other ECC members, have developed and are currently training bystanders in the use of AEDs following these accepted guidelines. I have brought examples of our training material.

The Canadian Red Cross looks forward to working with the Ministry of Health and Long-Term Care and other stakeholders to develop what is the most effective intervention in the chain of survival: public access defibrillation.

CPR has become so commonplace we don't hear about the tragedy of someone performing CPR and the patient not surviving because the compressions cannot replace an electric shock. Imagine what could happen if AEDs were available throughout the community.

Over the years, the Canadian Red Cross has helped to train millions of Canadians in CPR. Our efforts, along with those of the other national, provincial and local agencies, have ensured that ordinary people across the country have the knowledge and skills to save lives. We believe that Bill 51 is a significant step forward in our ongoing efforts to improve the health of Canadians and strengthen the chain of survival. Thank you.

**The Chair:** We have one or two minutes for each party for any questions or comments.

**Mr Kormos:** You are saying that AED utilization requires a licence, a medical doctor's supervision. What is going on with the 100 defibrillation units in Ottawa and almost as many, if not as many, in Windsor?

**Ms Braun:** They are presently licensed under a doctor.

**Mr Kormos:** Is that the base hospital licensing?

**Ms Braun:** Or the training agency. At the Red Cross we have our own doctor who provides licensing. Depending on who you train with, different organizations have their own doctors who provide licensing.

**Mr Kormos:** That means that unless I'm trained and authorized by somebody, I can't administer one of these defibrillation machines to, let's say, Mr Patten or Mr Colle or Ms Molinari.

**Ms Braun:** That's correct. That's why one of the things that needs to be looked at and that we'd like the committee to look at is the deregulation of AEDs, similar to what Alberta has done.

**Mr Kormos:** We saw a demonstration of the machine. I'm from a Bill 8 community too. I hope those machines are bilingual, because they would have to be.

**Mr Patten:** Ukrainian and English.

**Mr Kormos:** No, seriously, multilingual. You've got ethnic areas in Toronto, for instance, where the predominant language is any number of languages. But I'm assuming the machines can do that, which would be an interesting thing. Are you proposing that anybody should be able to use it, even if they haven't been trained? We've had the whole spectrum covered. Some people say, "No, there should be training," and then high standards of training or lower standards, and then some people say no. If push comes to shove, if I'm lying there with my fibrillation, I don't care. Let's face it, the downside is minimal, it appears, right?

**Ms Braun:** Correct.

**Mr Kormos:** Otherwise, I'm going to be dead. So are you suggesting it should be wide open? Because it's a self-taught process, the explanatory process, the arrows and the circles and the diagrams, are you saying anybody should be able to use it? I'm not challenging you to say that, but I—

**Ms Braun:** There should be some training provided. What level of training is in question. At Chicago's O'Hare airport, their level of training is that every hour there is a 45-second video clip on what an AED is, similar to a public PSA that could be run on TV. Do we suggest that there's some training? Yes, there should be some level of training, but what level is still to be determined.

**Mr Kormos:** Nobody has to watch that video, right?

**Ms Braun:** Right.

**Mr Kormos:** I hear what you're saying. So there should be some chart or diagram, but you're not saying that somebody should have to be four-hour trained before they have any right to administer that defibrillation shock.

**1000**

**Ms Braun:** We do suggest that people go through a training course, yes.

**Mr Kormos:** You wouldn't agree with the O'Hare model, which has a videotape?



**Ms Braun:** Personally, I think the O'Hare model is great, but—

**Mr Kormos:** Then why aren't you advocating it?

**Ms Braun:** —are we ready for that in Canada yet? It's a new program in Canada, and we're looking at it being more widespread than in one contained building.

**Mr Beaubien:** I agree with you. As the previous presenter stated, everybody likes the concept. I think it's very difficult to talk against the concept. But I'm glad to see that we're starting to dwell on the liability issue, because if you recall yesterday, we had a plethora of training, no training, or anybody can use these paddles.

**Mr Kormos:** I'm a lawyer. I like liability.

**Mr Beaubien:** That's right, I know. We'd really give you a lot of business.

This is what I was trying to convey yesterday, that nobody has come up with a plan as to what level of training or what kind of training. Yesterday we heard presenters saying anybody can give this, from grade 6 to anybody.

**Mr Braun:** My four-year-old daughter did it—

**Mr Beaubien:** That's right. Yet I also heard yesterday that even though the machine is fairly foolproof, if you have a radio transmitter within six feet of the equipment, it can play havoc with the equipment.

**Ms Braun:** That's hasn't been completely shown—

**Mr Beaubien:** The evidence was given to us yesterday at least. Consequently, I'm glad to see that we're dwelling on this, and I'm glad, Mr Kormos, that you requested that legislative research give us a report on this.

**Ms Braun:** If I can just bring up a point, when CPR first came out, there was the whole question of liability as well, and there were the risk factors involved with CPR. That was dealt with mostly across Canada by a Good Samaritan Act, and Ontario has just regulated one. The idea of the Good Samaritan Act was to take the liability away from the people who were trying to save lives.

**Mr Colle:** I just have a couple of comments. I think you've hit the proverbial nail on the head. It was the same sort of people back in the 1960s, with their heads in the sand, who had these dire warnings, "If you apply CPR, you're going to break people's rib cages; you're going to get infected. Don't use CPR; it should only be a doctor." I'm sure it's the same people in the Ministry of Health saying all these negative things about defibrillator programs. They were saying the same things then because they basically don't want to accept change. They're going to be the last ones, kicking and screaming, and they're going to have 100 excuses. Meanwhile, your experience as a trainer is that this is critical to saving a life.

**Ms Braun:** It is the most critical step in the chain of survival.

**Mr Colle:** If it's most critical, what do you think we have to do to basically get the old head-in-the-sand types to get over their fixation that this should only be done by doctors?

**Ms Braun:** I think it's to look at the models that are already out there and how effective they've become and look at the difference in the survival rate. When it comes down to the dollar—and I think Mr Kormos brought that up—what about these small communities that can't afford this? Then I ask, when the ambulance arrives eight minutes later, or 10 or 12 minutes later, and brings this person back but not in the state that an original shock in the first minute would have done, how much does it cost per day for the person to be hospitalized and under medical care when you look at months of rehabilitation, compared to the person who could walk out of the hospital three days later?

**The Chair:** Thank you, Ms Braun.

#### AED MEDICAL-SAFETY CORP

**The Chair:** Our next delegation, AED Medical corporation, has agreed to come forward. We're a few minutes early, which is good. Come forward and have a chair, sir. It's good to see you here. Just give us your name, please, for the Hansard recording.

**Mr Greg Birtch:** Greg Birtch from AED Medical. I'm going to be quite short with all this because I think yesterday you guys and ladies were in Toronto and heard everyone talking about somewhat the same thing, that these devices definitely do save lives and it's a great idea. What I wanted to bring forward was the fact that acquisition is a small part of this whole program. It's one small piece of the pie. There's ongoing training, ongoing maintenance with these devices.

I guess what I want to say, which I'm sure everyone is aware of, is that the acquisition is probably the easiest part of these programs. There's continual training. The city of Toronto is looking at doing training every 90 days as part of their program, and it becomes a logistical nightmare. Pad replacement every two years; where those devices actually are when you get into large numbers. If there's a recall on any of these devices, how do you track all of this? What I just wanted to bring forward was the fact that the acquisition is probably the easiest part; it's the ongoing training and the costs associated with that.

It's fairly short but I'm sure that you guys are aware of that, and that's what I just wanted to bring forward.

**The Chair:** Thank you, Mr Birtch. We have members of all three parties here and this gives us a fair bit of time for comments or questions, if anyone needs the time.

**Mrs Tina R. Molinari (Thornhill):** Thank you very much for coming this morning and thanks for leaving us a considerable amount of time to get into some discussion. Now, I'm not familiar AED Medical corporation. Could you just tell me a little bit about it?

**Mr Birtch:** We provide on-line training for different medical products or medical devices and just basically track individual students. So people can provide on-line learning. Particularly with this, what we do is deliver about 75% of the content on-line. What we're hoping is to get rid of that traditional style of training to try to keep up with where the students actually are. In sitting and

dealing with the city of Toronto at this point, what we have found and what tends to be a problem with a lot of these programs is tracking students. They're fairly transient. Whether it's security guards that are being trained or whoever, it's fairly transient employment. The way that jobs are right now, people coming in and out of business or losing their jobs, you have no idea where half of these people are.

Basically what we do is provide hospitals or manufacturers with on-line training for their medical devices and deliver as much content as possible up front, and there's still a practical application to the delivery of the training. What it does is free up work time so people can train at home on their own, rather than sitting in a classroom—you know, if a meeting is coming up, there's a loss of productivity. It's just an alternative way to provide training.

**Mrs Molinari:** You mentioned in your presentation that the acquisition of the defibrillators is an easy—

**Mr Birtch:** Is probably the easiest part of the whole implementation, buying these. There are about four manufacturers out there right now that pretty much all do the same and they'll sell you on each one of their own benefits. But I think the true pain comes in in the true implementation of these devices. It's not an easy program to deliver. In fact, if you took the room here, for instance, people would have meetings the day of the scheduled training. Maybe someone does not have this position in six months, or where are those people in six months?

I don't want to get into costs, but pad replacement every couple of years because the pads expire every two years; batteries expire usually in five years. So the whole tracking method of all of these, to know exactly where the devices are, becomes an issue.

**Mrs Molinari:** In our discussions yesterday with presenters, one of the concerns that I kept raising was that as much as this is a good thing and it will save lives, and we all acknowledge that, I think there is also the other component: if used improperly, are there dangers to someone using it? Because a machine is a machine, but you need an individual to push that button.

**Mr Birtch:** Right.

**Mrs Molinari:** What we heard yesterday from a number of presenters was that it's absolutely safe and there is no way that anything can go wrong with it, but I have a lot of concerns around those types of comments. You being involved in training, can you talk a little bit about the importance of having a trained individual? We don't have necessarily any fatalities on this issue. It's because up until now—

**Mr Birtch:** There have been people trained, right.

**Mrs Molinari:** —there have been people trained to use it, so it's understandable that it would be used in the proper way. What would happen with someone who's not trained to be able to use it? What would some of the risks be to an individual using it?

**Mr Birtch:** As far as I know about all the machines, you can't shock somebody who doesn't need to be shocked. If somebody was to put it on somebody who

had a heart rate, it's not going to shock them; it's only going to shock them if—

**Mrs Molinari:** What about the pulse? I'm confused about the whole issue and I'm trying to understand this, because this is all new to me.

**Mr Birtch:** There's a couple of rhythms that the device will shock in, which I'm sure you heard yesterday. I don't know what you heard yesterday but—

**Mrs Molinari:** But the pulse is the one that I'm still concerned—

**Mr Birtch:** You won't have a pulse, and the device will pick the shockable rhythm up. So you're counting on basically a \$6,000 medical device and your technology that's built into that to detect that as well. If somebody actually tries to find a pulse and they don't find a pulse, they should hook the device up and the machine will then decide whether or not it's a shockable rhythm.

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**Mrs Molinari:** But are there different periods of time when even a machine wouldn't be able to pick up the pulse; it would need to be the individual who would need to be able to pick up a pulse?

**Mr Birtch:** No, not according any of the manufacturers.

**Mr Patten:** I'll go along the same lines as the previous member was talking. Your company is in the business of training.

**Mr Birtch:** Right.

**Mr Patten:** I don't know if it's my authority complex, but I always find established organizations, especially the medical profession, are very reluctant to pass over things that historically, after the fact, people just kind of laugh at. They say, "This is a bit of a joke."

**Mr Birtch:** Right.

**Mr Patten:** Of course—and I throw this out somewhat in an advocacy way to you—the training for this seems to me, just this component—

**Mr Birtch:** Just the training component?

**Mr Patten:** —just the training component, is pretty straightforward. So the question is, you've got to have some training rather than no training, because there are three risks or four risks or whatever they are. It seems to me, on one poster beside where this machine is, if somebody can read—and it can be done in three or four languages or whatever it is. Follow this first step, the worry about other electrical or electronic devices that may interfere. Well, fine, that can be an instruction: anybody with a cell phone or whatever it is, vacate the area. The instructions, diagrams, visuals and the machine itself—we've heard testimony that some children, as a matter of fact—

**Mr Birtch:** Sure, they've done studies with grade 6 kids. They can put them on as quick as—

**Mr Patten:** So I would ask you, what would be your ideal, in spite of having an investment in training, and I respect that—

**Mr Birtch:** Right, and I understand the question, just for that reason. Typically, the training could be as little as, I think someone mentioned, the O'Hare model. They

play a video every hour and if you can speak English or, depending on—you know, I guess here in Ottawa we're sort of different from probably anywhere else in the world because of the bilingual issue. To date, most of these devices are in one language. So whether it's Mandarin Chinese or English or French, if somebody turns the device on and follows the instructions, they should be able to use this device.

This is an issue that comes up all the time. Heart and Stoke, which tends to be the governing body with a lot of this or sets the standards at least for a lot of medical devices have guidelines. Their idea is four hours' worth of training. Do you need to know what an SA node is in a heart if there's a security guard? Not really, but maybe somebody, if they're using them then in the hospital, like nurses—they're not being used in hospitals now. So it's a flip-flop issue for sure. Is 10 minutes' worth of training fine? Yes, for some people it probably could be. It comes down to that issue of, how much knowledge does somebody really need to use the device?

**Mr Colle:** Just a question, Greg: do you think it's more difficult to train people with AED use or with CPR?

**Mr Birtch:** CPR is probably more difficult.

**Mr Colle:** Please emphasize that, because people think that this is all of a sudden so dangerous and complicated, and meanwhile CPR, relatively speaking, is extremely—and this is why the old head-in-the-sand people said, "Don't use CPR." Now here's something that's easier and it's smarter. You're talking about pulse rate; this will detect that pulse rate.

**Mr Birtch:** Right. You're basically putting your trust in the technology that's been built around all of this.

**Mr Colle:** Could you just explain the difficulty with pulse rates and finding them?

**Mr Birtch:** Even professionals have a hard time. I was a professional firefighter for 17 years and sometimes it's difficult to find a pulse. If you don't, you then put the device on. The technology is there to—

**Mr Colle:** I just challenge all the members of this committee, try to find your pulse rate.

**Mr Beaubien:** I check it every morning.

**Mr Colle:** I sometimes wonder.

You mentioned that this is part of the chain of training. I think what you're offering here is something that really helps the private sector or the public sector, whatever it is, because you can do this training on-line.

**Mr Birtch:** It's just an alternative way to provide training if people did want to—and I think, again, the implementation is great and I don't think you'll have anyone in the room deny that these devices are going to save lives, but there are the issues of the implementation of these programs.

**Mr Colle:** But you have that ongoing monitoring program—

**Mr Birtch:** Just to find out where the devices actually are—we were in New York City last week with the people there who have purchased a thousand of these devices, and they don't know where to begin. Who's

going to be trained? First of all, how do you possibly train 20,000 people to use these? Do you just set them loose? My concern is to make everyone aware of the implementation of these devices. The acquisition will be the easiest thing you do on these. It's a difficulty—

**Mr Colle:** And then you put it in line with the people who are already trained on CPR and other first aid things.

**Mr Birtch:** That's the guideline usually. I'm sure most of the training agencies combine the two. Level A—basic CPR or adult CPR—and the device go hand in hand.

**Mr Colle:** Yes, because you're not just training people on this device. Usually the people who are being trained are being trained in all—

**Mr Birtch:** They should know CPR to go along with this device. Basically what CPR does is prolong the chance of somebody being defibrillated.

**Mr Colle:** Those training programs are already going on for people who are in first aid, so this would be part of that chain of training.

**Mr Birtch:** Right. It becomes that whole chain of survival. It has been added in as one of the heart-stroke links in their chain of survival.

**Mr Kormos:** I put it to you that the vast majority of Ontarians have very little, if any, first aid training.

**Mr Birtch:** Correct, or they forget it. I think it's proven that in three weeks they forget it.

**Mr Kormos:** As young people in any number of organizations, be it Air Cadets, Boy Scouts, Girl Guides, that sort of thing; perhaps in the workplace through any number of initiatives, depending upon what your job is; obviously if you're a security guard, police officer, firefighter, paramedic.

**Mr Birtch:** Right.

**Mr Kormos:** And you're in the training business. I was just reading about the paucity of CPR familiarity in the province or in Canada. One of the concerns has been who should be able to access these machines. We've heard everything from one end to the other, as you heard before, some people saying that even I, with my limited skills—

**Mr Birtch:** Bottom line: if someone is not defibrillated, they're going to die, so—

**Mr Kormos:** —could apply that machine, with no training whatsoever. Others are arguing we have to have some minimal level of certifiable training right across the spectrum. Where do you stand on that? Should the law be that even the most inept person—myself—would be able to apply that machine to somebody in a shopping plaza?

