SWAT Medics: *Tactical EMS*

By S. CHRISTOPHER SUPRUN JR.

The same issues regarding care of the wounded during wartime directly affect the role of the tactical EMS provider, who must care for those injured in backyard battlegrounds. Over the past 30 years, as EMS has become a fire-based service, police departments at the local, state, and federal level have developed Special Weapons and Tactics (SWAT) teams. Known by names including Emergency Response Teams, Special Operations Teams, and SWAT, these teams have been used to provide a specialized police presence when standard tactics do not work.

Though SWAT teams were developed as life-saving units, they do use the full spectrum of force, including lethal force. These teams need their own forward medical capability for a number of purposes, including the care of wounded officers, hostages, and victims; the treatment of hostages across the barrier; the development of medical threat assessments; and the provision of rehab services to SWAT officers.

Training and Preincident Issues

Training is a requirement for successful implementation of skills and techniques in high-risk situations that are used infrequently. The need to train with an assigned SWAT element or team is paramount. First and foremost, there is a camaraderie issue. A SWAT team has a much more highly tuned sense of itself than even the average engine company crew. Each team member must carry out an assigned role precisely and without error to avoid unnecessary confrontation with suspects or bystanders—and sometimes without a full sense of what else is happening except by knowledge of the plan.

This trust in stealthy teammates during extended operations requires that everyone on the team be trusted to know the operation; know his assigned role; have the ability to carry out the function; and know that weather, fatigue, and other factors will not stop the mission from proceeding in an orderly fashion. For this reason, EMS providers should practice with an assigned team. This practice should not occur as often as possible or most of the time but *all* of the time. Police officers who double in a SWAT function may be comfortable with your abilities at the scene of significant auto accidents or even violence, but SWAT exercises by their very nature are elevated police functions. Allowing yourself to get into a rut of thinking that way because you're the best medic in your house, on your shift, or even in your jurisdiction is dangerous.

Officer Rehab

An important function of training with a SWAT team is the opportunity to introduce rehab as a team-friendly concept. The fire service has long used rehab as a way of keeping firefighters from overexerting and becoming victims themselves. SWAT officers either on an extended operation or in poor weather conditions may need various rehab options, too.

By training with a SWAT team, a SWAT medic can learn how far officers push themselves physically and mentally and can also offer rehab in a way that may not be as threatening as it might be on a scene. Remember, officers on SWAT are driven. They will not want to rotate out of assignments. If possible, a medical component might be added to each SWAT practice, from self-bandaging and treatment to the importance of a proper diet to maintain overall health.

Officer Medical Information

Another area of concern for some SWAT officers is the use of private medical information by superiors. SWAT attracts a certain Type A personality, and sprained ankles, cuts, and bruises have a way of happening during training and live exercises. Realistically, some officers may not be comfortable telling a SWAT medic about previous injuries

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and medical conditions for fear that this information will make it into their employment records. This information could then be used to deny them workers' compensation at some point or, worse, may force their removal from a SWAT team for medical reasons. Because of this concern, some officers may not even provide the SWAT medic with such information as blood type or allergies.

Some departments overcome this fear by having SWAT members fill out a 3 x 5 or 4 x 6 card with name, social security number, blood type, allergies, medicines taken, and so on. Have the card laminated and reissued to the individual officer. Each officer can then maintain his own medical information in an accessible place on his tactical uniform so it is available if needed but is otherwise protected. Members may even buy into additional steps of carrying their own medical gear such as an Israeli bandage and/or oropharyngeal airway.

Medical Threat Assessments

Prior to any SWAT operation, there should be a detailed plan of action for the team. The SWAT medic should provide his own Medical Threat Assessment to the team commander. The assessment is made after determining the incident location; the projected operational time; and factors including weather conditions, medical information, and anything else known about the subject location.

Weather has an important impact on team operations. If a SWAT team is called for a barricaded subject in the middle of summer, what are the expected temperatures and humidity levels? The U.S. Fire Administration has developed indexes to factor temperature to work load, and these can be used to help guide the team commander's decision making on how long negotiations might run or the size and establishment of perimeters. Along the same lines, if the team is planning a dynamic entry into a subject house on a given night, it may want to know that the sky is expected to be clear with a full moon.

Some police departments have a resource book in place to identify the closest hospital, Level 1 trauma center, medevac helicopter, and ambulance service, but do they also consider the closest regional haz-mat team or hospital with a burn center? These are critical issues to identify *before* an operation starts and you are stuck scrambling for information that should be easily accessible. Depending on the size of your community, you may want to have a three-deep system where you know the closest three hospitals, helicopters, and haz-mat teams in case one is unavailable.

Incident Issues

Treatment Across the Barrier

On an average day, how many times do you discuss with patients where or how they are hurt? How often do you do it without the patient seeing you or vice versa? How many times do you direct this patient's care by phone? How good are your communication skills, both talking *and* listening? Can you direct the care of someone without seeing and/or touching him?

Imagine a reported bank robbery. The first patrol car arrives as the bad guys are leaving the bank. Shots are exchanged, and one of two bad guys is hit. The injured has taken a single round to the left anterior chest near the second intercostal space. The bad guys retreat into the bank and barricade themselves, taking hostages while a police officer establishes a perimeter and calls out SWAT. Shortly thereafter, you are standing next to the SWAT commander and the negotiator.

Can you listen to what the bad guy tells you about his partner and direct the negotiator on the proper words to use to help treat this suspect over the phone? How does your treatment/communication change when the suspect tells you his partner was shot in the stomach and is getting woozy now, instead of being shot in the chest? Does it change your mindset when the suspect declares he will kill hostages if his partner dies?

