Tactical Health and Law Enforcement

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FROM THE EDITOR
Public Health Calls for Changes in Police Practices

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In 2020, new attention focused on Black lives and deaths prompted many to call for law enforcement system reform, as police violence has long been a serious public health issue.[1] The International Association of Chiefs of Police (IACP) champions progressive, consistent internal reform and changes to law enforcement practices. The IACP also seeks to "advance the policing profession through advocacy, research, outreach, and education to provide for safer communities worldwide."[2] Police officers' roles seem to have expanded beyond service and protection and, in her current role as IACP president, Cynthia E. Renaud recognizes that police organizations face dangerous, tactically complex incidents in which they must employ new intelligence tools, work within interdisciplinary teams, and interact with persons experiencing crises of mental illness.[3] Law enforcement collaboration with health professionals is essential.

Tactical medicine physicians (TMP), colloquially known as SWAT team physicians, offer "medical support to law enforcement and military special operations teams"[4] to help maintain "a healthy and safer environment for both law enforcement and the public"[5] during tactical operations in which "severe injury to officers, hostages, suspects, and bystanders" is possible.[6] TMPs must apply emergency medicine ethics in difficult tactical scenarios: triage, for example, must be employed in responses to emergencies, such as mass shootings, to effectively utilize limited resources. Disasters complicated by chemical, biological, radiological, nuclear, or explosive devices require tactical health personnel to rescue persons in the field and perhaps engage in decontamination or containment.[7] Contributors to this issue discuss the nature and scope of clinical ethics in difficult tactical field-based and clinical situations.

Tactical clinicians' skill sets include giving psychological support to field personnel during crises; assessing whether, when, and how traumatized colleagues should return to work; managing deployment resources (eg, food, water, toilets)[5]; de-escalating mental illness crises in the field; and informing community safety policy and strategy. Frequent trauma exposure means that posttraumatic stress and moral injury are also risks for police officers, so tactical clinicians must consider community interests when assessing officers' moral, psychological, and emotional well-being. Here, clinical and police experts consider how to act as trailblazers when responding professionally and ethically in tactical scenarios.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE
How Should Clinicians Determine a Traumatized Patient's Readiness to Return to Work?

Tabitha E. H. Moses, MS and Arash Javanbakht, MD

Abstract
A clinician's standard primary role is to treat and monitor their patients' health and to be their ally. Clinicians with obligations to patients and to organizations, however, must also assess patients for nontherapeutic purposes (eg, readiness to resume work). These 2 obligations can conflict, and, when they do, clinicians must balance their duties to patients and to society. We propose criteria clinicians should consider when determining a patient's readiness to return to work and offer recommendations for interpreting factors that influence this decision.

Case
In the United States, police brutality is a leading cause of death among young men,[1] a fact well-known to Dr Z, a mental health clinician with many years' experience working with law enforcement officers in clinic- and field-based settings. Dr Z has been caring for TW since TW was shot while pursuing an alleged perpetrator last year in a city neighborhood of predominantly Black American residents.

TW has healed physically and has recovered preinjury levels of mobility and agility. But TW still experiences intense, prolonged distress when discussing details of the shooting, recurrent "night terrors" (replaying the incident), and inability to fall back asleep due to feeling hypervigilant. TW tries to avoid anyone who talks about Black Lives Matter (BLM) and is triggered to anger quickly by BLM banners in public spaces or on social media posts. Dr Z is concerned that TW's ability to regulate intense stress remains compromised by chronically heightened fight-or-flight responses[2,3] and is not at all convinced that TW is psychologically ready to return to community policing duties, particularly in the neighborhood that TW patrolled before the shooting.

In recent prior sessions, Dr Z has suggested that TW consider returning to the department but not to community policing just yet. TW has not expressed openness to an ease-in transition back to work and becomes increasingly irritated when Dr Z mentions this possibility again. TW responds, "I know you think I'm not ready because I

have the night terrors. Maybe I need to stop telling you about those. They're not real. They're just dreams! I don't want to push papers around or do a desk job. I feel good and I'm ready to get back out there now." Dr Z considers how to respond.

Commentary

Mental health clinicians are commonly asked to complete fitness-for-duty evaluations by police departments when there is a question about whether officers can safely carry out their job requirements and duties. Although these types of evaluations also give rise to concerns about employment discrimination due to real or perceived disability[4,5,6,7,8]—which is especially pertinent to professions such as law enforcement and medicine wherein the lives of others are affected[9,10,11]—the issues of fitness for duty and employment discrimination are separate. It is important to highlight that the purpose of this evaluation is not simply to identify whether a person has a psychiatric disorder; it is about determining risks associated with a person's behaviors, how to identify behaviors that could be dangerous in a line of work, and whether there are ways to mitigate harms so that a person can return to work safely. The goals of this commentary are to examine potential conflicts and clinicians' roles in performing fitness-for-duty evaluations and to offer criteria to inform clinicians' decisions about a traumatized officer's readiness to return to community policing.