**Mr Birtch:** I think time will tell on all that, because if you do—no one has turned this over to that extent in any of the PAD programs that are out there. I don't think anyone has just gone, "These things on a wall: feel free to use it."

**Mr Kormos:** The bill as it stands now says that.

**Mr Birtch:** Right.

**Mr Kormos:** And that's consistent with some of the stuff we've heard, that a complete novice can read the charts and follow—

**Mr Birtch:** Absolutely. If somebody can read or speak English or French—that's what I said earlier—and understands it, are they going to do any more harm than already has been done? Probably not, and I'm not a medical professional that way.

**Mr Kormos:** So what are you saying? Are you supporting that position?

**Mr Birtch:** I think there should be some form of learning. That goes with a PalmPilot or anything else like that.

**Mr Kormos:** Mr Birtch, for whatever reason I've had no interest in learning anything about this machine that's on the Seaway Mall wall in Welland. I'm in the Seaway Mall going to the bank, paying down my credit cards. Somebody I don't know collapses there. I think, "Yikes, there's the machine." Should I be able to use that machine?

**Mr Birtch:** Sure.

**Mr Kormos:** OK, that's fair enough.

*Interjection.*

**Mr Kormos:** Well, I don't know. That's a different scenario, right? I do my incompetent best, like I do on a daily basis with so many things.

**The Chair:** We wish to thank you, Mr Birtch.

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#### CHRISTIAN VAILLANCOURT

**The Chair:** I wish to call forward Christian Vaillancourt. Have a chair, sir. As a presentation by an individual, you have 10 minutes.

**Dr Christian Vaillancourt:** Good morning and thank you for inviting me to speak at the hearings this morning.

I'm actually Dr Vaillancourt. I'm a specialist in emergency medicine. I'm also a clinical researcher. I have access to a database of information on cardiac arrest on more than 9,000 cases across 21 communities in Ontario over the past five years. I'm here today to try to share some of that knowledge with you.

With regard to Bill 51, current survival of cardiac arrest in Ontario is approximately 5%. Out of 100 persons who collapse, less than five will actually be discharged from the hospital alive. Defibrillators are great machines. Basically they are great at saving lives, and that's why we equip most of the ambulances, firefighters and some police cars with them. We also know that, as was mentioned, the earlier the defibrillation occurs, the more chance we have to actually save lives. So the thought process behind Bill 51, I assume, is that if citizens would have access to those machines, defibrillation could be achieved faster and more lives could be saved.

A recent study nicknamed the "casino trial" is actually one of the largest trials that have been ongoing. You've probably heard about it. It was done in Arizona, where they trained security personnel to deliver and use those machines, basically non-medical personnel, and they did so in about 100 cases. They had great success both in using the devices and in saving more lives. So I'm not

one of those doctors who would basically preclude anybody from the population from using the devices. I think that if they could, it would be great.

Having said that, we have to understand the process a little bit more and whether or not this could be reproduced at the community level. One of the authors of the casino trial, for instance, has some training in health economics and performed an economic analysis of the cost of caring for cardiac arrest patients. I don't want to mention costs here in the matter of saving lives, but it is a concern when we have to deal with public bills. No matter what the outcome is, basically whether a person dies or not, the current cost of caring for a patient with cardiac arrest is approximately \$6,000. If we implemented a public access defibrillation program, he estimated that the cost per life, per person, could be increased to up to \$50,000. That's including material, training—I'm not the health economist, but that's an estimation he came up with.

That paper was published in *Circulation*, the previous one, and in the *New England Journal of Medicine*. They are both really highly respected journals.

Furthermore, although the results of the casino trial were promising, we lack information on the potential impact of a public access defibrillation program at the community level, as I mentioned before.

Having said that, there is currently an international study taking place in 24 communities across North America. This is called the PAD trial, and this should be able to tell us the impact of such a program on the community. Why don't we just wait for the results?

The greatest impediment to a public access defibrillation program comes from the fact that most cardiac arrests do not occur in public places. We looked at almost 1,400 cases of cardiac arrest in the region of Ottawa over a five-year period. Basically, our findings were that 85% of cardiac arrests occur in private homes, 10% on the street, and less than 5% of them in large public places. Again, there is a larger study currently underway in which I am involved looking for the same information in 21 communities across Ontario.

In addition, those people suffering from cardiac arrest in public places are not all going to be helped by defibrillators. In order for the machines to be helpful, we need at least some kind of electrical activity going on with the heart. You need fibrillation; you need ventricular tachycardia. From the database we have of cardiac arrests in Ontario, almost two thirds of cardiac arrest cases were in asystole. Basically, they had a flat line on the cardiac monitor when we applied the cardiac monitor. Those patients will not be helped by defibrillation, by the delivery of an electrical shock, and they will not be helped by a public access defibrillation program. Therefore, we estimate that potentially less than 3% of all cardiac arrest cases in Ontario could benefit from a public access defibrillation program, and we think such an endeavour may not produce the impact on survival that we expect out of it at this point.

On the other hand, I asked the Heart and Stroke Foundation about six years ago what percentage of the

Canadian population knew how to perform basic life support, the CPR that we've been talking about so far. The answer to that was less than 3%. I asked again recently, six years later, hoping that things would have changed, and it's still 3%. Once again, we know from our database that nine times out of 10, precisely 8.5 times out of 10, when the emergency services arrive at the scene of a cardiac arrest, nobody has been doing anything. They had their hands crossed waiting for them to arrive. Yet we know that people who receive CPR are three times more likely to survive their cardiac arrest than the ones who don't.

One of my colleagues developed an accurate mathematical model looking at what could be the survival rate of cardiac arrest if in at least 50% of the time, half the time, someone performed CPR before the emergency services arrived. If that was the case, survival of cardiac arrest could improve from the current 5% to over 30%. We have to keep in mind that the success of such an intervention would basically be applied to all cases of cardiac arrest, not only the few that occur in public places.

We also know that cities like, for instance, Seattle/King County and Singapore have been successful in implementing such a community-based CPR program that resulted in increased survival of cardiac arrest.

I am also currently involved in a study looking at developing an intervention best suited for the Canadian population, with the goal of increasing bystander CPR and survival of cardiac arrest, basically trying to look for why we still have to deal with only 3% of the population knowing CPR, whereas somewhere else things have been successful.

In summary, at this point I believe that a public access defibrillation program is premature. Its effectiveness in saving lives is currently under evaluation by a large international trial called the PAD trial. It may not be cost-effective, although this might not be a popular comment, and we estimate that less than 3% of all cardiac arrests could benefit from such an intervention.

We have to understand that you may be under tremendous public pressure to push such a bill forward, but I think this is the time to be strong and perhaps hold the horses until we actually get the information we need to push the bill forward. I thank you for your attention and I welcome any questions.

**The Chair:** Thank you, Dr Vaillancourt. We have about one minute for each—

**Mr Kormos:** Chair, this guy is pretty smart; he's done a lot of research. I'm wondering if there's unanimous consent, well ahead of time, to give us maybe three minutes per caucus.

**The Chair:** Permission of the committee? Yes, that would be fine, three minutes, and we'll begin with the Liberal Party in rotation.

**Mr Colle:** You're a doctor here in Ottawa?

**Dr Vaillancourt:** Yes.

**Mr Colle:** And what is your specialty?

**Dr Vaillancourt:** I'm an emergency medicine specialist.

**Mr Colle:** At the civic hospital here?

**Dr Vaillancourt:** Yes.

**Mr Patten:** Ottawa Hospital.

**Mr Colle:** Ottawa Hospital it's called. Could you leave that research with us, or a copy of it later on, that you quoted from?

**Dr Vaillancourt:** You have all the references on the bottom of your handout. There are seven of them.

**Mr Colle:** OK. We could get that.

**Dr Vaillancourt:** Yes.

**Mr Colle:** I guess you're saying don't do anything, it's premature.

**Dr Vaillancourt:** The bottom line is that there's no denying that the machines work. If you look at the chain of survival, because it's been mentioned often, of course, so far we think that the strongest link is defibrillation, but the weakest link right now is the CPR. I don't deny that defibrillation works and the reason why CPR is useful is basically it's getting the time until the machine actually is applied, and it even makes it more successful.

The only problem we see with it is that if you're looking at a policy that's going to cost something to the population, is it going to be the best bang for the buck? People seem to think that most cardiac arrests occur in public places, whereas what we are bringing to the table today is that it's a minimal amount of them. If you look at the Ottawa region alone, we've had about 1,400 cardiac arrests over a five-year period. If you look at 5% of them being in public places, not all of which could be helped by a defibrillator, we're talking about perhaps eight to 10 persons per year in the whole region of Ottawa that could be helped by such a program.

**Mr Colle:** You mentioned that where we have the most succinct type of research, the most direct, is in the casinos, in Las Vegas and in Windsor.

**Dr Vaillancourt:** Yes.

**Mr Colle:** If you've got evidence where there's direct access to portable defibrillators right there and that the survival rate jumps by 60%—

**Dr Vaillancourt:** A relative increase, yes.

**1030**

**Mr Colle:** —yes, 60%, don't you think it's pretty indicative of the fact that if you've got this kind of success rate—from five out of 100 to 60 out of 100—that might be telling you it's worth perhaps over the next three years examining locations throughout cities where access to these defibrillators might save those lives and dramatically increase that? That's what I'm saying. There's an example, clear cut. I'm saying let's find out where these similar-type locations might be. If we can get that kind of survival rate jumped up so dramatically—because they're all one minute away in the Windsor Casino, one minute away at O'Hare airport, one minute away in the Woodbine Casino in Toronto, where we've had the most direct studies. Isn't that the reason why the American government just passed legislation to have them in all rural communities in the United States and isn't that why the Federal Aviation Administration

mandated that every airplane that flies out of US airports carry a defibrillator?

**Dr Vaillancourt:** If you'll allow me to answer that, first of all, I have two comments. There is a difference in medical research between relative and absolute increase or improvement, and the 60% that you mentioned is a relative increase. So it's 60% of the already poor survival. It's not 60 out of 100 that basically survive; it's a 60% increase in the already low survival, for one.

Two, basically the absolute survival in the casino trial was closer to 30%, which is still great. That is basically also if the machine is applied within three minutes. I don't know how long it takes to actually read a board before you can apply the machine, but if you can achieve it within three minutes you can, at best, have 30% survival, which is great.

To answer your second point on whether or not we should do that on a broad basis, just keep in mind that you will have a tremendous improvement in survival in less than 3% of all cardiac arrest cases. Is that worth it?

**Mr Colle:** You're saying it isn't. We disagree.

**Dr Vaillancourt:** I'm saying everything is worth it when it comes to saving lives. I'm talking about if you have millions of dollars to spend, are you going to be spending it on this program or on another program that's going to benefit all cases of cardiac arrest and that also has been proven to increase their survival rate to probably about the same thing as this thing would achieve for only a small percentage of the population?

**Mr Kormos:** I was told the other day from very good sources that rich people—rich men—who have had heart problems buy these machines for their houses, and one obese, expatriate former newspaper magnate owns several. But again, he has to count on Barbara to push the button. Depending upon the pre-nup, that may or may not happen.

What bothers me is that down where I come from I've got a seniors' building, which is all seniors. I've got the seniors' centre. Is there any rationale for prioritizing or identifying groups? I appreciate all your statistical analysis of the casino, and that sort of downplays the dramatic numbers, but fair enough. But is there any rationale for saying that in my seniors' centre down in Thorold or Welland, where you've got, I presume, a higher-risk profile, one of these units with some trained people would be—you see, what I resent is that those rich guys can have half a dozen of these in their homes—

**Mr Beaubien:** What kind of car do you drive?

**Mr Kormos:** A Chevy pickup—and yet my seniors down at the seniors' centre have to wait for an already overloaded ambulance system that's being stretched thin because of the provincial downloading on to the municipalities. So do you understand where I'm coming from? I resent the fact that these rich guys have half a dozen, yet a group of 200 good, hard-working senior retirees have none in their seniors' centre. How do I resolve that based on what you have got to say here?

**Dr Vaillancourt:** Seniors' centres are considered public places, so as far as percentage of people who have

their cardiac arrests in public places, they still fall into the same range. I may have to suggest also that most seniors' centres are in the vicinity of a major hospital and that the emergency medical systems are usually able to get to them within the appropriate time. Having said that, we know that the earlier the defibrillation is, the better it would be. I'm not sure I can exactly answer that question, but yes, it—

**Mr Kormos:** Your three-minute time frame, you're talking about being shocked within three minutes in the absence of CPR.

**Dr Vaillancourt:** Yes.

**Mr Kormos:** OK. We've heard some people say that CPR is no longer a factor. We've actually heard that. The idea is to administer the joules promptly. Then we've heard from the other end of the spectrum that CPR is still very much a partner, at least an equal partner, in the whole process.

You're saying—

**Dr Vaillancourt:** The current response time for a cardiac arrest call is probably about seven to eight minutes. When nothing is done in that time before the defibrillation actually occurs, we know that survival decreases, and whenever people have actually been able to perform CPR, the survival increases. Basically what CPR does is that it gives at least a minimal amount of oxygen to the heart and it makes the defibrillation that much more effective.

If we could have those defibrillators nearby in all the vicinities, everywhere where cardiac arrest occurs, and you could apply them directly, there would probably not be a need for CPR if you can do it within three minutes. That would be the best intervention there is. That's assuming that everybody has their cardiac arrest in a mall or in a public place, which is not the case, unfortunately.

**Mr Kormos:** No, and I understand that. So you're arguing that that same amount of money—is this CPR versus PAD for you—

**Dr Vaillancourt:** No.

**Mr Kormos:** —in terms of, let's say, investing the money on CPR training for the general public?

**Dr Vaillancourt:** If you want to look at it this way, if you have the resources to supply and support both programs, I would say go ahead, because this would be the best thing we could do. The few people who are having their cardiac arrests in public places would benefit greatly from such a program. What I'm saying is that if you're looking for one intervention that would give you the biggest bang for your buck, it would probably not be this. I'd just want to make sure that people understand that if you go ahead with this program, it's not going to benefit 100% of people with their cardiac arrests; it's going to be an intervention aimed at less than 5%, and more probably 3%, of the cases.

**Mr Kormos:** I'd like to see the staffing of nurses return to local hospitals where I come from and emergency rooms supplemented, along with all this. The money is there, except the tax breaks take it out of the

health care system. It's choices. The tax cuts take money out of the health care system. It's a matter of priorities.

**Mr Beaubien:** I don't really have a question; I've got some observations here. Yesterday, Dr Verbeek mentioned that he questioned the definition in the bill of "perceived medical emergency." He had a lot of problem with the definition. Also, Dr Dreyer, who's the chair of the Ontario Medical Association section on emergency medicine, stated:

"According to OPALS data, it can be estimated that of the estimated 6,500 cardiac arrests occurring annually in Ontario, only about 90% are cardiac arrests occurring as a result of a cardiac cause."

Of the remainder, "only about 50% are witnessed arrests." I think the word "witnessed" is very key here. This leaves a total of approximately 3,000 cardiac arrests which are witnessed cardiac arrests which may be responsive to early defibrillation. Of these, 20% will be witnessed by paramedic crews, leaving approximately 2,400 cases. Further recognizing that approximately 80% of these cases occur in private residences or nursing homes, there remain only approximately 500 cases in the province of Ontario each year that could potentially benefit from the widespread introduction of PAD programs. Very interesting statistics.

Furthermore, the bill stipulates in section 2, "Privately owned buildings to which the public has general access." That could mean every 7-Eleven or Mac's milk store on the corner or any building that has public access. Yet when you look at the statistics given to us by the medical profession—and don't get me wrong; I don't always agree with what the OMA or medical practitioners have to say—the chair of the OMA emergency department stipulated that yesterday and Dr Vaillancourt this morning stipulated the same thing. Dr Verbeek had difficulties with the definition we're using in the bill.

I think as Dr Vaillancourt mentioned this morning and as the previous presenters have stated, everybody likes the concept. It is a motherhood issue. But I think we have to proceed very carefully in this matter, because it's kind of nice—as Mr Kormos said, we can try to make political hay out of this thing, but somebody warned us yesterday, and I can't remember which individual, that this is not a political issue; this is a health care issue.

1040

**Dr Vaillancourt:** Maybe one last finishing comment: there is an international trial underway that will give you the answer. It is looking at exactly what we are trying to establish here, a public access defibrillation program. They will come with numbers. They will give you how many more lives were saved and the cost of it all, and you should be able to take a decision when that study is over.

**Mr Patten:** What's the ETA on that?

**Dr Vaillancourt:** It's been ongoing since last summer. I'm assuming it's probably going to be another year or two. I can't speak for those people, unfortunately, but that's approximately the time I would say it would take.

**The Chair:** Thank you, Dr Vaillancourt. We appreciate that.

We have a group that is ready to present. We're running a little bit ahead of time. For the record, I'll just check to make sure. Centre Pauline-Charron? I know we're early. They're not here yet. Active Canadian Emergency Training Inc is not here.