Treatment across the barrier is very important. In a nontactical fire and rescue situation, we stage for injuries secondary to violence; but in a tactical environment, staging may not be an option. Nonetheless, it does not mean we break cover to rescue a person who may not be alive. Treating hostages, victims, suspects, and officers across the barrier may be necessary and will challenge your typical response. It needs to be trained on.

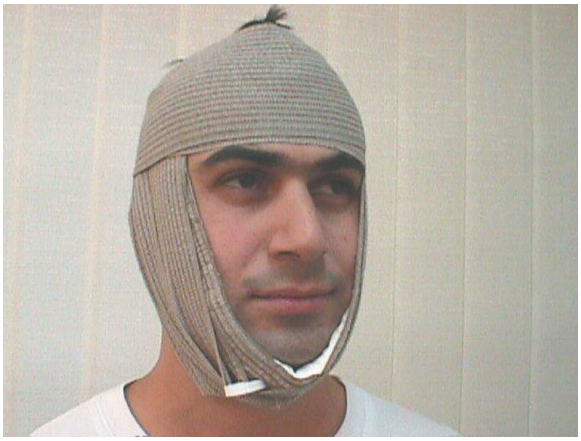
Triage

In tactical situations, triage should be used and based on a national system recognizable by providers who will ultimately assist in care. The START (Simple Triage And Rapid Treatment) method is one that provides an easy system for classifying patients' level of injury by considering their ability to maintain their own airway and respiratory rate, the presence of a radial pulse, and mental status. START triage is very easy and can be added to SWAT team medical training sessions. Teaching this concept can help the entire scene by allowing you to perform life-saving interventions on critical patients while officers locate and triage patients. Additionally, it should bring the police officer and medic closer by allowing them to learn about each other's skill set.

Triage is another skill that can be done across the barrier, in some cases, and should be used if possible to avoid entering a situation to save a life that has already been sacrificed.

Bringing Good Medicine to Bad Places

If you're not in a hot zone, there's not much difference in treatment between SWAT and conventional EMS. Once you cross the line into a tactical situation, whether you are



An "Israeli bandage" is a combination bandage and pressure dressing that can stop bleeding quickly. It should be part of a tactical EMS worker's utility package. (Photo courtesy of North American Rescue Products.)

technically in a warm or hot zone, your treatment and equipment need to match the situation.

That boils down to caring about breathing and bleeding and not much else. Although there are tactical medics who carry laryngoscopes for field intubations in the warm zone, a tactical EMS provider needs to strongly consider what's needed to get the job done. Do you need a BVM, or can you use a simple face mask until the patient is out of the hot zone? How many bandages are too much? How much equipment can you realistically carry?

One example of what not to do is found in the story of an overzealous physician ready to take on the world. "Doctor Starsky," as he was nicknamed, had a backpack filled with so much gear I thought he was going to unfold it all and have the whole gang from the TV show *MASH* assist him in field surgery. He even had a small oxygen tank! During one drill, it took him only about 30 minutes to get tired of wearing the heavy backpack with the extraneous equipment.

The lesson: Take only what you need and what you can carry. Equipment such as oxygen, which brings its own danger, has very limited use in tactical environments. Take a minimalist approach that focuses on "treat and move." Consider the length of the operation, the personnel involved, and the environment.

When I am working with police officers who are assigned to a SWAT team, I recommend they carry a personal bag of equipment. It should contain their medical card in case they become injured to the point of unconsciousness. It should have a presized oropharyngeal airway (OPA). While an OPA might seem ineffective by itself, it is an easy, small device that will not impede operations and will help maintain the airway in an officer who cannot maintain his own. Rather than fumbling with equipment trying to size an OPA in a hot environment, having a presized OPA is handy in less time when you might be exposed to further assault.

Finally, an Israeli bandage is a combination pressure dressing and bandage. Used properly, it functions almost as a pseudo-tourniquet and works well to stop bleeding very quickly. This is the largest of the three items, but together all three can easily fit into a utility pouch on a SWAT member's vest.

Individual teams should decide on how much treatment is feasible and under what conditions, but putting those SOPs into protocol form will be important. There should be an understanding that tactical EMS requires different rules than standard EMS and should have protocols that match those differences.

Postincident Issues

After the incident, critical incident stress management will be important. A debriefing of the situation may or may not be warranted, but the SWAT medic and others from the team should consider additional training in stress management. Emotional fatigue can lead to long-term stress and degrade the SWAT team's ability to carry out its missions.

Critical incident stress management (CISM) systems should be used to help identify officers and medics assigned to SWAT teams who are having difficulty with specific events and situations. Sometimes a specific SWAT event is not causing trouble, but the buildup of other life stressors from home and other assigned duties take their toll on SWAT members. These are important issues and should not be ignored, as they can lead to self-destructive behavior, degradation in skills, and loss of team cohesiveness.

Providing Better Care

The interaction between fire/rescue groups and the police during more mundane events cannot prepare us for the onslaught of emotion and sensory overload that will occur from a SWAT-type event. Because of these factors, training with a police unit in an organized way should help to make the medic a better care provider under tactical situations and enable the medic to give better care under poor circumstances to the victims of crime.

Tactical EMS is becoming a larger part of the fire and rescue communities' special responsibility to the public. It carries with it particular dangers and challenges. We still rush into buildings, take on hazardous materials, and dangle ourselves off skyscrapers for technical rescues, but we do it with education, training, and practice.

Providing tactical EMS to your community is just another area for specialized training. Tactical EMS training allows us to pick up our fellow responders when they have fallen; we should do our best not to let them fall alone. ●