Potential Conflicts

A central question concerns clinicians' roles in balancing patients' needs against those of the community. At first glance, one might assume this task to be simple: needs of one (officer) vs needs of many (community members). However, these needs are not actually in conflict. The major risk arising from officers prematurely returning to their extremely demanding and often high-risk work is to the mental and physical safety of the officers themselves, not only those they aim to protect. The needs of officers and communities are actually aligned.

Another possible conflict arises from clinicians serving 2 roles: primary mental health caregiver and judge of readiness to return to work. This case demonstrates the risks of this dual role, as conflict between these roles can undermine a therapeutic relationship and create communication pitfalls. TW appears to believe that Dr Z's concern about their readiness to return to work is solely based on night terror symptoms and expresses distrust, which is made evident by TW saying "maybe I need to stop telling you about those." If Dr Z's concerns are grounded in other symptoms, there has been a communication failure as well as erosion of the therapeutic relationship. Finally, we cannot ignore context. This case arises in 2020, when there is increased awareness of unjust violence against people of color, distrust of police, and very high levels of general civil unrest.[12,13,14] Increasingly, negative views of law enforcement have resulted in significant officer demoralization,[15,16] which might affect TW's reaction to Dr Z and hence undermine the therapeutic relationship.

We must recognize the role of social context and understand that, regardless of clinicians' efforts to remain impartial, their personal experiences and interpretations of world events can color their judgment. Neither a decision regarding readiness to return to work nor a conversation about which criteria should be used to make this decision exist in isolation. We must look outside therapeutic sessions to fully consider this case in social context and identify criteria that should inform clinicians' decisions. For the case provided, we do not have sufficient information to make concrete determinations about the therapeutic relationship (or lack thereof), TW's risk to self or others, or TW's

ability to return to active duty. Nonetheless, the case lays a foundation for a conversation about criteria to use in return-to-work determinations and for developing practice recommendations.

Clinicians' Roles

A first consideration is how clinicians should manage their apparent dual role as a mental health caregiver and a judge of readiness to return to work. In standard therapeutic relationships, the clinician's role is to diagnose and treat, so clinicians must create open, trusting therapeutic relationships in order for patients to perceive them as allies. When a clinician must also assess patients for nontreatment purposes, trust can be jeopardized. This confusion of roles and perceived loyalties might affect the way patients interact with clinicians: they might see a clinician as a judge rather than an ally, which could result in their withholding key information. Thus, whenever possible, clinicians should aim to serve in only one capacity: either as a psychiatric caregiver or as an evaluator for an external entity (eg, an employer or an insurance company). However, when clinicians do undertake both roles simultaneously (eg, due to lack of community resources), they must communicate clearly and share decisions to promote the best interests of all involved.

A next step is to consider the purpose of an evaluation. Typically, clinicians are asked by employers to evaluate an employee's fitness to return to work because premature return to work could result in harm, either to an employee or to those with whom they work. For physical injuries (eg, a broken limb), it is relatively simple to follow treatment guidelines and identify when an injury is healed.[17] It is not so simple for psychological injuries. Diagnosis of a psychiatric disorder or prediction of psychiatric symptom development depends on a patient's subjective report and a clinician's subjective observations, both of which can be affected by cognitive and emotional context. By developing a therapeutic alliance and joint understanding of risks and benefits of returning to work, clinician and patient can usually collaborate on a solution without pitting the needs of the community against those of the patient. These 2 considerations—the risks and benefits of returning to work and the cognitive and emotional context of the evaluation—are discussed in more detail below.

Balancing Risks

In this case, one risk to avoid is to community members; it is easy to recall recent articles about police brutality, accidental shootings, and harms to communities of color.[15,16,17] Risk evaluation should be intentionally divorced from the clinician's own beliefs.[18] Although consideration of community- and social-level harms is crucial, we cannot overlook the potential harm to the officer in returning to work. After a traumatic experience, if the officer is not ready to face trauma reminders, returning to work may worsen symptoms.[9,19] Furthermore, if the officer's symptoms result in a harmful or fatal mistake, the officer is likely to suffer long-lasting negative sequela. Officers who kill in the line of duty—even to protect their own life or the lives of others—often experience long-term guilt and negative consequences.[20,21,22] Finally, when officers interact with violent individuals, any distraction could have deadly consequences. In every case, risks to the individual, that individual's colleagues, and the community will differ, but the potential for harm to all involved must be considered. It must be underscored that adopting a paternalistic attitude during the evaluation is inappropriate, as the clinician should not make return-to-work decisions alone. Rather, the clinician should discuss concerns with the patient to ensure that the patient understands the evidence behind any reservations the clinician might have about the patient's return to work. The

clinician's ability to help the patient understand the potential risks of premature return to work is a vital component of developing the patient-clinician alliance. The goal is to support patient autonomy and for both parties to be in agreement about the plan for the patient's return to work.