#### MEDTRONIC OF CANADA LTD

**The Chair:** We do have a group that will come forward, Medtronic of Canada. Have a chair, sir, and we'll hear your presentation. We have 20 minutes, and if you could give us your name for the Hansard recording.

**Mr Steve Ellis:** My name is Steve Ellis. I am the sales and marketing manager of Medtronic of Canada, the Physio-Control division of Medtronic.

Just a little bit about Medtronic: we are the largest manufacturer of defibrillators in the world, supplying to paramedic systems, for ambulances and fire trucks, as well as to hospitals and in public access defibrillation and targeted first responder programs. We also make implantable defibrillators. You saw some of the press on Dick Cheney's implantable defibrillator and that's an example of one of our products. So we have a really good knowledge of how effective these things are.

My background is as a critical care paramedic in a previous life and I function now in involvement in most of the public access defib programs. I've been very much involved in Canada and am very familiar with many of them throughout the world that have been initiated.

I've actually put a little bit of a change to my presentation after hearing some of the information that was presented yesterday. I think probably the best thing I can do is offer myself and to try and address some of the issues that don't seem very clear, from what I've heard this morning, as well as perhaps answer some of your questions on some issues. I think some things are being stated as fact and some are being stated as probably a little bit misrepresented, so perhaps I can clear up some of that stuff.

First of all, I'd just like to say that I and this company very much support Bill 51 and applaud Mr Colle and his team for driving this initiative. You've seen a similar initiative in the US in different areas, but the large one that everybody has been referring to is the Sudden Cardiac Arrest Survival Act.

Just as a matter of point, I don't think anybody questions, or I hope they don't at this point, whether defibrillation is an effective treatment. I don't think there is any physician—I know there are different opinions about the cost-effectiveness or issues on that end, but no paramedic, physician or firefighter will do anything but grab the nearest defibrillator for somebody in cardiac arrest. I think that needs to be very clear. CPR is not instead of; CPR is a stop-gap measure until a defibrillator gets there. That is the medical standard. It is one of the few things in medicine that everybody agrees on. It's just

a matter of time to getting a defibrillator and how we get them there.

We all do the same treatment. Paramedics, physicians, nurses and firefighters are all doing the same treatment. It's a matter of how much training they have to make those decisions on their own versus letting a machine decide.

The technology has improved. I should probably qualify that. For us as a company, this is our eighth generation of automated defibrillators. We brought them out many years ago but the medical community wasn't ready. It seemed kind of a crazy concept to think that somebody else would be shocking other than a physician. Then paramedics got trained and for nurses it's accepted, so this whole process has had a fairly good education to it to realize that it is not such a difficult procedure to do.

The machines have definitely become easier to use and there's very little question at this point as to their safety. I can qualify that by saying that we have 80,000 of those automated defibrillators just in the Lifepak 500 form, which is the one we use for public access defibrillation, out throughout the world. They are not new; they've been on the market for several years. They are used by firefighters and police officers and they are being used in public access areas by the lay public, and people are not getting shocked who shouldn't be shocked. If anything, what's happening is that if the training and implementation hasn't been appropriate or if somebody freezes, you're just no further ahead than you are now, which means you've caused no further harm. You've just basically lost an opportunity or delayed an opportunity to save a life.

Time to defibrillation is everything. That is the one concept that everybody agrees on. So the question here, I believe, is not whether we should or should not encourage the use of defibrillators; it's just a matter of how we practically get these things to people who are victims of sudden cardiac arrest.

One of the problems we're all aware of is that sudden cardiac arrest strikes anyone, anywhere, any time, so that puts everybody in this room at risk right now. The single treatment is defibrillation.

I heard some general statements about response times. I would question those. Response time to the scene and response time to a patient are different and there are studies that have proven that. As soon as you have to enter public buildings or go into high-rise buildings, those response times can increase drastically. This city is a great example where survival rates were approximately 2% when looked at last year. Less than 5% is what's quoted in terms of generally out in the community, where survival rates are pretty poor.

We already know—the science is very clear—that if you get defibrillators to people quickly their chance of survival is much better than that, and the casinos are by far the clearest study of that. We have the same issues in hospital. We now put automated defibrillators in hospitals so that the nurse on the floor can defibrillate, because they don't want to wait the extra three minutes for the cardiac arrest team to arrive. As I said, this is a

proven concept and I don't think any physician or anybody representing is questioning that. I hope that's clear. If it's not, please feel free to question me and I can explain further.

It comes down to, where do these cardiac arrests occur and are ambulances and fire departments quick enough to respond? If they were, we would be seeing much better survival rates. We would see survival rates like 55%. I have trouble understanding, and perhaps I missed part of it, but the previous gentleman who spoke and talked about relative survival rates, those statistics from the casino are 55% survival rates. That means if you have a cardiac arrest, you have a 55% chance of being resuscitated and leaving the hospital with your brain and functions still intact. That's another important piece of this, because we can still get defibrillators to people and get their pulse back, and by some statistics and studies people qualify that as a save, but that doesn't mean much to most of us. The question of whether they still have brain function and can lead a normal life is a very important one too. You might get the defibrillator there in six or seven minutes, but if you can get the defibrillator there in two or three minutes it's that much better.

There is very clear information stated in the American Heart Association, which is the governing body for this. There is a great deal of research and there are experts who spend a lot of resources and time to develop these standards, and they're evolving, but very clearly the statements in here say that early defibrillation is key. We want to get defibrillators to people in less than five minutes.

I want to address just a couple of issues. First of all, I've heard back and forth about pulse checks versus defibrillator and perhaps I can address that. Defibrillators don't assess pulses. They don't measure pulse rates and they don't tell you if you have a pulse or not; that is, the mechanical pumping of the blood from your heart. They assess the electrical activity of your heart. The American Heart Association has now changed the guidelines as of last year that for people who don't have a pulse or even—the pulse check is actually somewhat optional. I don't want to get too much into detail, but if somebody looks dead, they probably are dead, is kind of the rationale behind that. So people are starting CPR now without pulse checks, because it's not a good indicator, based on how effective people are in taking pulses.

Automated defibrillators, on the other hand—and I think I can speak probably for all manufacturers—are very good at assessing if somebody is in cardiac arrest. There are also safety mechanisms in place, motion detection systems, so that if there is any movement—and frankly that's more to protect the responder or people walking around who might touch the patient—that will not let you shock if there is movement. We have all different ways of going about that across the different manufacturers.

The truth is nobody is being shocked who shouldn't be shocked. It's not happening. We are saving a lot of lives.



Frankly, we've been a little bit slow to adapt in Canada. Alberta has been by far the most progressive in this area. There are numerous programs throughout the US and Europe and very targeted areas like airlines and casinos which have been identified. Shopping centres are a great target. We've identified that in terms of public places there is a fairly reasonable—we talk about the top five, so shopping centres and high-rise buildings are all good places to put defibrillators.

**1050**

I've also heard some details about the OPALS data, the Ontario Prehospital Advanced Life Support data. I'm fairly familiar with this stuff because I work with all the EMS systems across the province. We have to be careful in terms of interpreting that data. As we get too deep into statistical analysis, it kind of loses a bit of the practicality.

Some 5% of cardiac arrests are not happening in public places, is that what I heard? I'm sorry if I missed—I understood somebody mentioned that. Most EMS systems across North America have similar demographics. We're looking more closely at the 20% to 25% of cardiac arrests occurring in more public places. That number is expected to increase and the number of cardiac arrests is expected to increase. The statistical use is approximately one per thousand in the population per year. So again, it's a bit of a statistical issue.

Back to the practicality, how do we get to those people? We're talking about 22,000 to 30,000-plus sudden cardiac arrests in Canada per year. That's a lot of people we potentially could be saving.

The other piece of this is that as we implement AED programs, there comes a much higher awareness and level of training and recognition of the need to do CPR, to recognize people with chest pain and to call 911 earlier. All of these spinoffs are really important. We've had no shortage of programs—EMS systems and ambulance services—that have taken a very good initiative in trying to promote CPR. They have been phenomenally unsuccessful in most areas because people aren't interested necessarily in doing CPR and, frankly, CPR alone does not save lives. You need the other pieces in there. So it's not either/or; it's both together.

Once again, it's back to how we get the defibrillators to those people. Can we predict where those cardiac arrests are going to occur? Certainly we have good indications as to where the most common areas are, and that's where the most people are, and as people age, that increases in incidence.

Fire departments: there are some fire departments that are doing a good job and improving response times.

Police programs: there is only one in Canada, right here in Ottawa. They just recently implemented it, so it's pretty hard to determine how effective it is at this point, but frankly, the more defibrillators out there, the better chance every one of us—family members and everybody else—has of surviving a sudden cardiac arrest.

I hope that clears up the pulse issue and the CPR versus the defibrillator. If you have any questions, please feel free to interrupt me at any time.

**The Chair:** Mr Ellis, we've got about a minute and a half for each party. We'll begin with the NDP.

**Mr Kormos:** It's day 2. You distribute or sell which piece?

**Mr Ellis:** Medtronic Physio-Control. We're the manufacturer.

**Mr Kormos:** Where are they manufactured?

**Mr Ellis:** Redmond, Washington, is our manufacturing site.

**Mr Kormos:** And it's manufactured by Medtronic?

**Mr Ellis:** Correct.

**Mr Kormos:** And it's one of, what, four brands of defibrillators available in Ontario, Canada?

**Mr Ellis:** There seem to be a few more coming out these days that are just getting licensing—

**Mr Kormos:** One is Norwegian-based, one is Hewlett-Packard. OK.

You and your colleagues from similar businesses talk about cardiac arrest or fibrillation: "anyone, anywhere, any time." Then you go on to say you can't identify places where they are more appropriate but then you say it's only because there are huge numbers of people there. Other people are saying no, that there are profiles.

We saw the videotape of the 33-year-old woman who had the totally unanticipated fibrillation or cardiac arrest but, come on, isn't that a little bit of a sales pitch?

*Interjection.*

**Mr Kormos:** I've heard it with so many other—come on, that's his job. I'm not disputing it. I'm saying good, God bless you. That's your job. You've got to do that. But please, don't say anyone, anywhere, any time, when in fact other people are saying—there are guys like me and a few other people around the table here. I'm told the alderman here, smoking, drinking, staying up, we fit the profile more than anyone, anywhere, any time. Isn't that fair?

**Mr Ellis:** No. I fit that same profile too, so let me address that. Yes, my job is to promote and sell defibrillators. I make no bones about that. But let's separate things out here for a little bit. As you increase in age, heredity factors, diet and all those things increase the chance of having a heart attack or a stroke or a combination, or other clotting factor. A heart attack is not a cardiac arrest. A sudden cardiac arrest, although it can be from chest pain of a cardiac nature—I could be talking to you and having a heart attack. Having chest pain is an indication of a heart attack. You need to go to a hospital quickly and they try and dissolve the clot.

**Mr Kormos:** Am I more likely than somebody who is in far better shape and whose lifestyle is far more attractive than mine is?

**Mr Ellis:** To be in sudden cardiac arrest?

**Mr Kormos:** Yes.

**Mr Ellis:** Or to have a heart attack that leads to—

**Mr Kormos:** No, to fibrillate.

**Mr Guzzo:** Don't answer that until you learn about his lifestyle.

**Mr Kormos:** I've told you everything there is to know. Am I more likely than a 20-year-old who is physically fit?

**Mr Ellis:** Yes.

**Mr Kormos:** Of course I am. There.

**The Chair:** I'll go now to the PCs.

**Mrs Molinari:** Thank you very much for your presentation. It certainly added a perspective from a manufacturer and we appreciate your comments.

Some of the difficulty I'm having is around the safety issue of using it improperly and the training of the individuals using it. As has been stated, this bill would allow for defibrillators to be placed and for anyone to have access to them and be able to use them, without the proper training.

I'm going through the Heart and Stroke Foundation book. They talked about some of the issues around safety and also the training. One of the things that is stated in here is ensuring the safety of others who are around. Someone who is improperly trained would, in my estimation, not have the knowledge of all of the intricacies around using a defibrillator. We all agree that these save lives if used properly, but it's not a mechanism that can be used on its own without an individual who is properly trained, who knows how to use it and knows the risks around using it.

I've heard you say that the worst thing that could happen if it's not used properly is that they are no further ahead. I would ask you to consider the problems with what could happen to people around them. We've heard disparate comments about the need to check for a pulse and that the defibrillator will tell you if there's a pulse.

**Mr Ellis:** That's not accurate.

**Mrs Molinari:** Well, we're hearing different—this is why at the end of this two-day session we have to filter through this and figure out which is correct and which is accurate. My main concern is that using it improperly will cause more damage not only to the victim but to people around it. It talks about it being in an area where it's exposed to water and the dangers of that, having cell phones and mechanical things around and what could happen. Could you comment a bit on some of those dangers?

**Mr Ellis:** Sure, I could do that. As a manufacturer, in terms of the cell phones, the water, those are questions we get asked all the time. We do encourage training and standards of training. Frankly, you'll find most of the programs out there have some kind of tie back to the manufacturers like us, who have developed the training programs and implementation standards for these, support the training agencies and the American Heart Association and sit on these boards and make sure that the training standards make sense.

**Mrs Molinari:** So it's necessary for someone using it to be properly trained to use it.

**Mr Ellis:** Let me back up. We encourage training and we encourage a standard of training, but we also discourage overtraining because that causes a bit of a barrier. If people think they have to do 12 hours of

training every six months or four months, then they're going to be too uncomfortable to start these programs because they're going to think that they can't do it.

The reality is, whether you endorse this bill or not, the defibrillators are going up on walls in public buildings. If you walk through many airports in the US—and very shortly you will hear the same thing in airports in Canada—there are defibrillators on the walls, and going on the walls in public buildings. There are enough people out there who believe in this concept and understand how simple these defibrillators are. So they are going out there.

The reality is that we should encourage as much training as possible because you could be on that Air Canada flight, you could be walking through the airport, you could be walking through Chicago airport and somebody beside you goes into cardiac arrest, and you are the best person to shock them because you are the quickest.

The machines are so easy to use and I have no problem showing—I understand you've seen a demonstration of another device. Frankly, they are all easy to use.

**Mrs Molinari:** If you could go back—

**The Chair:** We should go to the Liberal Party now, for a minute and a half, please.

**Mr Ellis:** Can I finish?

*Interjection.*

**Mrs Molinari:** The question is the danger to the victim and people around. I understand what you're saying and they are all things that we've heard about the benefits, but I want specifically to know what dangers there may be to the victim or individuals around them if it's not used properly.

**Mr Ellis:** OK. If somebody goes into cardiac arrest, number one, we need to establish the fact that the patient is unconscious, which is a fairly obvious thing to do.

**Mrs Molinari:** Someone needs to establish that, an individual.

**Mr Ellis:** Just the fact that somebody is not moving, is lying on the ground in the middle of a public building—it's generally an easy thing to establish the fact that there's something wrong. The fact that they're not breathing is usually—if somebody is obviously trained or listens or knows to look or listen for breathing. Pulse checks we could do or not do; it's not that important. Then you put the defibrillator pads on. If there is any recognition of anything other than a rhythm that is cardiac arrest, the device isn't going to charge up.

**1100**

**Mrs Molinari:** Now, someone who is not properly trained, if someone has a heart monitor or something, would they know not to put a defibrillator pad in the general vicinity?

**Mr Ellis:** Pacemakers generally get inserted here, the pads go here. There are big pictures on the pads. We all have the same placement. It's all set. Put the heart between the two pads; it's pretty straightforward. If you have a little bit of miss, it's no big deal. If they had an

implantable device, they're dead. We can't hurt them. If anything, what will happen is we'll be less effective. We might do some damage to the device that needs to be recalibrated after. We can't hurt these people. That's why these things are happening. We could not be putting these out there and getting overwhelming support from physicians and paramedics and everybody else out there if they had any danger to them.

**Mrs Molinari:** Putting a pad on a device would not hurt an individual?

**Mr Ellis:** Correct.

**Mr Colle:** I'm just going to change this around. I know my colleagues on the Conservative side like to talk about the dangers, the liability, all the negative things. I would hope that we'd think about the thousands of people whose lives could be saved and that we'd be a bit more positive in examining ways of helping those people.

What I'd like to do with respect to your deputation is read into the record, considering the last deputation especially, from certainly the most prestigious medical journal in North America, what the New England Journal of Medicine reported again last year. I guess it's from the Toronto Star here:

"NEJM Reports Two Studies Proving Portable Defibrillators Save Lives When Quickly Used by Trained Non-Medical Responders; Casino Research is Largest Study to Show Survival Rate at Least 10 Times.

"Two studies reported in the current issue of the New England Journal of Medicine prove a reassuring message: persons with minimal training can successfully use simple, portable defibrillation devices in public places to save lives that might otherwise be lost to sudden cardiac arrest.

"The studies also made a key point: the devices, known as automatic external defibrillators ... must be close at hand and easily available. Data prove the validity of efforts by the American Heart Association, airlines, public safety agencies and others to increase the availability of the lifesaving AED device to trained laymen and emergency personnel wherever people gather."

