



DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND  
2050 WORTH ROAD  
FORT SAM HOUSTON, TX 78234-6000

REPLY TO  
ATTENTION OF  
MCHO-CL-C

OTSG/MEDCOM Policy Memo 04-004

Expires 4 June 2006

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**MEMORANDUM FOR COMMANDERS, MEDCOM REGIONAL MEDICAL  
COMMANDS**

**SUBJECT: Guidance on the Placement and Use of Automatic External Defibrillators on  
Army Installations and within Army Facilities**

**1. References:**

a. Public Law 106-505, Public Health Improvement Act (Cardiac Arrest Survival Act of 2000), 13 November 2000.

b. United States Department of Health and Human Services, Guidelines for Public Access Defibrillation Programs in Federal Facilities, January 18, 2001; see <http://www.foh.dhhs.gov/public/whatwedo/AED/HHSAED.asp>.

c. Guidelines for Public Access Defibrillation Programs in DoD Facilities, Federal Register: May 23, 2001 (Volume 66, Number 100), Pages 28495-28511.

d. HR 3448, 22 May 2002 (Community Access to Emergency Defibrillation Act of 2002).

2. Placement of Automatic External Defibrillators (AED) and the development of a Public Access Defibrillator (PAD) program for Federal installations are the result of recommendations included in the Cardiac Arrest Survival Act of 2000 and the Community Access to Emergency Defibrillation Act of 2002. The Department of Defense (DoD) and the Army are currently developing definitive guidelines based on this legislation and on the guidelines published by the Department of Health and Human Services (available for public access at their website: <http://www.foh.dhhs.gov/public/whatwedo/AED/HHSAED.asp>).

3. The following is a list of general principles that form the basis of the developing Army policy and should be used in the development of any subsequent policies or letters of instruction:

a. First and foremost, in the Continental United States (CONUS) the use of the AED by persons appropriately trained in their operation is usually covered by Good Samaritan Laws. These laws vary from state to state and there is no set Federal Good Samaritan Law. As you establish a policy, utilize your command Judge Advocate General (JAG) to define the

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Good Samaritan Laws applicable to use of AEDs in your state. For those installations located outside of CONUS, a US State, Commonwealth, or Trust Territory, utilize your command JAG to establish the applicable laws and statutes governing the use of such "first responder" devices in that country.

b. Responsibility for AEDs rests with the tenant unit commander or directorate supervisor. Overall program responsibility rests with the installation commander.

c. Military treatment facility (MTF) commanders serving as the installation Director of Health Services (DHS) should provide subject matter expertise to the installation commander. The responsibility for ensuring compliance with the standards published by the installation commander rests with the supervisor or commander of each tenant unit or directorate. As a tenant unit commander, the MTF commander has responsibility for all AEDs deployed within the MTF.

d. The AED is considered by DoD to be a prescriptive device, meaning that a designated physician must sign off on the PAD plan. Therefore, the DHS should designate a physician as the PAD subject matter expert. This physician will advise the command on the development of the PAD plan and should be involved as a consultant in all aspects of the program, not only as the program's prescribing physician, but also as an active participant in all aspects. Medical and physician oversight does not mean that a physician is required to be present to manage the PAD program on a day-to-day basis. However, it is prudent for facility leadership to develop management and oversight protocols of lay program overseers to assure that quality is consistently maintained. Physicians can be extremely helpful in assisting installation leadership in linking their PAD program with the community at large and with appropriate emergency medical service (EMS) and hospital systems. Additionally, a central role for the physician is conducting assessment of the PAD system's performance after the use of an AED, including review of the AED data and the electrocardiograph tracing of a victim.

e. Any tenant unit or directorate that acquires an AED is responsible for all fiscal and personnel implications associated with the operations and maintenance of AED within their areas of responsibility. For example, if a commissary desires an AED, the commissary must buy the AED and recognize that the commissary leadership is responsible for ensuring that the AED is maintained and that commissary personnel are properly trained.

f. Within the limits of existing resources, the MTF should provide training opportunities for AED use. Each tenant unit or activity, however, retains the responsibility for ensuring AED training for all assigned personnel.

g. Each installation should have a master plan that coordinates the acquisition of all AEDs on the installation. This plan should attempt to standardize the type or brand of AED and should include a funded plan for maintenance. Many AED manufacturers provide a

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maintenance contract.

h. Any PAD program should be reviewed by legal counsel to assure that the program, as designed, comports with all applicable Federal, State, and local authorities. OCONUS programs should be reviewed by legal counsel to ensure that no host nation laws are violated. PAD programs establish procedures for dealing with emergent medical situations that present an appreciable risk of serious bodily injury and death regardless of the degree of care exercised by those involved in responding to the situation. These situations are often the subject of regulation by various authorities. The risk of liability for failing to comport with applicable regulations and for acts/or omissions that result in harm are important and ever-present concerns that should be addressed in the PAD program. Though DoD facilities generally are not subject to state and local authority, federal law can incorporate or adopt specific state and local authorities or otherwise make them applicable to federal facilities.

i. In summary, each PAD program should include the following major elements:

- (1) Support of the program by unit leadership.
- (2) Training/certifying and retraining personnel in cardiopulmonary resuscitation (CPR) and the use of the AED and accessories.
- (3) Obtaining medical direction and medical oversight.
- (4) Understanding legal aspects.
- (5) Development and regular review of PAD and operational protocols.
- (6) Development of an emergency response plan and protocols, including a notification system to activate responders.
- (7) Integration with installation or area security and EMS systems.
- (8) Maintaining hardware and support equipment on a regular basis and after each use.
- (9) Development of quality assurance and data/information management plans.
- (10) Development of measurable performance criteria, documentation, and periodic program review.
- (11) Review of new technologies.

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4. The POC for the Army AED policy is COL Marina N. Vernalis, Cardiology Consultant to The Surgeon General, at DSN 662-4273, COMM 202-782-4273, or by e-mail at [Marina.Vernalis@NA.AMEDD.ARMY.MIL](mailto:Marina.Vernalis@NA.AMEDD.ARMY.MIL)

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