Symptom Context and Strategies

Although the exact processes by which psychological injuries heal is murky, it is possible to use neuroscientific research to develop practical criteria for determining readiness to return to work. During stress, the autonomic nervous system activates the fight-or-flight response via the sympathetic nervous system (SNS), resulting in symptoms typically associated with stress (eg, elevated heart rate).[20,21] SNS activation also affects the brain, resulting in altered functionality across multiple cognitive domains.[23,24,25] One pathway commonly affected by stress is executive functioning.[22,26] Executive functioning encompasses a series of cognitive skills that allow individuals to plan and control behavior[27]; exposure to acute stressors can significantly impair executive functioning.[28] Although small amounts of stress can be beneficial, too much uncontrolled stress can impair attention and memory and make a person more likely to respond inappropriately.[23,24,26,29] Moreover, a person who has undergone trauma can experience hyperarousal,[25] which can accentuate the effects of stressful situations[28,30] and increase sensitivity to trauma-related triggers, which in turn can lead to impulsive responses.[31,32,33,34]

Immediate responses to stress can also be dramatically altered by mindset. For example, negative mood increases the likelihood that a person will identify neutral situations as negative.[27,35] Diminished executive functioning combined with low mood can be particularly problematic; in police officers, decreased working memory, combined with negative mood, is associated with an increased likelihood of shooting errors.[36] These are not the only relevant neural factors, but they are key to gauging risk.

Fortunately, emotions do not define behavior. High-risk emotional responses must be evaluated against a wider backdrop of behavior and circumstances. Although a patient might be quick to anger, responding with anger in a given situation does not always mean anger is unwarranted or disproportionate. In fact, it's not anger, but the patient's response to anger—both immediately and upon reflection—that matters. Individuals who have responded with anger after trauma are more likely to respond with violence in the future.[37,38] Patients' emotional awareness lays the foundation for their ability to respond in constructive and healthy ways to negative emotions. Patients who carefully consider symptoms, their causes, and how to mitigate them demonstrate greater emotional awareness. In the case, TW appears to recognize and verbalize triggers (BLM banners and posts) and associated negative responses (anger). A next step would be for Dr Z to identify positive strategies (eg, mindfulness practice, skills learned during cognitive behavioral therapy, channeling negative energy into nonharmful activities like physical exercise) for managing TW's negative responses.

Patient coping mechanisms provide another key consideration for the clinician. Certain methods for managing emotional distress (eg, drugs) might increase the likelihood of impulsive, harmful, and violent behavior.[31,39] Patients who cope with negative feelings with substance use could be at higher risk of harming themselves or others when returning to work than those who have developed positive stress management strategies.[40,41,42] Conversely, seeking social support is a positive coping mechanism. A habit of reaching out to others for support when experiencing a negative response to a

trigger is an example of a potentially positive coping strategy. Patients with strong, positive extrafamilial support systems are at decreased risk of developing negative coping strategies and succumbing to stress.[32] No person lives in isolation, and no experience occurs in a vacuum, so all individual factors—both internal and external—must be considered.

Finally, clinicians might consider recommending gradual return to work if they or the patient are concerned about returning to work. Controlled reintroduction to the potentially stressful and triggering environment provides the patient with an opportunity to practice regulating emotional responses and allows the clinician and the patient to observe how the patient manages job duties and associated stressors. Gradual reintroduction is not necessary for all patients but can help some develop the confidence needed to feel comfortable returning to full duty.

Recommendations

There is not enough information provided in the case of TW to come to a decision about how Dr Z should respond in that specific situation. Nevertheless, an understanding of neuroscience and psychology allows for the development of practical recommendations. People who work in high-stress and high-risk occupations (eg, law enforcement) may already have a baseline of heightened arousal, consistent with the risks of the job.[33,34] As such, the return-to-work evaluation and the implementation of any recommendations will require nuanced consideration of the individual case. Every patient differs in terms of the symptom burden with which they can safely return to work. Likewise, the way in which individuals return to work can differ. Clinicians should consider options for gradual reintroduction, which could consist of reduced hours or specified patrol areas to minimize trigger exposure. When care is managed appropriately, patients should recognize that there is no conflict between their needs and those of the community.

To evaluate an individual's risk of harm to self or others, clinicians must conduct a thorough review of the patient's behavior and attitudes beyond the immediate symptoms; this review should include an evaluation of past and recent behavior, along with patient successes and failures in emotional regulation across multiple social, familial, occupational, and clinical contexts. The recommendations provided here focus on communication, risk evaluation, and risk mitigation.

1. *Communication*. The development and maintenance of the therapeutic relationship is paramount. Clinicians entering into the dual role of provider of mental health care and evaluator of readiness to return to work (which we do not recommend) must be careful to ensure that patients have a clear understanding of the implications of their dual roles.
2. *Risk evaluation*. Clinicians should evaluate the risks to all involved and consider symptoms that may indicate higher risk of harm to the patient or others.
3. *Risk mitigation*. Clinicians should evaluate positive factors that could mitigate identified risks. In conjunction with the evaluation of positive and negative factors, clinicians should consider patients' historical and current responses to stressors.