I just wanted to put that on the record. Hopefully, what might help, if I can ask the permission of the Chair, is for the deputant to give us an example of how this simple machine works if you have one here. I think the more times we see it—we've got a couple of new members here. This most complicated training on an unreliable device that's going to hurt everybody—let's see it. Let's bring it out, unleash it. It's going to go into every 7-Eleven. Watch out—it's coming to the 7-Eleven near you.

**Mr Ellis:** Who's the biggest sceptic?

**Mr Colle:** Just look to your left. Not all of them.

*Interjections.*

**Mrs Molinari:** You're not going to put it on?

**Mr Ellis:** No, I'm not. I'm the trainer. I'm not going to shock anybody.

**Mr Colle:** Be careful. Be careful.

**Mrs Molinari:** Do it on someone who has so much faith in it.

**Mr Colle:** I have faith in it, that's right.

**Mr Beaubien:** OK, you be the guinea pig.

**Mr Kormos:** In that context, if you were to attach that to me while I'm conscious, what would I experience when you shock me?

**Mr Colle:** Nothing.

**Mr Ellis:** I can't shock you.

**Mr Kormos:** No, assuming that you're—

**Mr Colle:** Put it on, Peter.

**Mr Kormos:** No, I'm not going to, but assuming that you could, what would I experience?

**Mr Beaubien:** Come on, Peter, put it on.

**Mr Ellis:** What would you experience? An electrical shock to you that would cause movement of your body—

**Mr Kormos:** Convulsion?

**Mr Ellis:** —that potentially could stop your heart. A very short, sudden movement, but it can't shock you if you're moving.

**Mrs Molinari:** But it can stop your heart.

**Mr Colle:** No, no, no, it can't. I want to explain that.

**Mr Kormos:** I've been shocked in wall sockets. Is it similar to the wall socket shock?

**Mr Ellis:** The energy is delivered a little bit differently and it's more impact. The fact that it's here means it's concentrated to your heart.

**Mr Beaubien:** I feel safe because we've got a doctor in the audience.

**The Chair:** OK. I'm going to call for order. Hansard cannot pick up—

**Mr Kormos:** That's OK, but I wanted to know.

**The Chair:** We'll ask for the demonstration.

*Interjections.*

**Mr Ellis:** My pleasure. This is a trainer device. I have a little remote control here. But somebody is in cardiac arrest, so we've determined that they're unconscious—

**The Chair:** Sir, for the purpose of Hansard, if you could demonstrate it when you're sitting down in front of the microphone, then the recording device can pick it up.

**Mr Ellis:** Is this one OK?

**The Chair:** That'll be fine.

**Mr Ellis:** The pads are marked with pictures on them, so it's pretty hard to miss. That's part of what we do in the training. Other than that, all I ask you to do is to turn on the machine. So we put the pads in place—

**Automated voice:** Connect electrodes. [Series of beeps.]

**Mr Ellis:** So you've attached the electrodes.

**Automated voice:** Push "analyze." [Series of beeps.] Stand clear. Analyzing now. Sta—

**Mr Ellis:** Sorry. That's my batteries. That's not a good thing. It's just a trainer device.

**Automated voice:** Connect electrodes. Push "analyze." [Series of beeps.] Stand clear. Analyzing now. Stand cl—

**Mr Ellis:** My apologies, guys. I grabbed this out of a car. I didn't intend to bring this. It's a trainer device that I

use frequently and it's just DC batteries. I could do a demonstration for you after.

After the analyze period—it basically tells you to push “analyze.” It recognizes if the patient has a shockable rhythm. If it's not a shockable rhythm, it doesn't charge up. If it doesn't charge up, you cannot shock. The machine doesn't let you do that, and there are safety points in place. I don't know how else to explain it to you.

**Mr Colle:** It runs on a lithium battery?

**Mr Ellis:** It runs on a lithium battery. As I said, this is a trainer device that's just getting a lot of activity. But it works off a lithium battery. The batteries are generally foolproof.

**Mrs Molinari:** It's important that those that are displayed then would have the proper batteries and everything so that ongoing—

**Mr Ellis:** And there are the battery indicators on the handle that tell you if the battery is charged up. There's a service. It does its own test on itself, and if there's a problem—as I said, if everything goes wrong and your batteries are dead because you left the machine on or anything happened, you're back to the same place you started, which is waiting for a first responder with a defibrillator to come.

**Mrs Molinari:** And someone doing CPR?

**Mr Ellis:** Or someone doing CPR in the meantime.

**The Chair:** Thank you very much, Mr Ellis.

**Mr Ellis:** Sorry, can I just make one last point as a final note? It costs us approximately C\$1 million to staff and equip an ambulance 24/7 and put them out on the road to reduce response times. You can make a pretty big impact with those kinds of dollars in public access defib programs.

**The Chair:** OK. Thank you very much.

1110

#### CENTRE PAULINE-CHARRON

**The Chair :** I'd like to call forward our next delegation, Centre Pauline-Charron. Good morning. Welcome to our committee.

**Mr Léo Lavergne:** Thanks very much. My presentation will be fairly short. It won't be as technical as the previous one, I assume, but I hope it will be useful to the committee.

**The Chair :** All right. I'd ask you to identify yourself for Hansard, and we have 10 minutes.

**M. Lavergne :** Very good. Monsieur le Président et distingués membres du comité, merci de m'avoir accordé cette occasion pour vous adresser la parole sur le Bill 51, projet de loi sur les défibrillateurs cardiaques portatifs.

Je suis Léo Lavergne et je suis directeur général du Centre Pauline-Charron. Le Centre est exploité en vertu du paragraphe (2) de la Loi sur les centres pour personnes âgées. Je crois, selon l'article 2.3 du bill que vous étudiez, que les centres comme le nôtre sont inclus dans le projet de loi qui est présentement à l'étude de ce comité.

Plusieurs raisons motivent ma présence ce matin.

Premièrement, je tiens à féliciter M. Colle pour son initiative en déposant ce projet de loi visant à sauver la vie des Ontariens qui souffrent d'un arrêt cardiaque, en promouvant la disponibilité et l'usage généralisé de défibrillateurs cardiaques portatifs dans les lieux publics, lequel, j'espère, sera adopté par la Législature ontarienne, car même si seulement une vie est sauvée, cela en vaut le coût.

Deuxièmement, au Centre Pauline-Charron nous venons récemment de nous procurer un défibrillateur cardiaque, ceci grâce à une contribution du ministère de la citoyenneté, de la culture et des loisirs ainsi qu'une contribution de la Fondation Pauline-Charron, dans le cadre d'un projet sur le bénévolat durant cette année sur le bénévolat. De plus, nous avons bénéficié d'un prix spécial d'achat grâce à une initiative de la région d'Ottawa-Carleton, qui avait négocié un prix de faveur pour les groupes communautaires et les entreprises qui désiraient se procurer un défibrillateur. Je crois que suite à l'adoption de ce projet de loi, le gouvernement devrait négocier avec des fournisseurs pour un prix spécial d'achat ainsi qu'offrir des subventions pour l'achat d'un défibrillateur.

Troisièmement, dans notre projet sur le bénévolat nous procéderons à l'entraînement, par des gens qualifiés, de plusieurs bénévoles sur l'utilisation du défibrillateur, ceci pour assurer que dans la mesure du possible, à chaque fois qu'il y a des activités au centre, qu'il y ait quelqu'un de qualifié pour opérer l'appareil. De là l'importance de ce projet de loi, qui empêchera les poursuites civiles contre les utilisateurs de défibrillateurs et les propriétaires des locaux dans lesquels des défibrillateurs sont installés.

We therefore support this bill and hope that Parliament will pass it, ensuring that individuals are exempt from civil liability.

In closing, I reiterate that in approving this bill, the government should ensure that funds are made available to organizations and businesses wishing to comply with it. Also, the government should negotiate with suppliers for special purchase rates for the defibrillators, as was done by the now defunct Ottawa-Carleton regional government.

Thank you for your time. If there are any questions from the committee members, I will be pleased to answer them.

**The Chair:** Thank you, sir. Ten minutes is not a very long time, and we have about a minute and a half.

**M. Beaubien :** Bonjour, M. Lavergne. Merci pour votre présentation ce matin. Je suis d'accord avec vous que selon l'article 2.3 du bill, les centres comme le vôtre sont inclus dans ce projet. Mais ce qui m'inquiète, c'est que tous les centres publics, comme les dépanneurs, n'importe quel centre, celui de votre mécanicien peut-être, seraient des centres publics. Selon le projet de loi, tous ces centres-là devraient avoir un défibrillateur. Est-ce que vous avez un commentaire ?

**M. Lavergne :** Disons que pour moi, à savoir s'il faut obliger tous les endroits, comme vous dites, le magasin

du coin, d'en avoir un, je pense que dans un monde idéal, la réponse serait oui. Je pense que si on va de cette façon-là, ce que je mentionnais là, c'est qu'il va falloir qu'on rende quand même des subventions disponibles pour aider. Si on regarde soit des petites entreprises ou des organismes comme le nôtre, des organismes de bienfaisance, on n'a pas toujours les argents de budget pour acheter une machine au complet. Si on regarde que le bienfait est pour la communauté dans son ensemble, je crois que le gouvernement à ce moment-là aurait une obligation. Donc, pour moi de dire qu'on devrait choisir, pick and choose, les endroits qu'ils devraient aider, je pense qu'à la longue, peut-être sur une plus grande période de temps, on devrait en trouver une à tous les coins des rues.

**M. Beaubien :** Oui, mais selon le projet de loi, vraiment si on suit le projet de loi au point, on devrait avoir un défibrillateur à chaque bâtiment public. Alors, le montant d'argent que cela prendrait soit pour le gouvernement fédéral, provincial ou municipal, n'importe lequel, serait énormément grand.

**M. Lavergne :** Oui.

**M. Beaubien :** Je crois que ce serait très difficile d'obtenir les fonds, soit au niveau fédéral, provincial ou municipal, pour être capable de remplir la condition dans le projet de loi.

**M. Lavergne :** Je comprends. Moi, je parle en principe quand je regarde l'endroit d'où je viens, des centres pour aînés, qui je trouve devraient être hauts sur la priorité, certainement. Tout projet de loi qui est mis devant le gouvernement est ouvert à des modifications, j'imagine. Je ne pense pas qu'il faut le passer tel quel, si on pense qu'il doit avoir certaines modifications. Je pense qu'il ne faut pas jeter le bill complètement à l'extérieur parce qu'il y a des affaires qui peuvent nous choquer un peu dedans.

**The Chair :** A question from Mr Patten and then Ms Boyer.

**M. Patten :** J'ai une petite question, Monsieur Lavergne. Premièrement, vous avez déjà acheté une machine. Alors, est-ce que vous avez eu l'occasion de l'utiliser ?

**M. Lavergne :** Non. À date, nous n'avons pas eu l'occasion. On l'a achetée vers le début de l'année dans le cadre de notre projet. On attend de procéder à l'entraînement du personnel et de certains bénévoles avant de l'exposer parce que, mettre une machine et s'attendre—cela devrait se faire dès le début de l'automne, en septembre.

**M. Patten :** C'est-à-dire que vous avez des programmes de formation pour les bénévoles ?

**M. Lavergne :** Notre projet, qui nous a permis d'aller chercher des argents pour acheter la machine, c'est justement ça, qu'on veut entraîner. C'est pour ça ; c'est un projet sur le bénévolat. On est un centre de 1 300 membres. On a environ 150 bénévoles qui fonctionnent là, qui oeuvrent, donc on veut en entraîner autant que possible pour que ce soit couvert.

**M. Patten :** La dernière chose : ça a l'air d'être un modèle pour assister l'utilisation de cette machine-là, parce que vous avez eu ces pas du ministère, de la municipalité et de votre organisation. Combien est-ce que cela coûterait à votre organisation seule, en effet ?

**M. Lavergne :** Le prix que nous autres avons payé pour la machine est environ 3 900 \$. C'était un prix de la compagnie qui était ici, Medtronic, que la ville d'Ottawa, la région, avait négocié avec, parce qu'ils en mettaient d'autres dans les arénas, dans les piscines, dans différents endroits, et ils avaient offert ça au public, et notre conseil d'administration a jugé à propos d'aller d'avant et le faire. Je pense qu'il serait environ 5 700 \$, le prix régulier.

**M. Patten :** Merci bien, monsieur.

**M<sup>me</sup> Claudette Boyer (Ottawa-Vanier) :** Merci d'être venu présenter le bienfait de cette machine. Je vois par la réponse que vous avez donnée à M. Patten que vous avez la machine dans le moment, mais que vous ne vous en servez pas parce que vous n'avez pas, justement, la formation. Maintenant, j'ai vu dans votre présentation que vous parlez d'un entraînement par des gens qualifiés. Qu'est-ce que vous entendez par là : des gens qui se sont déjà servis de la machine, ou si la compagnie qui a vendu la machine prévoit qu'eux vont donner la formation ? Je pense que ça, c'est important.

**M. Lavergne :** Nous autres, quand on a acheté la machine, notre contact était la ville d'Ottawa, le service de santé de la ville d'Ottawa, les ambulances, et on nous a fait parvenir immédiatement après notre achat de la machine, après notre intention de l'acheter, le lieu—il y a trois ou quatre regroupements à Ottawa qui fournissent de l'entraînement—

**M<sup>me</sup> Boyer :** Qui sont spécialisés.

**M. Lavergne :**—qui sont spécialisés, dont le collège Algonquin est un, et d'autres. Dans le moment on regardait probablement—on s'attendait à ce que la Cité collégiale l'aurait aimé. Dans le moment on sait qu'au collège Algonquin il est là, et il y a d'autres compagnies qui offrent l'entraînement.

**M<sup>me</sup> Boyer :** Dans des présentations qu'on a eues avant la vôtre, on disait bien que c'est très important que la formation soit adéquate. Alors je me demandais pourquoi la compagnie elle-même, avec l'achat de la machine, ne pouvait pas prédire—ça n'a pas été fait ?

**M. Lavergne :** Non. Pour les autres, cela n'a pas été fait, mais ce sont des affaires qui pesaient dans les négociations.

**M<sup>me</sup> Boyer :** Qui à la ville d'Ottawa s'occupe—

**M. Lavergne :** C'était le service des ambulances. C'était Joe Micucci qui était notre personne-contact à ce moment-là.

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**M<sup>me</sup> Boyer :** Alors, c'est peut-être aussi, puisque le Centre Pauline-Charron est vraiment un centre franco-phonie, qu'on a peut-être quand même poussé la Cité collégiale à donner—

**M. Lavergne :** À donner le même cours.

**M<sup>me</sup> Boyer :** Alors, je vous trouve très prudent de ne pas commencer avec la machine avant d'avoir des gens bien qualifiés. Mais d'un autre côté, il ne faudrait peut-être pas retarder parce qu'on ne sait jamais quand ça peut arriver. Si jamais j'ai besoin d'aide, je suis là.

**M. Lavergne :** Merci beaucoup.

**The Chair:** Thank you very much, sir.

**Mr Lavergne:** My pleasure. Merci.

#### ACTIVE CANADIAN EMERGENCY TRAINING INC

**The Chair:** Our next delegation is Active Canadian Emergency Training Inc, if you wish to have a chair, sir, and we have 20 minutes available. If you wish to identify yourself.

**Mr Dean DiMonte:** My name is Dean DiMonte and I represent Active Canadian Emergency Training, which is a training agency in Ontario as well as throughout Canada. I guess today I want to quickly talk about just two perspectives. One is implementation, because we have extensive experience in implementation of the program here in Ottawa and what the factors regarding implementation of AED are. You've heard several perspectives with regard to, "AED is good." "Is it safe?" "Is it unsafe?" I'm not going to dwell on those issues. From our experience, they are safe machines. Cardiac arrest is a major problem in Canada, and early defibrillation is key to survival.

When Active Canadian started—we have extensive experience as practising paramedics both on land and as flight paramedics in Ontario, and typically what we found when we arrived at scenes was that nothing was really being done for patients, because of nervousness or fear of communicable disease etc. So our idea was to congregate practising paramedics to deliver emergency training programs and teach a simplistic approach to managing emergencies from a paramedic's perspective. I have managed probably over 300 to 400 cardiac arrests in my 17 years of experience. With that experience, coupled with medical direction through emergency physicians we've networked with, we came up with an implementation program.

With regard to factors on AED implementation, I'll use our experience here in the city of Ottawa, which has the largest public access defibrillation program in Canada. There were certain factors that we came up with through our experience, and I'd just point you to the handout on page 3 with regard to those factors, and that's my perspective which I want to point out.

Basically, implementation of a program really can't get off the ground without initiative from a centralized management system, and obviously with the honourable member Mike Colle bringing Bill 51 forward, that's really where it starts. It's to have some sort of central management system within an occupation or a public site to start administering that program.

