

# Every Team Needs Tactical Medical Support

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By Todd Burke

The tactical arena is inherently dangerous and requires additional preplanning and deployable resources. Members of tactical teams sustain casualties at a rate of 1.8 per 1,000 officer missions. Perpetrators are injured at the rate of 18.9 per 1,000 officer missions, and bystanders are injured at the rate of 3.2 per 1,000 officer missions.



Tactical Emergency Medical Support (TEMS) is not new. Many jurisdictions have been using tactical medics for over 25 years. Shortly after the inception of SWAT in the 1970s came the addition of front line medical support. Los Angeles, Minneapolis and Pima County, AZ, are a few of the many that have helped establish models for this unique specialty. The term tactical medic refers to an EMT (basic or advanced), paramedic or pre-hospital trained physician, nurse or physician's assistant.

Operating with a team that does not incorporate tactical medics exposes the team to unnecessary risks and places the department behind the litigation power curve. Bringing properly equipped and trained medical professionals to the incident minimizes injuries and reduces the likelihood of mortality. It also significantly increases the morale of all responding officers, including patrol, perimeter and K-9 handlers.

Incorporating medical support means that the medical provider is a part of the team, regularly trains with the unit and responds with the stack during callouts. Having an ambulance on stand-by in the area or posting a non-tactically trained medic at the command post is not tactical medicine. It is not going to work to have an armed and armored SWAT officer to run up to an ambulance and tell the medics inside: grab your stuff and follow me!

Many reasons exist to include medical support with your team:

## **The Golden Minute**

Surgeons refer to the golden hour as the time when a traumatic injury is sustained to when that victim is delivered to the surgeon's table. Pre-hospital professionals use an even shorter and more compressed timeframe called the golden minute to describe the period between injury and definitive field care. Obvious benefits of having medical support include opening and maintaining of an airway or stopping critical bleeding. When our civilian community activates a heavily armed and trained critical response team as a result of a real or perceived threat, it indicates that serious physical injury to someone is a possibility. It makes sense to take a lesson from our military and extend a trained and equipped medical echelon into the civilian battlefield.

## **Training**

Many more injuries occur in training than on callouts. Injuries such as dehydration, hypothermia, hyperthermia, sunburn and diabetic emergencies are preventable if there is a safety officer or tactical medic monitoring the training with these specific issues in mind. Many teams consider anything beyond four hours to be an extended operation. This means that the members will need to be fed nutrients appropriate for the climate and conditions. Individual food preferences and allergies will need to be considered. This is preplanning in its purest form.

## **Team Health and Well Being**

Preventive medicine is the best medicine, and the medic can be a valuable resource for: sick call issues that do not require taking an operator off line; orthopedic injuries; diet and exercise preplanning; maintaining medical records so they are instantly available; recommending critical incident stress debriefing; and training team members how to act as medical support providers themselves. Every member of the team should carry a blood stopper and a pocket mask as required basic equipment.

## **Preplanning**

Preparing a risk or threat assessment is one of the most important parts of any operation, and planning ahead is paramount. Operational briefings are usually secure meetings and this is where most of the information is disseminated. If the person responsible for preparing the medical threat assessment is not present, much information will be missed. This is a key reason why the medic must be a part of the team. Preplanning issues include weather conditions, sunrise and sunset times, plant and animal threats (sensitivities and allergies), hazardous material exposure and decontamination (meth labs), nutrition and hydration, location of trauma and burn centers, available evacuation routes by air and ground, advanced life support transportation resources and notification, and much more. Some threat assessment preplanning documents are eight pages long. On a hot summer evening of warrant service, the last thing the team commander needs to be burdened with is how much water should each operator drink each hour, and where they will refill with a fresh supply.

## **Transportation of Injured**

Suspects in custody can be protected more effectively when they are transported in a designated unit and while under the care of medical providers familiar and comfortable with the custodial process. This means that officers must be present in the patient care area of the ambulance. If the medic is also a commissioned officer this creates an easily managed situation. If a relationship already exists between the tactical medic and the ambulance personnel, this very high-profile event is likely to go more smoothly.

## **Command Post Resource**

Many teams stage their medics at the command post— a good general location. This places the medical professional in a designated and secure location where the team commander or negotiator can utilize him instantly in the command decision-making process. The medic can provide the team commander with information and suggestions regarding medical intelligence or pre-existing medical conditions involving suspects or hostages. The medic is also likely to think of things that others may miss.

## **Interagency Liaison**

Many of the preplanning issues are critical to a safe operation, but the team commander cannot be burdened with all of them. The medic can do many things. If there is sufficient lead time the medic can interface with the local EMS resources and give them general information such as time frames and potential injuries that may be expected if the light turns green. In the non-emergent role the team medic can visit other departments and agencies, and facilitate training or respond to questions.

## **Suit Avoidance and Good Faith**

How many times in recent years have we seen officers accused of preparing to kill someone while off duty because they carried a firearm, and being accused of not preparing to make an arrest since they did not carry handcuffs or a restraint device? One tactical team in Missouri has actually been able to demonstrate this good faith mentality more than once. The team videotapes all of their entries. A suspect forced them to make an entry and one officer delivered a burst from his MP-5. The team secured the suspect and immediately called the medic up. The point man is seen holding the suspect's head and patting him, saying,

“You’re going to be OK,” while the medic and another team member stabilized his injuries. What price can you place on documentation such as this?

### **NTOA Best Practices**

The National Tactical Officers Association is arguably the most well-known and professional resource for training and procedural guidelines in the civilian SWAT arena. The NTOA specifically endorses the inclusion of a tactical medical support component.

This may seem new and a bit overwhelming. It is not necessary to reinvent the wheel. Your first step should be to gather information and talk to as many teams and operators as you can. This will help you discover the how’s and why’s of where you will fit. If you have not gained the trust and acceptance of the police agency and team, your next step should be relationship building with them.

If you are not a physician, consider who your medical director is going to be. Look for one who is officer-friendly, American College of Emergency Physicians (ACEP) or American College of Osteopathic Emergency Physicians (ACOEP) registered and Board Certified in emergency medicine. Your doctor may have to be the director of your trauma center or you may know someone who is willing to do some favors in exchange for a tee shirt and an afternoon on the range with a machine gun.

Once these issues are addressed you can begin to deal with issues such as equipment, funding, schedules, contracts, insurance, policies and procedures, medical skills validation and maintenance, and more. Begin with the end in mind and don’t lose sight of your mission or the reason you decided to pursue this necessary endeavor in the first place.

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*This article is available online at [www.trmagonline.com/Spring2003TR/spring2003tems.htm](http://www.trmagonline.com/Spring2003TR/spring2003tems.htm)*