It is vital that clinicians communicate clearly to patients and engage them. Clinicians should outline potential concerns with return to work—including risks both to the patient and to others—and provide a clear explanation of their reasoning and plans for future decision making. Clinicians should work with patients to develop mutual guidelines for a

safe return to work with the understanding that the goal is to ensure the patient's well-being. When possible, bringing to the table others whom the patient confides in (eg, treating mental health clinicians, peer support colleagues, family) might facilitate such discussions. Clinicians should be careful to ensure that this process is collaborative and respects patient autonomy; if a clinician believes a decision is in the best interest of the patient but the patient does not agree, every effort should be made to improve communication and ensure that both parties clearly understand the goals and concerns of the other.

Conclusion

When evaluating a patient's fitness to return to work, what is best for the patient and what is best for society are usually not in conflict. If officers truly cannot manage their symptoms, then returning to regular duty may worsen their health and put them in a position wherein they overreact to a perceived threat. Although Dr Z's immediate reaction in this case may be to focus on harms to civilians and society, TW's premature return to work would also negatively impact TW and TW's peers. Clinicians must recognize their own assumptions and biases and consider how their decision can be made and communicated in a way that serves the best interests of both the community and their patient. In following the above recommendations, clinicians should not be placed in an adversarial position with patients. Self-awareness and intentionality, as well as nuanced consideration of the individual case, will allow clinicians to follow best practices that maximally protect and support all involved.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE
Should a Physician Ever Violate SWAT or TEMS Protocol in a Mass Casualty Incident?

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Abstract

Mass casualty incidents involving active shooters are becoming more common, and many involve special weapons and tactics team responses. Standard of care is to have tactical emergency medical services paramedics or physicians direct triage and administer immediate interventions. In these situations, a clinical and ethical value is to do the greatest good for the greatest number of people. Cases in which beneficence and justice are at odds are particularly complex. This commentary on such a case argues that directing resources to patients most likely to survive accords triage principles and explores ethical complexity in resource allocation decisions.

Case

After hours of talking, negotiations break down and, in the worst possible scenario, bullets ring as a shooter indiscriminately fires several rounds in a local business place and takes hostages. Law enforcement officers immediately make emergent entry into the building and engage the shooter. The shooter collapses, gunfire ceases, and officers rush to ensure that the shooter is contained. Additional law enforcement personnel begin to search and secure the scene. Due to staging until the scene is determined safe, combined with lack of protective armor and helmets, the nearest ambulance is 2 blocks away and stays back until ordered in by law enforcement.

The tactical emergency medical services (TEMS) physician, Dr M, who is embedded within the special weapons and tactics (SWAT) team, enters and begins performing rapid triage of the patients who lie at the scene. Dr M notes 6 dead; 1 law enforcement officer who sustained a gunshot wound to the chest is unconscious, not breathing, and has a weak pulse; 1 civilian who sustained extensive injury by a gunshot wound to the right side of the neck is unconscious, with heavy bleeding, agonal respirations, and weak pulse; and 1 suspect who sustained a gunshot wound to the high right lateral chest is awake with minimal bleeding and significant respiratory distress.

Dr M's heart sinks. Clinical and ethical principles of triage and protocol in this case suggest that lifesaving efforts should first be directed towards the suspect according to the Sort-Assess-Lifesaving Interventions-Treatment and/or Transport (SALT) mass

casualty triage algorithm.[1,2] Dr M does, however, have equipment available to attempt to save either the law enforcement officer or the civilian, although either attempt is unlikely to be successful. Dr M decides which patient to approach first.

Commentary

Mass casualty incidents (MCIs) involving active shooters are becoming more common today,[3] and several scenarios involve SWAT team responses. These teams are increasingly recognizing that the standard of care is to have specially trained TEMS paramedics or physicians to direct triage and administer immediate interventions to those in need. In these situations, a basic principle is to do the greatest good for the greatest number of people. But when principles of beneficence and justice are at odds, a TEMS clinician is required to make an ethically difficult decision. We explore ethical complexity in resource allocation decisions and argue that triage principles dictate that resources be directed to those most likely to survive.

Disaster and Triage Tools

The World Health Organization (WHO) defines MCIs as "disasters and major incidents characterized by quantity, severity, and diversity of patients that can rapidly overwhelm the ability of local medical resources to deliver comprehensive and definitive medical care."[1] In simpler terms, an MCI is any crisis requiring more resources than are available. In this case, with 3 critical patients and only 1 responder, it could be argued that the current resources to provide acceptable care are insufficient and thus meet the WHO definition of an MCI disaster. Allocation of limited resources to one patient over another during an MCI is dictated by triage principles and algorithms (see Table 1). Of note, while a triage tool might be chosen for its perceived superiority in accuracy or time of implementation, it is commonly chosen based on local preferences, training, and familiarity.