Point 2 indicates medical direction. Truly to have a public access defibrillation system, medical control or

medical oversight is essential, but currently it's necessarily under the Regulated Health Professions Act. With this bill going forth, medical direction would be more oversight from a medical standpoint for the purposes of expertise. But we found that medical direction specifically helps evolve the program into those issues that you brought up earlier, which I was listening to, regarding safety and quality assurance and training etc.

Another impact: we found that the public sector should be aware of regulations with regard to the Occupational Health and Safety Act, due diligence, those types of things.

With regard to training and a written AED program description, we felt, through our success, that the curriculum should include didactic, which has three components—lots of practical evaluation and a certification process with medical oversight approved by the medical director—along with the coordination of emergency medical services, specifically transfer care issues with regard to a cardiac arrest that happens, whether it be in a residential or public place where EMS ends up arriving, that transfer of care, of what the AED provider has provided for that patient, and communicating that to the responding fire or paramedic personnel.

Emergency response plan: we've had several clients where they've purchased a program and we've recommended that certain things be in place. The real key is getting that box to the patient. It's all well and good to spend the money on the program, but if you can't get the box to the patient in a timely manner, the survivability will obviously decrease.

Selection and technical consideration of AEDs: of course, as you know, there are all the manufacturers out there, and there are some machines that have better battery life, some that have different waiver forms, but traditionally those four or five or six machines that are out there are all very good machines. In the technical aspect they are very safe, and the technical aspect pretty much mirrors what they use in emergency departments and on ambulances.

Ancillary medical equipment is another factor with regard to implementation, having barrier devices for the risk of possible communicable disease, which is a nervous thing for certain individuals who take training, and other ancillary equipment like responder bags. Not actually having the first aid kit fixed on a wall so that you have to unscrew it and bring it to the patient, that sort of thing, is another factor in implementation.

Emergency needs assessment of number of AEDs and supplies: if there are six people in an office, you don't necessarily need to buy 12 machines. So assessment of the number of units and the number of people trained is essential.

The last point: scheduled maintenance with regard to skill update and maintenance on machines is a factor that would affect the success of a program.

The last comment I wanted to bring up with regard to the challenges from my perspective is that the lack of

government regulations and support has made the implementation of an AED program difficult.

We have found that most of our clientele base in the corporate sector typically take about eight to 12 months to implement a program, and generally the thrust, in the end, is when they have a sudden cardiac arrest in their workplace. Liability is a big concern for people; hence, we go back to the point with regard to medical direction. We currently have a network of emergency physicians who basically license these programs under their licence, so liability is covered off for the lay rescuer personnel who are actually responding to these patients.

While strict anti-smoking bylaws, fire suppression and that sort of thing have evolved over a number of decades, no law actually exists to regulate the placement of AEDs in public places, even though heart disease is still the number one cause of death in Canada.

Just to close out with regard to the prehospital care survival rates being less than 5%, we're basically saying we'd like to join the many agencies out there that want to go ahead and implement this bill because we feel it's a worthwhile cause and will save thousands of lives in Canada as well as in Ontario.

I'd be happy to take any questions if anybody has any with regard to our experience here in Ottawa and other sectors of the corporate sector with regard to implementation.

**The Acting Chair (Mr Gary J. Guzzo):** Thank you very much, Mr DiMonte. The time remaining is about three minutes per caucus.

**Mr Patten:** Thank you very much for coming. You're a Canadian organization?

**Mr Dean DiMonte:** That's correct.

**Mr Patten:** I'm somewhat aware of what's going on here in Ottawa, and I think some of the members here are as well.

I have two questions. One is, Dr Vaillancourt this morning talked about how current survival rates in Ontario are less than 5%. But of course that's the existing model, and the existing model is not the public access model. I know there are a variety of concerns that people have raised around that, but it's worthwhile, of course, looking at it.

If, as your deposition suggests, one of the reasons is that for every minute you lose 10% of the potential for survival, and the response time is eight to 10 minutes, then you're at almost 80% to 90% to 100%. Therefore it would seem logical that that 5% is based on an existing model that we're suggesting be changed to improve the probabilities of that. Would that be your reading as well?

**Mr Dean DiMonte:** That's correct. Absolutely.

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**Mr Patten:** Could you talk a little bit about what's happening in Alberta and what their experience is?

**Mr Dean DiMonte:** To be honest with you, I'm not too familiar with Alberta at this point with regard to the survival rate and the public access defibrillation. I know they have moved to deregulate the act, being a controlled medical act, to truly make it a public access system. As

far as success rates in Alberta, I'm not familiar with the success rates at this point. We've had conversations with individuals out there who were responsible, as a matter of fact, to make recommendations here prior to the Ottawa program being implemented, and they have had successes out there.

Again, the percentages that happen out there are fairly in line with current survival-demise rates here in Canada, but truly, in order to get a PAD program like they have in the United States where you have machines displayed everywhere—I know one honourable member mentioned about 7-Eleven. We're just saying that with regard to the implementation, there's more than just putting a box on the wall, and successes are dependent upon a lot of co-operation among membership and among occupations and among people. That would be my comment on the Alberta, which is not very well informed.

**Mr Kormos:** What is it about the bill, what part of the bill, or maybe all of it, is critical for you?

**Mr Dean DiMonte:** With regard to implementation, I think the frustration we've had of having experienced cardiac arrest from our clientele base—you know, as Steve said earlier, and we make no bones about it, we're in the process of providing training, but with regard to that question, I think it would accelerate the fact, that AD implementation be much quicker.

**Mr Kormos:** How? What in the bill does that?

**Mr Dean DiMonte:** I believe what the bill does is, once you tell employers or public people to have machines in place, then that accelerates the implementation factors.

**Mr Kormos:** So the requirement that the one, two, three—government buildings, employers and workplaces, and privately owned property to which the public has access—

**Mr Dean DiMonte:** Correct.

**Mr Kormos:** So the requirement that they have this PAD equipment there. OK, fair enough.

The liability issue isn't of concern to you? Obviously it has not been a concern so far.

**Mr Dean DiMonte:** That's right. The liability issues with us—as I mentioned earlier, from a medical standpoint, all of our programs are under a physician's licence.

**Mr Kormos:** So there's no need to create immunity from liability, as the bill does?

**Mr Dean DiMonte:** I would say no.

**Mr Kormos:** See, I'm a fan of liability. I am. I think people who do bad things to other people should have to pay.

**Mr Dean DiMonte:** Absolutely, and that's why these machines—as I said, I've managed over 300. I've shocked myself. It was funny earlier, what you mentioned with Steve with regard to the dangers and that sort of thing. I've been shocked by actually hands-on machines, and the safety issue with these machines is that they're hands-off.

**Mr Kormos:** You know what? I've been at Queen's Park for 13 years, and I can't be shocked any more.

**The Acting Chair:** Mr Beaubien.

**Mr Beaubien:** Thank you for your presentation this morning. Do you train across Canada?

**Mr Dean DiMonte:** Yes, we do.

**Mr Beaubien:** You mentioned that you don't have any concerns with regard to the liability, but yet you mention it's more than just putting a box on the wall. I think those are your words.

**Mr Dean DiMonte:** Absolutely.

**Mr Beaubien:** Your training program comes under the physician's licence?

**Mr Dean DiMonte:** Correct.

**Mr Beaubien:** Yesterday we heard that people did not have to be trained and they were not under a physician's licence. We had a whole plethora of different ramifications of training, from no training at all to having certain standards.

**Mr Dean DiMonte:** Right. The Chicago O'Hare model.

**Mr Beaubien:** So I'm somewhat confused. In your presentation you say, "As well, liability is a concern for most organizations because of lack of understanding of program implementation issues."

**Mr Dean DiMonte:** Right.

**Mr Beaubien:** So I'm somewhat confused. Where do we start?

**Mr Dean DiMonte:** Let me clarify then. Currently under the Regulated Health Professions Act, it's a controlled medical act to do this skill. Therefore, there is some existing liability, from our understanding. The only people who actually can defibrillate under the act are people who are duly qualified practitioners or their designates, so what we do is the physician who takes that designation designates through a program and through quality assurance to minimize liability to perform the act of defibrillation.

When we started with this program I didn't want to confuse the facts with regard to the liability, because you have the Chicago O'Hare airport model where you walk through the airport and it's a one-two-three approach. That's what we're saying: the machine is very, very simple to use. The problem is when you get John Jones at the cubicle desk at pillar 11 on the seventh floor and he develops chest pain and collapses. It's great that you have a defibrillator on site, but how do we get that box to the patient? That's the liability I'm talking about, the reverse liability, if you will, of having the unit on site and not actually performing the act or not being able to get to the patient in a timely manner and all of those things. Our model is to say that the question is not about the safety or the simplicity of the machine. That's not the liability. The liability is actually accessing that patient and getting to that patient.

As a medic, I'll just talk from experience. When we arrive at scenes at the 12-minute mark, you have the spouse saying, "What the hell took you so long?" Our response plan—we're in the west end of Ottawa and we had to race across town and there's traffic and this and that—really becomes the liability. It's not my skill in

performing the act for that patient; it's actually getting at the patient that becomes more liable than the actual act itself.

**Mr Beaubien:** So therefore there is a liability issue we have to deal with. I think in your presentation when you look at the implantation factors, your number one factor, as you said, is establishment of a centralized management system for the AED program. I think that's the key criterion. That's the foundation of your presentation this morning.

**Mr Dean DiMonte:** I agree.

**The Acting Chair:** Thank you very much. We're out of time. I do appreciate your submission.

#### HEART AND STROKE FOUNDATION OF CANADA

**The Acting Chair:** The next presenter is the Heart and Stroke Foundation of Canada, Dr Wilson. Thank you for coming, Doctor. You have 20 minutes, and you can use that time as you see fit.

**Dr Elinor Wilson:** Thank you very much. I do appreciate the opportunity to present to the committee today on behalf of the Heart and Stroke Foundation of Canada. I am their chief science officer and have been involved in the issue of prehospital emergency cardiac care for more years than I would care to account. If it weren't for the colour in my hair you would know how many years.

**Mr Patten:** Oh, come on. You can tell us.

**Dr Wilson:** Well, I taught the first course in cardiopulmonary resuscitation in Canada back in the 1970s. So for me, the historical perspective of being here to see how far we've evolved—and here is yet another piece of the evolution of saving lives prehospital—is a very exciting time. You are to be commended on bringing forward this draft piece of legislation.

I would like to present today our organization's response to this. As I said, we do congratulate Mr Mike Colle for this laudable legislative effort, because it will make a difference to the lives of Canadians.

As most of you are aware, the Heart and Stroke Foundation of Canada is a national voluntary, non-profit organization whose key objective is to reduce morbidity and mortality from heart disease and stroke through prevention, through funding research and through advocacy for lifestyle change. We have taken the key leadership role in this country since the introduction of CPR almost 30 years ago and have worked with most of the other national organizations in this field in helping to establish standards, coordinating efforts, and promoting the chain of survival.

I won't go into great detail about heart disease and stroke, but we do know that it remains the number one killer in Canada. Almost 22,000 deaths a year are as a result of heart attack. Every year between 35,000 and 40,000 Canadians suffer a cardiac arrest. If you suffer your cardiac arrest outside of hospital, you're pretty well out of luck in this country. Fewer than 5% of people who arrest outside of hospital do survive to hospital discharge.



By survival, that's surviving with their faculties intact and able to go back to becoming a productive member of society.

These victims who arrest prehospital need immediate and timely treatment in order to increase this likelihood of survival. Truthfully, if you look at it this way, the community is the ultimate coronary care unit. Heart disease begins in the community, and all too often for our citizens it ends in the community in terms of sudden cardiac death.

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Increasing the availability of automatic external defibrillators and training more Canadians to operate these will increase this chance of survival quite dramatically. This is why our organization is supporting the Portable Heart Defibrillator Act and why we have been active across this country for the last five years in promoting automatic external defibrillators as a key part of the chain of survival.

The citizens of Canada also are onside in terms of this. In December 1999, we did an Environics omnibus survey of over 2,000 Canadians asking them about automatic external defibrillators and asking the public's opinion on whether or not these devices should be available more widely in Canada. Ninety-five per cent of Canadians said these devices should be more widely available. In terms of their simplicity and ease of use, we also asked them if they would personally like to learn how to use an automatic external defibrillator, and 86% of the Canadian public said yes, they would be interested in and willing to learn how to use this device.

The foundation is the leader in the area of emergency cardiac care in Canada. In August 2000, our organization, along with every other organization that is involved in this business in Canada, adopted new guidelines for CPR and emergency cardiac care. It looks like a big red brick. It weighs about the same as a big red brick. These guidelines were based on the latest scientific evidence from a worldwide review. This is the first time in the history of the world where all organizations internationally have come together and said there are certain guidelines based on science that will make a difference in saving lives. So the Australian Resuscitation Council, the South African, the European, the American Heart Association, all of these resuscitation councils worldwide participated in this, including the Heart and Stroke Foundation of Canada.

Out of these guidelines, the Heart and Stroke Foundation of Canada, working with other national organizations, has developed guidelines for Canada, including an action sequence that's widely used throughout the country. These guidelines, if followed, will certainly increase the chances of survival, so we encourage the Ministry of Health and Long-Term Care to adopt the guidelines. We also out of this, with our partner organizations, have developed training programs to ensure that a high quality and a high standard of training is ensured for people who will use these devices.

Going back to my earlier reflections, it's interesting to note that when I first started teaching CPR in this

country, CPR was regarded as a skill that only medical doctors inside of hospitals were allowed to perform. We very quickly realized 30 years ago that if that's who the skill was limited to, we would have thousands of people who were going to die before cardiopulmonary resuscitation could be taught. We're in the very same situation now with automatic external defibrillators. The curve of how you get the best scientific evidence out into the community in a safe and timely fashion is extremely important. We think the guidelines that are in place and the proposed legislation, with its safeguards in there, will allow for the diffusion of this scientific evidence very quickly. It sets the precedent for more action in that field.

The key to improving the outcome for Canadians and Ontarians suffering a cardiac arrest are those key links in the chain of survival. AEDs alone will not solve this problem. So the thought that if you just stick a bunch of these machines in a bunch of places you're going to save lives is not what we are promoting. We are promoting automatic external defibrillators as a key component of the chain of survival that starts with the early recognition of chest pain and the activation of the emergency care system. We know from the data you have heard that the chance of survival decreases 7% to 10% with each minute after cardiac arrest.

We believe that with the passage of Bill 51, the government of Ontario will be in a leadership position in Canada in terms of access in public buildings and in places where traditionally this kind of information has not been available.

We are also very pleased to see the provision of the "good Samaritan" provision in Bill 51. In fact, given the absence of good Samaritan legislation, we would advocate that this provision be extended to cover first aid and CPR as well. Although some provinces have good Samaritan legislation and others have deregulated AEDs, there is no doubt that Bill 51 will serve as a model for other provinces to follow and will support the efforts of communities in this province that have already taken that very vital first step.

In conclusion, the Heart and Stroke Foundation recommends that the Ontario standing committee on justice and social policy endorse Bill 51 as part of a chain of survival for the province; encourage the Ministry of Health and Long-Term Care to adopt scientifically-based guidelines that have been promoted and completed by the Heart and Stroke Foundation and their partners; insist that these devices follow a recognized program that meets certain high-quality guidelines and standards; make sure that AED programs are included in Ontario's emergency medical services; expand the good Samaritan provision to include first aid and CPR; encourage all communities in this province, workplaces and public venues to establish programs; and encourage funding agencies and corporations across the province to support and establish standardized AED programs.

Canadians value the role the foundation plays as a provider of information on CPR and as a leader in the area of these types of guidelines. It is because of our

involvement in these critical areas, which have so much potential to save lives, that we believe Bill 51 is a very vital bill to receive passage. We thank your committee for the opportunity to present, and we thank your committee for the foresight and wisdom in improving the health of Ontarians.

**The Acting Chair:** Thank you, Dr Wilson. We have about three minutes per caucus.

**Mr Kormos:** I've been impressed by what the cities of Ottawa and Windsor have done, and we're told a whole bunch of private sector operators—the Eaton Centre, big plaza operators, apartment building developers—are buying these machines and putting them in their buildings.

I understand you like the limitation on liability, the exemption from liability except for gross negligence. What else about the bill is critical to people or programs being initiated in the manner that you wish?

**Dr Wilson:** One of the very important pieces about a bill, which is why I'm assuming politicians pass bills and legislation, is that it establishes the legitimacy of something.

**Mr Kormos:** Except this doesn't, though, deal with the regulated health professions, because by implication—and I'm going to ask research to do something on this—the bill would still require that the only people who administer these shocks are people who are trained and authorized by a physician. Am I correct in that?

**Dr Wilson:** Yes, and certainly we support that, because we support the concept that this is part of a systems approach to emergency care delivery in our communities, and all emergency care delivery requires physician oversight. What it does not require, though, is a physician on the scene every time a device is used. So this is part of the accountability in the broader sense for emergency cardiac care and devolving accountabilities and responsibilities to a level where, under strict standards, guidelines and training, people are able to utilize these devices.