Table 1. Examples of Mass Casualty Incident Triage Tools[a]

Simple Triage and Rapid Treatment (START)
JumpSTART
Sort-Assess-Lifesaving Interventions-Treatment and/or Transport (SALT)
Sacco Triage Method (STM)
Care Flight Triage
Secondary Assessment of Victim Endpoint (SAVE)
BLS-Logistics-ALS-Situational Triage (BLAST)

Abbreviations: BLS, basic life support; ALS, advanced life support.
[a] Pepper, Archer, Malhoney[4]; Jenkins, McCarthy, Sauer, et al[5]; Heightman.[6]

The SALT triage algorithm is commonly used to stratify patients based on injury severity. While teaching more about this algorithm is beyond the scope of this article, it is important to note that it is endorsed by several national organizations[2] and results in patients being sorted into 5 groups: (1) minimal (green), (2) delayed (yellow), (3) immediate (red), (4) expectant (gray), or (5) dead (black). In the case, use of the SALT algorithm would result in patients being sorted as follows:

1. The law enforcement officer would be categorized as *dead*, even though a weak pulse is present.
2. The civilian would be categorized as *expectant*, meaning that person will likely soon die, even if treatment were provided.
3. The suspect would be categorized as *immediate*, meaning that if rapid treatment is provided, there is improved likelihood of survival.

TEMS responders have no rights or authority to assess and treat patients outside of MCI protocols, such as SALT, which allocate care based on needs. Incidents involving multiple patients spread over a large area, as in many MCI or SWAT incidents, generate more challenges for a TEMS responder attempting to allocate limited resources; a responder's assessment based on need alone is important.[7] According to triage principles, a trained responder should not use limited resources on individuals who would likely die regardless of lifesaving efforts. In this case, following accepted standards and protocols, beneficence dictates that the suspect should receive Dr M's care, on the grounds that it would be better to save at least one person than to attempt to save the officer or civilian, which would likely lead to the deaths of all 3 individuals.

Balancing Beneficence and Justice

The World Medical Association's "Statement on Medical Ethics in the Event of Disasters" states:

The decision not to treat an injured person on account of priorities dictated by the disaster situation cannot be considered an ethical or medical failure to come to the assistance of a person in mortal danger. It is justified when it is intended to save the maximum number of individuals.... The physician must act according to the needs of patients and the resources available. He/she should attempt to set an order of priorities for treatment that will save the greatest number of lives and restrict morbidity to a minimum.[8]

Health care professionals, in any setting, seek to relieve suffering and preserve life, guided by the ethical principles of nonmaleficence (do no harm), beneficence (act in the best interest of others), respect for autonomy (self-determination), and justice (fairness and equitable allocation of resources).[9] Beneficence would dictate that resources should be allocated to save those most likely to survive (the suspect, in this case); justice, however, suggests that treating a suspect and withholding treatment (and chance of survival) from innocent victims is unfair.

As mentioned above, objective application of standard triage and treatment protocols would favor beneficence: the TEMS responder would determine that the suspect would benefit most from immediate care and has the highest likelihood of survival among the patients. Given that the law enforcement officer and civilian have very little chance of surviving their injuries even with rapid care, it would be harmful to the suspect to divert resources or efforts to others. Furthermore, it could be argued that it would be unethical *not* to treat the suspect, as some might argue that the suspect, since not yet proven guilty, deserves a chance at life-sustaining treatment or that even a guilty perpetrator is no less deserving of care than an innocent victim. An objective TEMS responder would simply perform their role in saving those who can be saved, regardless of the patients' circumstances.

Yet it should be noted that beneficence entails a limited duty, unlike nonmaleficence, which is often considered a perpetual duty.[10] For example, physicians have a duty to try

to benefit any or all of their patients but might choose who becomes their patient in the first place. As a result, there is no duty towards persons not considered patients, with whom there is no established patient-physician relationship—including, in this case, the suspect and officers. In the case, conflict between benevolence and justice arises because there is more than one patient in need. Since the triage principles don't account for fairness, Dr M might feel torn between following protocol to treat the suspect and breaking protocol to provide likely ineffective treatments for known innocents.

In situations with multiple victims, the National Tactical Officers Association's safety priorities can influence TEMS responders' triage decisions. According to this guidance, a TEMS responder must prioritize (1) hostages, (2) innocent civilians, (3) law enforcement, and (4) suspects. This order is not based on value of one life over another but suggests that whoever is most imperiled should be accorded beneficence.[11] For example, hostages, in contrast to suspects, have little or no ability to remove themselves from or affect outcomes of a situation. Because officers sometimes knowingly risk their own safety to save innocents' lives, they understand that a TEMS responder would likely try to save a hostage or civilian first.

Different priorities would be yielded by applying Beauchamp and Childress' 6 material principles (see Table 2) that inform just resource distribution.[9] In the case, principles 3, 4, and 5 would seem to suggest that Dr M should direct lifesaving efforts to the civilian or the law enforcement officer rather than the suspect, since they neither contributed to nor deserve their current predicament.

Table 2. Material Principles of Justice[a]

1. "To each person an equal share."
2. "To each person according to need."
3. "To each person according to effort"
4. "To each person according to contribution"
5. "To each person according to merit"
6. "To each person according to free market exchanges"

[a] Beauchamp TL, Childress JF.[9]

Crises are further complicated if additional victims (especially children, pregnant women, or elders) are in the same triage category as—or are worse off than—the suspect. A TEMS responder who categorizes victims as dead or expectant and then cares for the suspect might experience conflict, with accompanying psychological or moral repercussions.[12] Had this case included such victims, Dr M might have applied the principles of justice and beneficence differently and then triaged differently.

Training and Objectivity
While decisions about whom to treat in a case such as this have the potential to be emotionally overwhelming, thereby clouding objectivity, it is important to understand that triage protocols exist to promote standard of care across a variety of ethically and clinically complex situations. Following triage protocols can support ethical and legal

defense of one's decisions in MCI situations or in other unusual tactical health cases. A TEMS responder is trained to practice objectivity when assessing and delivering care in austere environments and conditions. Doing the greatest good for the greatest number can only follow hard decisions about precious resource allocation.[10,13,14,15,16]

Making more resources available would help alleviate some decisional stress, especially for rapid treatment. Cross-training law enforcement officers to perform basic maneuvers and medical procedures and cross-training paramedics and physicians in law enforcement techniques, tactics, and practices would also help expand the resources available for MCIs and obviate the need for triage to some extent. In the end, the only way to avoid making difficult ethical decisions in MCIs is, as described here, to either increase resources or avoid MCIs altogether, which is often out of our control.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE
What Should Clinicians Who Care for Police Officers Know About Moral Injury?

Daniel M. Blumberg, PhD

Abstract
Police officers and clinicians are exposed to a broad range of moral risks in the field. When they perceive that a moral transgression has been committed by an agent responding to those risks, they are susceptible to moral injury. This article canvasses situations that can generate moral injury and describes symptom profiles of moral injury in law enforcement personnel, which tend to be more diverse than those in military personnel. This article also offers recommendations to clinicians who work with and care for police officers experiencing moral injury regarding symptom identification, recovery, and possible prevention.

Moral Injury in Policing
According to Litz et al, "Potentially morally injurious events, such as perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations might be deleterious in the long-term, emotionally, psychologically, behaviorally, spiritually, and socially (what we label as moral injury)."[1] Although the risk of moral injury among police officers might not be significantly different from that of members of other helping professions, the present paper focuses specifically on the circumstances that police officers face, which make them susceptible to transgressions that result in moral injury. It is important for clinicians who treat police officers and for those who work in the field of tactical medicine to understand moral injury, how it affects police officers, and how it follows from other moral risks.

Somewhat surprisingly, moral injury in policing has not received much empirical attention. The term originates from work with military service members and veterans.[1] Combat situations, in which service members engage in and are exposed to violence and experience its aftermath, are commonly identified as potentially morally injurious events (PMIEs). There is some overlap between moral injury and posttraumatic stress disorder (PTSD). One criterion for the diagnosis of PTSD is exposure to actual or threatened death, actual or threatened serious injury, or actual or threatened sexual violence.[2] In law enforcement, reported incidence rates of PTSD have varied

considerably—from 3.9% to between 7% and 19%[3,4]—which are little higher than prepandemic rates reported in the general public. In one study of police officers, moral injury predicted PTSD as well as its symptom clusters.[5] Therefore, whenever a police officer presents with symptoms of PTSD, it is vitally important also to assess for moral injury (see Currier et al on treating PTSD in the military[6]).

In policing, however, PMIEs can occur in the absence of actual or threatened violence, just as they can in health care.[7] Accordingly, the symptom profile of someone suffering from moral injury can diverge from that of someone with PTSD (ie, moral injury can result from an event that does not meet the *Diagnostic and Statistical Manual of Mental Disorders* diagnostic criteria for PTSD[2]). Furthermore, in the absence of violence or another potentially traumatizing event, it is more difficult to identify PMIEs. Lack of awareness of PMIEs and their impact on officers' functioning extends from police leaders and supervisors to mental health professionals and the officers themselves. The result has been a lack of early intervention following PMIEs that occur without any violence. For example, although it is common for officers who are involved in a shooting to receive a post-incident debriefing at which questions about moral transgressions can be posed, other PMIEs that occur without violence typically receive no such debriefing. Instead, officers who develop moral injury from a PMIE in which there was no violence might experience symptoms that are not even temporally connected to the PMIE.

Types of PMIE
Before describing the symptom profiles of officers who suffer from moral injury, it is important to shed some light on PMIEs in law enforcement. Greater awareness of PMIEs would improve early intervention with officers who experience moral injury and help to prevent the significant decline in officers' functioning that inevitably occurs when moral injury remains untreated. In addition to traditional PMIEs, which involve violence, police officers encounter a variety of other PMIEs. The following list has been adapted from Blumberg et al.[8]

1. Police officers can experience a moral injury when they are ordered to perform enforcement actions that run contrary to their moral values. For example, an officer might be ordered to relocate people who are experiencing homelessness.