**Mr Kormos:** But again, that's already happening now, is it not?

**Dr Wilson:** Well, it's happening through emergency medical services, but—

**Mr Kormos:** No, it's happening in the private sector. It's happening at the Eaton Centre. I learned about some rich people who buy these to put in their homes, so it's already happening now.

**Dr Wilson:** And our concern would go backwards, as in, how has the Eaton Centre, for example, in its positioning of defibrillators and training—how does that link in to the emergency plan and the Toronto emergency medical services? Our emergency medical services must know where these defibrillators are placed.

**Mr Kormos:** OK, so you're talking about building a system. Are you, then, interested in the issue of compatibility? Emergency medical services folks are concerned, and they got into a little bit of a dispute with the manufacturers and distributors because they are concerned that the equipment they arrive with be inter-

changeable with the defibrillator that's there on site. They want to be able to plug in wires without having to worry about it. Is compatibility a big thing for you folks?

**1150**

**Dr Wilson:** My understanding of compatibility is that most of these devices operate very similarly. My understanding of laypersons' involvement with this is, if I am a layperson in the Eaton Centre, an employee who has been trained in this—

**Mr Kormos:** A trained layperson.

**Dr Wilson:** Yes, a trained layperson—and I take this action, when I am buying the time until the emergency medical services arrive, they would take over the accountability and the responsibility. If there was a need to quickly remove the paddles from one machine and stick on another two, this takes seconds. This isn't a very long, involved procedure to do that.

**The Acting Chair:** I'm sorry, I'm going to have to interrupt.

**Mr Kormos:** I know you feel bad about it, don't you?

**The Acting Chair:** I do. I apologize.

**Mr Kormos:** You're teary-eyed.

**The Acting Chair:** You have noticed. If there's extra time I'll come back to you, sir.

**Mrs Molinari:** Thank you very much for your presentation. I do have a copy of the 2000 guidelines.

**Dr Wilson:** Have you got it memorized?

**Mrs Molinari:** Not quite memorized, but I have highlighted some points in it that are certainly interesting for me: the whole issue around the training and someone to be properly trained to use a defibrillator, the crucial importance of it and the possible effects and danger of someone not using it properly.

I just want to quote from your introduction. It says, "Public access defibrillators, which place AED in the hands of trained laypersons, have the potential to be the single greatest advancement in treatment," which is something that is certainly supported.

It also talks about inappropriate shocks or failure to shock. Under that it says, "Failure to follow the manufacturer's instructions for the use of a fully automated external defibrillator has in rare instances resulted in the delivery of inappropriate electrical countershocks." Then it goes on to talk about some of the specific and special situations that may require additional actions for an individual using a defibrillator.

I compliment you on putting such an extensive guideline together, because it's important for those who are using the defibrillators to have the knowledge in how to use them.

Bill 51 does not cover the training. In essence what it says is that defibrillators will be accessible throughout public places and that anyone who is close by to someone who has cardiac arrest may be able to use a defibrillator to save that person's life. What we've been hearing from several presentations through yesterday and some today is that there are no dangers in someone using such a device if they're not properly trained. Certainly in your guidelines in various cases—and I've only highlighted

three. It's probably as heavy as a brick, so there's a lot more in there that covers some of those aspects.

Could you comment, first of all, on the importance of the training and some of the effects that are negative in not using the defibrillator properly, and on some of the dangers? Certainly as a member of the Legislature passing a bill, I need to be assured that there aren't dangers and that in fact the device does what it is intended to do, and that is to save lives.

**Dr Wilson:** Thank you very much for that question, because you are absolutely correct. That's a very vital question. That took a great deal of the discussion as these guidelines were being promulgated internationally, because there's a certain base of evidence that exists and the feeling of the international experts in this field was that the evidence was solid enough to recommend the use of automatic external defibrillators by trained individuals. You will notice in their recommendations that they have indeterminate recommendations around getting them down, to deploy them just anywhere anyone might wish to buy a defibrillator. If you look at patients, for example, of a cardiologist, for a high-risk patient, that individual physician may recommend that to his patient and their family and train them in the use. So they would be trained.

But you're quite correct. Our position would be that this kind of a device, as safe as it is, is like any device. We have standards and guidelines when we work in factories or when we work in stores about occupational health and safety and devices etc. This is why we are recommending that this be looked at as part of a broader emergency services system, and that if organizations are going to buy and utilize these devices, there is the assurance of adequate training programs in place.

It's going to be an evolution over time. I liken it very much to the computer evolution. It gets simpler and simpler and easier and easier.

**Mr Beaubien:** But it's not simple enough yet.

**Dr Wilson:** I would agree to that. I'm a Luddite, so I would agree.

**Mr Colle:** I just want to correct the record. It's a very short bill. I wish the members would read the bill. It's two pages and there's a program. On page 3, it says:

"Training program

"(3) The ministry shall develop a training program and protocol in the appropriate use of portable defibrillators in conjunction with stakeholders that provide emergency services."

I just want to correct the record, that this bill does believe that training is an important part of introducing these life-saving machines.

I would also like to mention—and maybe I would ask for your input—that one of the suggestions I was given is that these machines can also save lives if untrained people can access them, as in the case of O'Hare airport, where every minute you can access one. We've got a lot of negative comments from the Conservative side. Would the Heart and Stroke Foundation then say, "Don't follow perhaps the O'Hare example in certain high-risk situa-

tions like casinos or perhaps golf courses"? Would Heart and Stroke say to people, "Don't touch that dangerous machine if that person's lying on the ground because you're not trained"?

**Dr Wilson:** I think that's a very excellent question and I think what we would say is we believe these should be used in a context with training, as you've pointed out. However, there have been many, many instances where people have had a cardiac arrest and an untrained bystander has performed cardiopulmonary resuscitation and made a difference in that person's outcome.

They may have broken several ribs while doing it; we do that in the hospital as well. However, the alternative to that is death. So I think your point is very well taken, Mr Colle, that no, we would absolutely not say, "If you're not trained, stand with your thumb in your ear and wait for the emergency services to do that."

These machines have a very high safety level. They're very well programmed, as you know from your background research. It's very difficult to make a fatal error with these machines. However, having said that, we would promote them in the context of training. That would be our preference.

**Mr Colle:** Just one other short question: I think you also made a very valid point, that there's been a bit of a misconception here in terms of medical oversight. I think the practice that is in place right now in the city of Ottawa is that the city's medical officer of health is the physician with the oversight, which allows the city of Ottawa therefore to place the machines in appropriate places as designated by the committee. Therefore you don't have to have a doctor directly involved with the specific location.

The other point I just want to clarify again is that, as you mentioned, the location of these devices shouldn't be willy-nilly everywhere. As this bill says, there's a stakeholders' committee that examines the epidemiology, the occurrences of high risk; therefore you start with the highest-risk locations where you would have these. My colleague from Sarnia talks about every 7-Eleven. This is not about every 7-Eleven. This is about casinos, airports and shopping centres. This is all done historically and very systematically. I think you concur with that approach of implementation, of looking at an audit of where they would be most effective.

**Dr Wilson:** Absolutely. That is exactly the way you would want to approach this. The people who are most likely to use them would be, first, fire, police, ambulance, lifeguards, people who are trained to do that. Then you would look at high-density areas where there is a higher-than-average occurrence of cardiac arrest and train there.

You're right; you move it down the system. But we would not recommend you start at the bottom and don't do any of these other pieces here. Our recommendation would be that you start in a systematic way.

**Mr Colle:** Highest priority.

**Dr Wilson:** Yes, sir.

**The Chair:** Thank you, Dr Wilson. We wish to thank the Heart and Stroke Foundation.

The committee will now take a break.

**Mr Kormos:** Chair, once again, to research.

**The Chair:** A question to research?

**Mr Kormos:** Yes, this whole relationship between the Regulated Health Professions Act and administration of one of these machine processes as a controlled act, so the status quo and its interrelationship with this bill. Do you know what I'm saying? I would appreciate it. I think I'm correct in saying the bill is still subservient to the Regulated Health Professions Act. End of story. I'd like to see that role.

**The Chair:** You had a question for research?

**Mr Colle:** If you look in the preamble: "The Ministry of Health and Long-Term Care in consultation with emergency health stakeholders is required to develop ...." That's in the explanatory note, first of all. Then, if you look under "Guidelines," "The Ministry of Health and Long-Term Care shall develop and publish guidelines in the use and maintenance of portable defibrillators in co-operation with appropriate health and emergency service stakeholders." Then also a training program is done with the same stakeholders committee. I didn't, obviously, do a good enough job of wording that, but there would have to be an expert committee that would decide all this stuff, that would be part of it. Not having a team of lawyers to draw this stuff up—

**Mr Beaubien:** This is what Mr Kormos has been suggesting for the past couple of days.

**Mr Colle:** Yes.

**Mr Kormos:** Well, the health professions act—

**Mr Colle:** So there would be an expert team that would decide all this stuff, in conjunction with the Ministry of Health.

**The Chair:** I'll remind the committee, we now break until 1:20 this afternoon, our first presentation. Those staying at the hotel here, checkout time is 1 o'clock. Committee adjourned.

*The committee recessed from 1203 to 1400.*

#### CITY OF OTTAWA LIFEGUARDS

**The Acting Chair (Mr Marcel Beaubien):** If I can get your attention, I'd like to bring the committee to order. I do have the blessing of the Chair, by the way.

We have a presentation from the city of Ottawa lifeguards. I would like to ask the presenter, Kim Desjardins, to step forward and state your name for the record, please. You have 20 minutes for your presentation.

**Mrs Kim Desjardins:** My name is Kim Desjardins. I am a lifeguard and pool supervisor for the city of Ottawa, currently at the Walter Baker Sports Centre pool.

Thank you, honourable members, for letting me speak on this issue. I just wanted to tell you quickly about the opportunity I had to use this machine in a real-life incident that happened earlier this year at the Nepean Sportsplex pool. As pool supervisors, it's our job to ensure that our lifeguards are well trained, and I participate in that training as well. It has always been

unnerving when you get a phone call or you hear a whistle indicating that your help is required.

On the day in question, I received a phone call in my office from the customer service clerk, who indicated that there was a gentleman who had lost consciousness in the male change room. At that point in time, the lifeguards responded quickly and secured the area and went in to assist the gentleman. By the time I got there, the lifeguards had discovered that he was not breathing and was without a pulse, and they were beginning to open up the trauma kit to apply oxygen and to use the AED that we had on site. We had had it for over a year and had been doing training etc, and this was the first time that we were going to use it.

At that point in time I opened up the machine and followed its directions and followed the training that I had had. After one shock was given, or shortly thereafter, after following the protocols, we noticed that the patient started breathing again. He regained a pulse. It was quite an amazing thing to see a lifeless, frail body that was grey and blue go back to a normal pink colour and to hear that breathing again. It was incredibly satisfying to see that transformation, as opposed to seeing the patient being wheeled out still having compressions done on them and not knowing what's going to happen. At least we knew we had done something at that point in time.

Having that experience, I wanted to just quickly talk about my feelings toward this private member's bill. I am in support of it. When we first were told that we were getting the AED machines at our site, as a lifeguard and coordinator of the administration of the facility my first reaction honestly was, "Oh, God, another piece of specialized equipment that we have to train the lifeguards on and monitor, whether we have the equipment or whatever." But having the machine there, it's so easy to administer: you do one check a day. Having used it in a real-life situation and been trained as an AED instructor, it's an incredibly valuable piece of equipment.

The reason I speak so highly of it is that as a rescuer, when you're doing CPR and rescue breathing, you have no time to stop and think, "Have I done everything else that I'm supposed to do as a lifeguard within a rescue?" With the AED machine it slows the rescue down. It gives all the people involved time to gather their thoughts, to think, to say, "Yes, I've completed this. I've called 911." In the instance that I'm referring to, before the patient even left the facility our lifeguard team had not only gathered all the witness statements that were required but had also contacted the family to let them know what hospital the patient was going to. Normally we wouldn't be that organized because we would be doing CPR and rescue breathing throughout the entire rescue. With the AED machine, when it's analyzing and shocking, it gives you that moment to take a deep breath, to say, "Has this been done? Has this been done? Do this." It really improved the quality of our rescue by leaps and bounds.

It is also an excellent machine because the rescuer doesn't have to do artificial respiration and CPR constantly until the paramedics arrive, so it's not as

tiring. If you can imagine pushing on someone's chest and giving breaths for a period of five to 10 minutes, it's not an easy task. It's very tiring, and it's very disturbing to someone having to do this knowing that this person might not survive. With the AED, pressing a button is very easy to do. There's no gross-out factor involved; all you're doing is putting the pads on and pressing a button. You do have to do CPR for a minute, but that minute goes by so quickly and the machine counts it down for you. It's basically foolproof.

One issue is the fear factor. As an AED instructor for both the Lifesaving Society and Active Canadian, the first question I always get, whether it's from lay people or trained lifeguards, is, "What if I put the pads on wrong or what if I put it on someone who doesn't need it?" The machine is so foolproof and safe that I don't think it would be an issue at all. I really want to push that. It's safe, it's easy to use, and it's easy to train people.

Currently, many people get CPR training. It's very easy to include this training, and I believe most associations are including the AED training in their CPR course. The more people who get trained, the more likely there will be in a public place at least one person who has seen the machine used before, whether it be in a CPR class or on television, or who has just read about it in the paper and realized that it's so easy to use and it's safe, and so they will attempt to use it and hopefully save someone's life.

That's all I have to say. Do you have any questions?

**The Acting Chair:** Thank you very much. Yes, we do. We have approximately three minutes per caucus. I can't remember which caucus is up, so I'll start with the official opposition.

**Mr Colle:** Kim, it certainly made me think of how frightened we might be encountering the situation that you did. How long before that incident occurred did you get the defibrillator on site?

**Mrs Desjardins:** We had the defibrillator on site for approximately a year, give or take, prior to that incident.

**Mr Colle:** When did you get trained?

**Mrs Desjardins:** I was trained probably 11 months before the incident happened.

**Mr Colle:** Was there a sequence when you were retrained or updated?

**Mrs Desjardins:** I was trained initially as an instructor with the Lifesaving Society, and so it was part of my job to initially train our staff on the use of it. All of our staff was trained the one time at that point in time, and I was fortunate enough that I had an opportunity to practise when giving the course.

**Mr Colle:** When you were training others.

It was the city of Ottawa, I guess, that installed it at the Nepean Sportsplex. Is that where it was?

**Mrs Desjardins:** Actually, the city of Nepean had two defibrillators the year before amalgamation, but now the city of Ottawa has an excellent program where they have distributed it to all of our aquatic sites.

**Mr Colle:** Where was it placed on the site there in the configuration of where the pool is?

**Mrs Desjardins:** At that point in time it was placed in our emergency trauma bag so only the lifeguards had access to it. Presently we have two units in that building, in particular one that remains within the lifeguards' possession and another one that is placed in a public area in the lobby.

**Mr Colle:** But this thing that happened there, you went as soon as the alarm sounded, or how did you get notified there was this gentleman?

**Mrs Desjardins:** The gentleman collapsed in the pool public change room, and another patron alerted the customer service clerk that he was in distress. The lifeguards obviously have emergency procedures that they follow, so the customer service clerk notified the lifeguards and then we responded as per usual.

**Mr Colle:** Where were you at the time?

**Mrs Desjardins:** In the main pool office.

**Mr Colle:** How far away did you have to go?

**Mrs Desjardins:** About a two-minute run.

**Mr Colle:** You ran down and then you had the whole kit with you?

**Mrs Desjardins:** The machine was there when I arrived.

**Mr Colle:** Who had brought it there?

**Mrs Desjardins:** One of the on-duty lifeguards. I'm certified as a lifeguard, but I was the pool supervisor. The lifeguards had already initiated everything.

**Mr Colle:** So you were the supervisor at the time. Who opened up the machine and started to apply the pads?

**Mrs Desjardins:** That would have been me. I stepped in. They were transferring the patient. He was beside a set of lockers and a bench, so it was a very confined area. When I arrived they were just moving him into the middle of the floor so we had room to work. That's when I opened up the bag and took out the AED.

**Mr Colle:** Had someone already been doing CPR?

**Mrs Desjardins:** Yes.

**Mr Colle:** The CPR had already been started.

**Mrs Desjardins:** Yes.

**Mr Colle:** Then you applied the—

**Mrs Desjardins:** The pads.

**Mr Colle:** And he wasn't breathing?

**Mrs Desjardins:** He was biologically dead at that point in time: no breathing, no pulse.

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**Mr Colle:** OK, and then you applied the pads. You just had to shock him once?

**Mrs Desjardins:** We had to shock him once, yes.

**Mr Colle:** And then he started to—

**Mrs Desjardins:** Then we followed the protocol for a little bit longer, where it re-analyzes and asks you to re-check pulse. It was very obvious when he regained a pulse, because he took a deep breath and started to pink up right away.

**Mr Colle:** The last comment I'll make: you mentioned that the machine helped you with the quality of the rescue. Could you just explain that to us? We're all novices here, really.