2. Police officers can experience a moral injury when they observe the behavior of trusted colleagues or supervisors violating their moral beliefs.
   a. Such behavior includes a supervisor giving orders that officers view as morally wrong, which might result in officers losing respect for the supervisor, who is now seen as less morally upstanding.
   b. The behavior viewed as morally wrong can include policies and procedures of the organization as well as actions of command staff personnel who are not the officers' direct supervisors, which might result in officers becoming disillusioned with their agency's moral "compass."

3. Police officers can experience a moral injury when they do something or fail to do something that violates their core values, which is independent of the orders of a supervisor.
   a. Such behavior can be committed intentionally, without thinking about the subsequent reactions that might be experienced. For example, due to a deliberately slow response to a radio call, the officer does not get to the scene in time to prevent a tragic outcome. Parenthetically, this behavior

stems from other moral risks of policing, such as moral disengagement, which can lead to the behavior that results in moral injury.

    b. Such behavior also can be unavoidable due to circumstances beyond the officers' control. For example, due to heavy traffic, the officer is not able to respond to a call in time to prevent a tragic outcome.

4. Police officers can experience a moral injury following a mistake. For example, due to choosing the wrong route, the officer is not able to respond to a call in time to prevent a tragic outcome.

5. Police officers can experience a moral injury due to a momentary lapse in judgment. For example, due to a traffic accident while speeding to the scene of a call, the officer is not able to get there in time to prevent a tragic outcome.

When a PMIE is experienced as a moral transgression, a moral injury has occurred. Such an injury causes officers to question the kind of person they are or the kind of person that a trusted colleague or supervisor is. Moral injury erodes confidence in one's own or others' character. A result can be an officer in crisis who begins to question their purpose and goals, allegiances, and personal relationships.

Symptom Profile

A moral injury manifests in 2 primary ways. Officers who perpetrate a moral transgression, whether through an act of commission or omission, might experience feelings of guilt, shame, remorse, and regret. Officers who experience a sense of betrayal from the moral transgression of a trusted colleague or supervisor might experience feelings of anger, disappointment, and disillusionment. Thus, treatment of moral injury must focus on these emotions and the concomitant cognitive, behavioral, social, and spiritual symptoms that such feelings engender. Unfortunately, early intervention poses a challenge, because signs of moral injury can be concealed, as some officers choose to suffer in silence. Therefore, rather than waiting for symptoms to become disruptive to officers' functioning, it is imperative for officers as well as police leaders to learn about PMIEs and to implement a variety of preventative measures.

Preventing and Minimizing Moral Injury

Although police officers regularly encounter PMIEs and might experience a moral transgression from time to time, there are strategies that officers can utilize to minimize the impact of moral injury. These strategies should be introduced in police training and regularly reinforced during officers' mandatory continuing education classes. They should also be modeled by supervisors and peer support members. Although beyond the scope of the present article, training and leadership are factors that can mitigate the impact of PMIEs. (These factors are described in considerable depth in Blumberg et al.[8]) Given the current climate of policing, it is especially important to consider budgeting for resources that would enable officers to navigate moral risks more confidently and successfully. In addition to this strategy for improving relations between communities and police, the following prevention measures should be utilized specifically by mental health professionals who work with police officers.

1. *Showing self-compassion equates with being more self-accepting.*[9] Officers able to forgive themselves for a transgression are less likely to suffer long-term consequences associated with feelings of guilt and shame.

2.   *Making amends can assuage feelings of guilt*. In law enforcement, amends might not be able to be made directly, due to impending legal proceedings or department policy. However, officers can donate time or money to a related cause as a form of restitution for their transgression. For example, if a "tragic outcome" involved an act of child abuse, the officer might volunteer at or donate to an emergency shelter for children who have experienced abuse.

3.   *Forgiving others can reduce feelings of anger associated with a sense of betrayal*. If the moral transgression was committed by a colleague, the officer might consider having a discussion, expressing their feelings, and coming to a mutually agreeable decision about how similar situations could be avoided or prevented in the future. If the transgression was committed by a supervisor or higher-ranking member of the organization, the officer must weigh the potential consequences of reporting the behavior or discussing it with the transgressor. Although the sense of betrayal might remain whatever the officer chooses to do, the officer must find a way to let go of the anger.

4.   *Accurately apportioning blame goes hand in hand with accepting responsibility for one's moral transgressions*. Police officers can learn to accurately apportion blame because many PMIEs involve numerous people (eg, other officers on scene, supervisors, perpetrators, and civilians). Rather than irrationally thinking, for example, *I am responsible for what happened*, after recognizing that others played a part in an incident, a police officer can more rationally think, *we messed up there*. Accordingly, as Blumberg et al note, the intensity of officers' "anger or guilt or frustration will decrease to more tolerable emotions like shared sadness, group remorse, or collective frustration."[10]

Additionally, to minimize the most harmful outcomes, it is imperative for law enforcement agencies to bring moral injury to light. Police officers, like everyone else, make mistakes, including moral transgressions. Organizations with strong wellness and ethics cultures will address and normalize moral injury in policing during recruiting and hiring; academy, field, and continuing professional education training; supervisory and disciplinary efforts; and promotional practices.[8] It is essential for police leaders to destigmatize moral injury and provide resources to address it.