**Mrs Desjardins:** The lifeguards are very well trained. They have excellent emergency procedures. But without that piece of equipment, the lifeguards have to focus on actively treating that person by giving compressions and breaths for the entire rescue. There's no pause. With this machine, once you put the pads on, you actually can sit back, press the button and wait until the machine analyzes, and then it will tell you either that a shock is advised or no shock. So you have that time to sit back and go, "We're doing OK. Has the ambulance been called? Has the pool been secured?"

As the leader of that rescue, it gave me an opportunity to sit back and take a break and go, "OK, everything is being done. The patrons are safe. The pool is secure and 911 has been called. We've got witnesses waiting to give their statements." It just gave us so much more time to sit back and think, "Is everything being covered that we need to do?" By the time it's analyzed and a shock is indicated, again, all you have to do is sit there and make sure the area is clear and press that button and then follow the prompts. You don't have to be too bright to use the machine.

**Mr Kormos:** You don't have to be too bright to use the machine? Any of us could do it.

**Mrs Desjardins:** Any of you could do it within about five minutes here, I think.

**Mr Kormos:** Thank you very much; I appreciate what you've had to say to us this morning.

**Mrs Molinari:** Thank you very much for your presentation. Certainly in your job you've had some interesting experiences. From sharing one and the benefits of having a lifesaving technique and ability and being trained in that, the benefits of it, certainly it did well for you in that incident.

The one concern that resonates for me constantly is the issue around improper usage and improper training of an individual, or no training for that individual who might be using it. To presenters throughout yesterday and today, I consistently asked this question, because I need to be reassured that all of the safety factors are taken care of and that it's not going to be used by someone who is not trained and could in fact cause harm rather than benefit, not only to the individual who is being treated but also to other individuals surrounding.

I've done some research. The Heart and Stroke Foundation indicates there are certain steps that one needs to take to ensure it's used properly. One presenter yesterday, a manufacturer, Philips Medical Systems, also made a presentation about the equipment. They were asked the question that I'm asking all presenters about the dangers of improper use. At the time they had said there are no dangers, that it's foolproof, yet when you look at their user guide, it has warnings. It says "conditions, hazards or unsafe practices can result in serious personal injury or death," and then the danger, "immediate hazards which will result in serious personal injury or death."

Could you comment on that factor and what one needs to be aware of in case of improper use or someone using

it who's not trained and what the negative effects to that would be?

**Mrs Desjardins:** As I had mentioned before, when you're teaching people, that's always their first question: "What if I hook it up to someone who doesn't need it: they're just sleeping and I hook it up?" Or, "What if I hooked it up to my dog? What would happen?" With the new technology, those machines will only indicate a shock and charge up to deliver a shock—now, I'm not a manufacturer; I'm not an expert—when a certain rhythm, a shockable rhythm, is indicated. For normal sinus rhythm, it won't indicate a shock. So for all of us sitting here, it would never indicate that a shock should be delivered.

That fear aside, I don't have any fears of it being hooked up to someone and used, the button pressed and some terrible harm coming to the person because they didn't need a shock. The only safety issue is to stand clear when you're administering the shock. I believe all the machines indicate "stand clear."

I just taught my mother-in-law how to use the machine two weeks ago and she was amazed at how easy it was. She hates doing CPR, but she was so focused, because she had never used the machine before, listening to what that machine was telling her. I believe any layperson who has the guts to take it off the wall and use it without any training is going to listen to the prompts. So if it says, "Stand clear," I think that person is going to be listening to the machine and saying, "Hey, everybody, stand clear," because they're going to be nervous and they're going to want to do the right thing. They're not going to be lackadaisical about it and just be pressing buttons randomly. I would hope that anyone who used it without proper training would be following the prompts to the letter.

The safety issues—when I get in my car, it has an air bag. The first thing I do when I flip the thing down is—there's a warning about the air bag: you shouldn't have your little child in the front seat, you shouldn't have your seat too close to it. You have to use safety equipment properly for it to be effective. I believe the benefits far outweigh the risks with this machine.

**The Chair:** Thank you very much for your presentation.

**Mr Colle:** By the way, did the guy ever thank you after the fact?

**Mrs Desjardins:** Yes, we got several letters from his family and his grandchildren and he came in and thanked us, and he swims every day again. He's back at it.

#### PARAMEDIC ASSOCIATION OF CANADA

**The Chair:** I now wish to call forward the Paramedic Association of Canada. Do we have a representative here? If you'd have a chair, sir. I'd ask you to identify yourself for the purpose of Hansard.

**Mr Paul Morneau:** Certainly. Mr Chair, committee members, my name is Paul Morneau and I appear today on behalf of the 16,000-plus paramedics represented by

the Paramedic Association of Canada, PAC. PAC is a professional association that acts as a patient advocate and supports the profession of paramedicine. I would like to thank the Chair and committee members for the opportunity to appear to speak about Bill 51.

I'm an advanced care paramedic and have worked as a professional in the field for over 12 years in both eastern Ontario and in the Dufferin and Caledon regions. Prior to my professional status, I worked over a seven-year period as an emergency first responder for several groups. I will endeavour to share with you today the concerns of front-line paramedics on the issue of poor survival rates in sudden cardiac arrest patients in Canada.

I know that several groups have already enlightened you on the poor survival rates for cardiac arrest patients. Presently in the best-case scenario it is unlikely that a person who suffers from a sudden cardiac arrest will have a trained rescuer by his or her side in less than five minutes or so; often it's much longer than that. The Heart and Stroke Foundation and all the scientific studies that back them up have made it clear that the key to saving more victims of sudden cardiac arrest is rapid defibrillation. In fact, the Heart and Stroke Foundation has shown that there is a chain of survival that is required in order to reasonably expect a person suffering from a sudden cardiac arrest to survive.

This chain of survival can be summarized into four basic steps: early access—having 911; early CPR—someone starting CPR; early defibrillation; and having early access to advanced life support.

The Paramedic Association of Canada represents the men and women of the last link in this chain of survival: the paramedics. Paramedics across this province and the country work very hard every day to try and save victims of cardiac arrests, and yet survival rates tend to be dismal. It is so upsetting to us when we are unable to save someone's father, mother, other family member or a friend, not to mention the people who are related to this person or are friends of this person.

Having access to advanced life support paramedics plays a critical role in saving patients suffering from sudden cardiac arrest. The province of Ontario and now the upper-tier municipalities—the UTM's—across the province continue to do an admirable job in increasing the education of paramedics to the advanced level. However, we realize, like any chain, we are only as strong as the weakest link. We must have an established public access defibrillation program if we are to ensure that victims of sudden cardiac arrest have the best possible chance for survival.

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PAD programs must have (1) consistent standards that are used province-wide or, at the very least, throughout the local UTM; (2) medical oversight; and (3) local coordination. The local emergency medical service, the EMS system, may be an ideal group to coordinate the training provided by various public and private agencies. They may also be an ideal group to monitor the PAD

program locally and ensure that quality assurance and quality improvement processes are put in place.

Having uncoordinated use of PAD leads to varying protocols, with different pieces of equipment which may hinder the ability to properly evaluate the successes and/or failures of the program. In addition, paramedics who respond to the scene of a sudden cardiac arrest must know what to expect and must be familiar with the protocols and equipment being used in their communities.

Both the cities of Calgary, Alberta, and Ottawa, Ontario, are good examples of functional PAD programs which are coordinated through the local EMS systems. These systems help ensure consistent standards, medical oversight, quality assurance and quality improvement.

Paramedics are the professionals of prehospital care. PAD programs should be a coordinated effort, and our EMS systems may be a good place to establish them.

Paramedics from the Ontario Paramedic Association and the Paramedic Association of Canada should be an integral part of any committee that comes from this bill or anything that is developed further. We want to be a part of that.

I would be happy to answer any question you may have. We ask for your support for this legislation that will help to save the lives of our patients.

**The Chair:** Thank you very much, sir. We have a little over three minutes for each party. Comments or questions?

**Mr Colle:** Thanks very much for coming, Paul. This is based in Kamloops, the national paramedic association?

**Mr Morneau:** That's where the address is. We're across the country. I'm actually based out of Ottawa.

**Mr Colle:** Do you keep any data in terms of the use of defibrillators by paramedics among your professional association?

**Mr Morneau:** We wouldn't keep specific data about the use of defibrillators, other than that it's widespread. It's very rare to have a paramedic in this country who doesn't have a defibrillator at this point in time. They've been around for years now. We're at the point now where it's become so sophisticated, yet easy, that we have public access defibs, machines that are very smart and very safe to use, and it's time that the public can use them. It doesn't have to just be in the hand of a paramedic.

**Mr Colle:** What percentage would you say of paramedics operational in Canada use external, portable defibrillators?

**Mr Morneau:** I would be guessing.

**Mr Colle:** How high is that guess?

**Mr Morneau:** I would suggest 98%.

**Mr Colle:** When a paramedic goes out on a call, they more than likely have an external—

**Mr Morneau:** Absolutely. Unfortunately—

**Mr Colle:** The paramedic would not want to go out to a call without one of the defibrillators, right?

**Mr Morneau:** No. It's a critical piece of the equipment we carry today.

**Mr Colle:** In all these calls the paramedics make across the country, what percentage of these calls involve accidents or some kind of mishap caused by the use of an external defibrillator?

**Mr Morneau:** I've never heard of any incident.

**Mr Colle:** For how many years have paramedics used the defibrillators?

**Mr Morneau:** At least 10 years. You know, Johnnie and Roy from Squad 51, almost 30 years ago from TV. I know it's a TV show, but where paramedics were initiated early on, they had machines. Defibrillators have been around for a long time and certainly in the past 10 years, I'd say, it's widespread in pre-hospital use. Like I said, it's time now that the public gets a hold of this.

**Mr Colle:** We've heard some deputations here that say, "Be careful of water, be careful of radio signals. There are all kinds of dangers with the machine." The experience of the paramedics is that the so-called mishaps have been few and far between as a result of using—

**Mr Morneau:** Absolutely, and I've certainly heard of the occasional mishap where a paramedic has shocked themselves or they've been touching the stretcher and the defibrillator's gone off, but it literally has been nothing significant other than being written up as happening because they were touching the stretcher or something. It is nothing more than if you were working on your electrical system at home and your screwdriver touched the wrong wire for a second. No one that I know of ever required any kind of treatment or care—no paramedic, that is—because of any mishap. Certainly those mishaps are few and far between.

**Mr Colle:** When we were in Toronto there was a debate about whether or not to let firefighters use the defibrillators—they shouldn't use them because they aren't trained and so forth. Was there a debate 10 years ago of whether or not to allow paramedics the use of the external defibrillators? Did that come about basically within the professional association? How did you get them?

**Mr Morneau:** I think the need was there. Especially over the last five to 10 years in Ontario the education level of paramedics has gone up dramatically and, of course, the defibrillators we use are much more sophisticated than what we're talking about here so we obviously require training. I suppose you could say that even the defibrillators that came out years ago required more training at that time. Now, these public access defibrillators are so automated and so automatic and are able to determine whether or not to shock someone so accurately that the level of training that we require for our machines certainly isn't required for the public. That's not to say the public shouldn't be trained. We certainly do advocate training and standards to train the public.

**Mr Colle:** Thanks so much, Paul, for taking the time to come.

**Mr Kormos:** I appreciate the comments. You should know that your Ontario counterparts were in Toronto yesterday. Johnnie and Roy?

**Mr Morneau:** Squad 51? It's the old—

**Mr Kormos:** I'm older than you are.

**Mr Morneau:** —emergency, you know, Rampart General. It was on TV 30 years ago. It was a great show. That's probably why I am what I am today.

**Mr Kormos:** Had it been on 40 years ago I'd remember it, OK? Thank you.

**Mrs Molinari:** Thank you for your presentation as well this afternoon. Certainly, as a paramedic, your training to be able to use a defibrillator in life saving and all of that has done you well.

The drafter of the bill asked about the mishaps that might have been caused, and we need to hear about any of those. I'm pleased to hear there haven't been any in the ones that you've indicated. I think at this point it's been because all of those who have been using them have had the proper training and know exactly what to do when they're using a defibrillator.

If they're not at this point in time readily available for someone who has not had the proper training, my concern comes around the whole issue of someone using it and not being properly trained. As a representative of the government, and as a member who represents a constituency in my community, I need to be assured that what we're putting out is life saving, which we've all heard it is so I don't dispute that. But I need the reassurance on the other side that it won't cause any harm or damage or injury to anyone using it who is not properly trained.

We've had presenters from the manufacturers who have talked about how foolproof it is and how safe it is, yet in their manuals and users' guide they highlight all kinds of warnings. The Philips Medical Systems is one that says "possible explosion hazard if used in the presence of flammable anesthetics and concentrated oxygen." The warning is: "Improper use can cause injury." The Forerunner, which is what they call the defibrillator, "delivers electrical energy that can potentially cause death or injury if it is used or discharged improperly."

These are the concerns that I have, and in the hearings I need to be reassured that this in fact is something that can be used with the proper training. What is it that we need to do to the bill to ensure that these types of fatalities don't occur? Could you comment on the use of such a device by someone who would be properly trained, because I think you also mentioned that the general public can use it. What about all of the safety factors and not knowing all of those and being able to use it and causing some harm, in essence?

**Mr Morneau:** Yes, certainly the general public can use it once they're trained and we agree that they should be trained to certain standards before they use that machine. With regard to the fatalities that it may cause, I would suggest that there are thousands and tens of thousands more fatalities from cardiac arrest every day.



But I understand your concern. All I can say is I suppose you might be talking about the one-in-a-million chance of something like that happening if someone doesn't have the training and if they go ahead and use it for some reason and everything comes into place that they cause this accident, that might happen. I'm sure the manufacturers or whomever you're quoting here, as per a lot of manuals you read, are very careful in the way they word things; they want to cover their behinds in case anything happens.

My experience is that those things don't happen, and when they have happened, they've been minor. The paramedic I'm thinking of, the situation where they were touching the stretcher when it went off, the electricity was going through the two pads. It was just a slight shock. It didn't require treatment or anything; we just know about it. So even the instances that have happened have been so minor that I doubt—I've never heard of a fatality because of someone using a defibrillator. I think the benefits outweigh the slight chance of any of these downfalls.

**The Chair:** Thank you, Mr Morneau. We appreciate that input.

There are several delegations who, to my knowledge, have not arrived. I'll just check again with the people in the room. City of Ottawa Community Services—I don't think they're present. The other one, city of Cornwall and SD&G Emergency Services—I don't think they are here. Prescott and Russell Emergency Services has cancelled, to our knowledge. Our clerk has indirectly been in touch with the remaining delegation, the city of Ottawa Emergency Medical Services. We understand they may be arriving in 10 or 15 minutes. That would be the only remaining deputation.

**Mrs Molinari:** And city of Cornwall?

**Mr Colle:** City of Cornwall cancelled.

**The Chair:** Wishes of the committee? I might suggest a 10-minute recess.

**Mr Kormos:** What about the folks waiting, Chair?

*Interjections.*

**The Chair:** Coffee is available.

*Interjections.*

**The Chair:** I think we're into the recess.

*The committee recessed from 1433 to 1450.*

#### CITY OF OTTAWA EMERGENCY MEDICAL SERVICES

**The Chair:** I think we can reconvene. We wish to thank the city of Ottawa Emergency Medical Services for coming in a little early. We got ahead of our schedule and we really appreciate your coming forward to testify. If we could ask you to identify yourselves for Hansard, and then we have 20 minutes for your presentation.

**Mr Anthony Di Monte:** Very well. Thank you very much, Mr Chair and members of the committee. Good afternoon and thank you for allowing us the opportunity to come and meet you this afternoon. My name is Anthony Di Monte. I am the director of emergency

medical services for the new city of Ottawa. To my immediate left is Mr Mike Nolan. He's the manager of program development and is responsible for quality assurance and training of our paramedics. To his left is Mr Andy Robert, who is our manager of operations, responsible for the day-to-day street operations of our service.

We'd like to give you a general summary. I know a lot of this will be redundant for the eminent members of the committee. You've heard over the last few days, both in Toronto and here, a lot of the technical jargon, but we feel it's still important to slowly walk you through it, if you'd permit us to do that, and then after that we will certainly answer any questions that you may have.

Just to give you a bit of an overview, the city of Ottawa assumed responsibility for land ambulance as it became a new, integrated city on January 1, 2001. So this is a new initiative for the city, running an ambulance service. At the same time, council probably struggles with a lot of the questions this group has been hearing the past few days: issues of security, issues of value added to the citizens and to what extent we will be saving lives with this type of program. The decision was made to integrate this within our emergency medical service as probably a best practice. We have in the city of Ottawa as of today one of the largest AED programs in North America. We're quite proud of it and I'm going to walk you through that this afternoon.

A bit of the history of our program here: in 1988, the Ottawa-Carleton ambulance service, then run by the Ministry of Health, began its first AED program. Then followed the fire services of the area in 1993. In 1999, the survival rate in the city of Ottawa was only 3.8%, which is dismal when we compare it to other statistics across North America in some more progressive cities. In August 2000, the then regional council approved the implementation of the PAD program within the new city of Ottawa's EMS service to be a way of assuring quality, continuity and distribution where there would be value added. Ottawa is now, as I mentioned, not only the Canadian leader but, as far as we know, the North American leader in placements of AEDs. Some 337 are placed throughout the community of the new city of Ottawa.

This year, regardless of the program, 400 of our residents and visitors will have a cardiac arrest incident and, without an intervention, will die. In one case study which I know this committee has already heard of, we had a 70-year-old male in one of our sports complexes, which is one of our success stories of a total integrated EMS response, AED being one part of the chain of survival. That's why we are so convinced that it is important to put that in the context of a total chain of survival response and emergency medical response. I won't get into more detail; you have probably first-hand knowledge of the person who intervened in that case, and that person probably did a much better job than I would relating after the fact what happened in that situation.

As we speak today, we have 182 public sites that have AEDs. We sponsor training of approximately, when we

complete this by the end of the year, 3,500 targeted staff throughout the city. Our EMS quality assurance and continued quality improvement program assures continuous review of each of those cases. Where it's necessary, we intervene with post-debriefing of rescuers. For the lay public that may use this, it's extremely important for us to intervene afterwards, post-debrief with them. The monitor is then taken and charged by the EMS service. A new one is replaced in the facility. It is then taken and put through its preventive maintenance program and through our quality assurance program. Our medical director is able to review for medical appropriateness the entire case that took place, and we assure the quality of the intervention as well. Then we have an equipment exchange, as I've already mentioned, of the defibrillator that was used immediately on site. The device is replaced immediately in case there would be another incident in that facility. There is no delay.

We also continue a promotion of our Ottawa AED program and community challenge, where we believe there is a partnership. Our corporate citizens have responded well to this, not only the public side of things, where the city has intervened and we have added these apparatus to different facilities, but we believe our very strong corporate community here has stepped up to the plate, through both their employees as well as the visitors to their corporations, and have added AEDs in many of the large facilities such as Nortel, Alcatel, golf courses etc, and many provincial and federal government facilities as well. You can see that this is, from our perspective, more a community approach to this program. It is one component in the chain of survival. On page 4, at the top you see a very small map—probably difficult to read, but it gives you a general idea. All those little red dots are where AEDs are placed throughout our community.

Essentially our vision is that we believe this bill should be enacted into law. We think it is an excellent piece of legislation. We respectfully submit that perhaps there would be a couple of recommendations for improvement:

(1) We believe the bill should include the necessity to add this within the Ministry of Health and Long-Term Care funding to emergency medical services, because we believe this is a medical device that requires medical supervision, quality assurance etc.

(2) Giving the responsibility to the local emergency medical service is probably the way to go, for several reasons: there is already strong control by the Ministry of Health of these programs; there is base hospital medical control, which would control the aspect of medical supervision of this program; and the EMS services, such as ours, are quite capable with the staff to intervene, to support local community services that wish to do this and, within our staffing and our capacity, to replace used defibrillator pads etc, with the appropriate funding.

So those certainly would be two of the recommendations: (1) for funding to be provided to EMS services and (2) for these programs to be devolved under the

responsibility of the local EMS service, whatever it may be across this province, as each community has made its decisions over the last few years.

That's the presentation. As I said, I didn't want to get into too much technical detail. I'm sure you've all heard those things, but I am more than willing to answer any questions and entertain any of those technical details you wish. Thank you very much for your time, Mr Chair.

**The Chair:** We have about three minutes for each party. We'll begin with the NDP.

**Mr Kormos:** Ottawa had done all this without any enabling legislation. Why do you need Bill 51 now?

**Mr Anthony Di Monte:** Certainly, you are correct in pointing that out. There has been a community initiative. It's something that this community did as an initiative and that this council felt very strongly about and we certainly believe in. We believe, however, that legislation would go a step further and provide not only to the citizens and the visitors of the city of Ottawa but to all citizens of the province of Ontario the incentive, the initiative and the capacity to do that. Bill 51, outside of our very myopic view of just the city of Ottawa, avails to all the citizens of this province what we believe is an important program.

**Mr Kormos:** Not all organizations, places, spaces, have the resources that Nortel does, but then again, Nortel doesn't have the resources that Nortel used to have. I wonder if you had to give back any of those units. I am concerned because I'm confident where I come from down in Welland—we've got little ethnic halls, places like that in smaller-town Ontario—they simply don't have the resources. Do you agree that the government should fund appropriate places: institutions, non-profit organizations who accommodate, let's say, groups of seniors, who have high-risk communities within them? Would you as a taxpayer agree that it's in all of our interests to help these people buy these units and pay for the training?

**Mr Anthony Di Monte:** I believe that certainly is—and I don't want to defer the question—a decision for the policy-makers around the table.

**Mr Kormos:** But we need help. Those guys have short arms and deep pockets.

**1500**

**Mr Anthony Di Monte:** I'm not here as a taxpayer, but rather as a public administrator of a system. I just want to reiterate that I not only support this but I believe this is a very important program. We believe that by enabling the legislation it also would provide the capacity, whether it's a direct payment or not, were there to be more of these defibrillators available, to perhaps drive the price down through private industry. I think there are innovative ways to look at that, so it could be direct billing, but perhaps by encouraging private enterprise to say, "Well, we're going to have more clients out there. Maybe we can drive down the cost of these units." There are many methods that I would respectfully leave to your better judgment than my own.

**Mr Kormos:** I know what you're thinking, though.

Has it been your experience that when these machines have been put into workplaces, been put into public places, that this generates, let's say, more awareness, more discussion about the whole process, including CPR; that people start to get tuned into it and maybe they are easier to talk to about CPR and a broad range of things?

**Mr Anthony Di Monte:** I would submit to you, without any doubt. As well, it opens a much broader range. You've heard from other experts about the chain of survival. It's one component of the chain of survival. Recognition of a problem is the first thing; activation of 911, the community resources. We integrated this in our police service, in one of our police cars. We train every one of our police officers, our firefighters and our advanced care paramedics. So it's a whole community; it's a chain. It's not just microscopically focused on AED placement.

So the answer, quite directly, is yes, it stimulates discussion within industry, within workplaces, within the community, and it gives us, as an EMS service, the opportunity to go in there and do prevention and really have a grassroots, community approach to health care.

**Mr Kormos:** And you clearly believe it's imperative that EMS, as part of the public sector, as public servants, as leaders in their communities, be involved in the development of this in respect of communities.

**Mr Anthony Di Monte:** Without a doubt. I think we are, for lack of a better term, at the end of the chain of survival. With the fire services we've seen over the years prevention programs; with police services, community policing. EMS is just another one of those components. This is a way for us to get into the communities, a way for the communities to become part of the solution and to help us do our job and, at the end of the day, save lives.

**Mr Kormos:** And you're saying you can do the training as a public sector body?

**Mr Anthony Di Monte:** With appropriate support. The model that we chose in Ottawa—and I would submit that each community would have to make those choices—is that we didn't take on extra staff and extra public burden to do the training internally. What we did as we ramped this up is that we purchased equipment and then we went out to training institutions to partner with them—

**Mr Kormos:** You contracted out?

**Mr Anthony Di Monte:** We did. We contracted out for several reasons. One, they had the capacity to do it. They are already doing it out in the community. They are doing a good job under the heart association norms. As well, it was a way for us to assure the quality assurance through our medical director and that group. So we felt it was very successful. It was contracted out through an RFP and through several teaching institutions, and it was successful for us, so we didn't have to take that extra burden on board.

**Mr Kormos:** To the private sector?

**Mr Anthony Di Monte:** There was private sector involvement, yes.

**Mr Kormos:** And you and I were getting along so well. Thank you very much.

**Mrs Molinari:** Thank you very much for accommodating the committee today and coming early. We certainly appreciate it.

First of all, I want to congratulate all the work that Ottawa has done on the implementation of this. It certainly is an example for all of the other municipalities to follow.

I was interested in your response to Mr Kormos's question about why you need this bill. You've done a great job at it; why don't other municipalities just follow your example and continue on?

As a legislator, as an individual member and part of the government side, one of the concerns I have raised—and I have done it consistently with all of the presenters because I need to gain a comfort level with some of the issues I have with regard to the danger of having non-trained individuals using the device. You're all professionals, you're all trained in using it, and you're training others to do the same. In Ottawa, my understanding is that you have a system where those who are using it are trained, and it's fairly new.

We heard one presenter earlier, a doctor from Ottawa, who said that this bill is premature. There is a study now being conducted on the effectiveness of PAD and whether or not it is all it is intended to be. His suggestion was, why don't you wait until that study is completed before implementing something like this province-wide; at least you'd have some data?

We've had presenters who are manufacturers of the device, and some have commented that it's foolproof and there is absolutely no danger in someone's using it. Yet when you look at their user's guides and manuals, they highlight all kinds of warnings. I highlighted some of them previously. Philips Medical Systems is one that presented to us yesterday and said there wasn't any concern, that anyone in the public could just take it and use it because it's that easy to use. Yet they caution in all these warnings. One is, "Caution: this equipment is for use only by a qualified person." So a "qualified person" would have to be identified. Who is a qualified person? Obviously it's someone who would be trained.

In the remainder of my three minutes, I hope you will have time to tell me some of the dangers of someone using it who is not qualified and not trained, what dangers there would be to the victim, to the individual and to other bystanders and people who are in the general vicinity.

**Mr Anthony Di Monte:** As I stated earlier, as you are grappling with some of the security issues, our council did too. We certainly believe the benefits far outweigh some of the risks. I don't deny there may be risks. I know you have probably heard horror stories from fearmongers who talked about past apparatus that you could jump up and down and defibrillate yourself. The newer apparatus has more foolproof systems.

I believe nothing is foolproof. Perhaps the analogy would be that in the 1970s cardiopulmonary resuscitation, CPR, was only done by physicians. Today that

notion would be deemed a little ludicrous, because the lay public can certainly do that well. I believe this is another stepping stone toward that. As well, some of the risk factors—once upon a time we didn't have fire extinguishers in every building and in every public room, and there were risks for that. You could use a water extinguisher on an electrical fire. There may be dangers or hazards, but I think the benefits far outweigh the hazards. I submit to you that it's the same thing with AEDs.

Quite clearly, our position is that only trained people should be using this apparatus, and as such ours are mounted in facilities, fixed in facilities. There's an alarm when you open the thing. Yes, I know what the question will be. Absolutely, a teenager will do that and somebody can open it up. They are in areas of high visibility where there's staff, and we take all the reasonable precautions that anybody in any society does with regard to things that may have risks. Again, I truly believe the benefits far outweigh those minimal risks. However, it hasn't been our experience in the short amount of time we have been using them. We haven't had any incidents, and I'm touching wood that we never have an incident with regard to misuse of that apparatus etc.

Directly to some of the risks, I believe there are probably more technical people to give you those things. But as far as our program is concerned, and what we would recommend to this learned group, it should only be trained personnel who use it. The program should be based that way. While they are placed in public realms, certainly there is always a risk. But as I said, I think you can negate those risks by putting them in areas where they are very visible and fixed to the walls—there is that alarm system—and where there is permanent staff. I think there are a lot of counterbalances you can do. Without being melodramatic, and respectfully, that's not my objective here, I submit to you that 70-year-old who is at home with his family—I would perceive that their view on a PAD program is probably different from the naysayers who perhaps have been trying to dissuade this committee from moving forward.

1510

**Mr Colle:** Did you or any of your family ever go to St Pat's college?

**Mr Anthony Di Monte:** No, sir.

**Mr Colle:** That's an inside thing.

I certainly want to congratulate the emergency services in Ottawa and city council for being so progressive and such a model for the rest of the country, along with Windsor, which has a program perhaps. I think you're doing a service and maybe setting a standard for the province and the country. I think you took a risk to save people's lives by setting in place a comprehensive program that I hope the province will copy as its model.

You have really dampened a lot of the fearmongering, which took place with CPR, about machines exploding. Somebody mentioned the arguments about air bags being dangerous, too. They say: "Danger." But remember the hearings on seat belts? "Don't use those seat belts. They could rupture your spleen."

So I certainly want to thank you, and please pass on my thanks and the thanks of all my colleagues here for the great work EMS in Ottawa is doing. I really do think this is going to be the model that will be replicated. I'm going to pass on to Richard Patten.

**Mr Patten:** Likewise. Your cousin Dean did an admirable job earlier this morning.

**Mr Anthony Di Monte:** It's problematic having a relative in the same business.

**Mr Patten:** No, not at all. Just on the training issue, I think everyone says the ideal situation is for people who are trained to use this thing. This is just pushing the envelope a little further to try to engage the community, beyond professionals. It attempts to stimulate training, of course, but it seems to me we're pretty close, having gone through the latest piece of technology. I remember using one a few years back when I was with the YMCA, and it was about this big. I saw the one that one of the city staff—the person who actually used it in the case of the 70-year-old is here with us today, and someone else from the Red Cross was showing me a little, tiny package that is quite amazing.

It's almost at a foolproof stage, it seems to me. In any hearings you'll get those who will find the most definitive possibility of an error, and of course most systems have that. Obviously you support training for users. But knowing that we're moving toward trying to engage the public a little more in this and the advancements in technology, what suggestion would you have, either in terms of an addition to the bill that might answer that question or in terms of initiatives a city might take through city council or in conjunction with organizations etc, public education and awareness campaigns or what have you? What kinds of suggestions would you have to move the yardsticks along?

**Mr Anthony Di Monte:** You raise a very good question. Now we're entering the realm of the hypothetical and, as you say, pushing the envelope. Certainly I can give you an opinion on that; there are some innovative things that are taking place. I concur with you that the technology—foolproof, perhaps, is not the best word, because there's always minimal risk and you have to balance that and make decisions as legislators. There are examples of communities that are starting to look at the possibility—I've heard, but I don't have the factual information here—of a closed-loop training program on a little video screen about how to do CPR while you're waiting in an airport. I've heard of programs in schools, as well, where in the washrooms, instead of bringing your own reading material, you have ABCs of how to do CPR. Perhaps we could push the envelope and have basic—I would certainly suggest, at the point we are today, that training is probably the right way to go to start with. But perhaps as a refresher to that, you could have that interactive type of thing or that type of reminder, a refresher—as I said, while you're in the washroom, instead of your reading material, being reminded of what you learned in training.

I think there are all sorts of initiatives. Perhaps, as a group of legislators, something that has been explored in

other jurisdictions in North America: looking at the education programs in phys=ed, that it be part of the education program that you take a CPR course in high school and every year that's refreshed. Perhaps we can push the envelope and look at AED as another component. I think there are a lot of things to do out there.

Again, I'd risk entering a realm that wouldn't be my level of responsibility. But each community can look at some of those innovations, and perhaps there are communities that will find solutions we don't have here today or haven't thought of. I think that's the environment we want to create, so we can find the best ways of doing things. Perhaps to repeat, we've been very successful in the partnership role. I think the public sector has a very big role in the leadership. We've had our corporate partners who have helped us a lot in this program, and I think enabling legislation such as this will just give us a better tool to move forward.

**Mr Patten:** You have some experience under your belt now. Are you keeping track of your experience; in other words, is your data collection able to tell you the time that has elapsed and what happened and the success rate and all that kind of thing?

**Mr Anthony Di Monte:** Absolutely. That is an extremely important part of our component. We analyze each and every case. The medical director looks at it. We look at ways we can perfect, move forward. Successes, non-successes—was it a question of the system, or was the pathology of the patient such that unfortunately we just didn't have a patient to resuscitate? So, yes, every one of those cases.

As I said, our police service—we train them all, and we've added in every marked police car a defib on board,

the one you saw, the little one. They just started operating and responding to calls in June as part of our tiered component, and they've already intervened in four cases. In two of those cases, they converted patients. Those patients didn't go on to survive, as we were successful in the Nepean incident, because of other pathology. But the machine did what it had to do. It took a ventricular fibrillation and converted it to an appropriate rhythm. Those patients didn't survive in hospital for other reasons. The other two cases were traumatic cardiac arrests where major trauma had occurred as a result of a car accident or a head-on collision. Unfortunately in those cases—and the literature will show you medically—there was no chance of survival.

But we're seeing great community involvement. We have police, we have firefighters who have first aid and have defibs on board. Now we're moving to bring all our paramedics to the advanced medical care level. So that whole systems approach with the lay public and defibrillators—that's what we want to reiterate. We believe it's not one person but a community approach to that. This legislation certainly would move us a step closer, we believe, to where Ottawa is, but provide that capacity to all citizens and visitors across this province.

**The Chair:** On behalf of the committee, I would like to thank you for your presentation. This concludes the hearings on Bill 51.

**Mr Colle:** Thanks, Mr Chair, for your patience.

**The Chair:** I think any further direction on this bill will be once the House has reconvened.

The committee is adjourned.

*The committee adjourned at 1518.*



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