Moral Injury Causes
A discussion of moral injury in policing is not complete without some attention to why moral transgressions occur in the first place. Moral injury not directly related to human error is best understood in the broader context of other moral risks of policing. These moral risks are prevalent in routine policing and take 2 converging paths: risks that increase the likelihood that officers will experience emotional and spiritual distress (eg, moral distress,[11] compassion fatigue,[12] and emotional exhaustion[13]) and risks that increase the likelihood that officers will engage in misconduct (eg, moral disengagement,[14] moral compromise,[15] moral licensing,[16] and the slippery slope[17]). (For detailed descriptions of moral risks, see Blumberg et al.[18]) One result of police officers' moral disengagement and emotional exhaustion is that they become vulnerable to ethical erosion. With their ethical values compromised, officers are more likely to commit moral transgressions and suffer moral injury.

Clinicians' Roles

It is especially important for physicians and other health care professionals who work in the field with police officers to understand the complexities and subtleties of moral injury in policing. Knowledge of PMIEs provides an understanding of the context in which moral injuries occur. When working with police officers during a PMIE, clinicians can defuse an officer's psychological reaction to what the officer perceives as a moral transgression (and, in some cases, the clinician can prevent the transgression from occurring). In such cases, it would be helpful to provide a supportive statement of awareness that the incident might have caused the officer to question himself or herself and to suggest how beneficial it might be for the officer to reach out to a member of the department's peer support team or chaplaincy program. Clinicians should pay close attention when an officer experiences or expresses the following symptoms:

1. Excessive or inappropriate anger, which might be an indication of a prior betrayal by a trusted colleague or supervisor
2. Guilt, shame, regret, or other emotional experiences of moral injury
3. Dehumanizing behavior toward others, which conveys moral disengagement and increases the likelihood of a future moral transgression
4. Anxiety, depression, hopelessness, or powerlessness, which could lead to a future moral transgression[19]

No instrument is currently available to assess moral injury in police officers, although one is currently being validated (D. M. Blumberg, K. Papazoglou, M. D. Schlosser, unpublished data, 2021). When clinicians observe these symptoms, they should consider initiating a one-on-one conversation with a member of the command staff to discuss some intervention strategies.[8]

Finally, during a PMIE, all members of a tactical team are susceptible to moral injury. During a critical incident, everyone is capable of falling short of personal expectations, which could be experienced as a moral transgression; awareness of moral injury can mitigate its most harmful outcomes. However, it would be a mistake to assume that time alone can heal moral injuries. Tactical clinicians should seek support for their moral injury experiences.

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POLICY FORUM: PEER-REVIEWED ARTICLE

How Should Tactical Clinicians Help Make Use of Force More Just?

David Callaway, MD and Faroukh Mehkri, DO

Abstract

Law enforcement (LE) use of force (UOF) is a complex social, medical, and legal issue. In recent years, highly visible and publicized UOF incidents have sparked public outrage about racial inequity and motivated broad institutional reflection on sanctioning violence in the name of protecting communities. A public health approach to violence and to LE-UOF is required to develop 21st-century policing recommendations. Tactical emergency medical services physicians are uniquely positioned to convene and to serve as advisors, educators, and advocates to LE departments, community leaders, and public policy developers in order to improve UOF policies.

In Plato's vision of a perfect society ... the greatest amount of power is given to those called the Guardians. Only those with the most impeccable character are chosen to bear the responsibility of protecting the democracy.
Michael Nila and Stephen Covey[1]

The ... calculus [of reasonableness in use of force] must embody an allowance for the fact that police officers are often forced to make split-second decisions about the amount of force that is necessary in a particular situation.
Graham v Connor[2]

Guardianship

Law enforcement use of force (LE-UOF) is socially, legally, and medically complex. Public outrage about racial inequity in UOF has prompted many to question how violence, rooted deeply in foundational systems of modern US society, has been sanctioned over many years in the name of community policing, service, and protection. Ultimately, outbreaks of violence express failures in education, housing, employment, governance, and health care and underscore the importance of LE officers' roles as guardians of human rights, peace, and order and of emergency physicians' roles as guardians of life. Although these guardianship roles might be viewed by some as overly idealistic or even naïve in ignoring the complex historical roots and realities of policing in US communities, they are nonetheless crucial to maintaining social order: when guardians fail to live up to their oaths or are perceived to violate their core values, societies convulse.

Long-term media coverage of numerous UOF incidents exposes a lack of national professional standards, agency policies, and rigorous data collection on LE-UOF.[3,4,5] Although absence of uniformity undermines LE accountability to the public, coverage of high-profile UOF incidents reveals legitimate, deep-rooted fear and suspicion of LE's treatment of people of color and of individuals with mental health illness and drug use disorders.[6,7,8,9,10]

Emerging research suggests that police contact is a determinant of health inequity and a cause of early mortality among people of color.[11] The LE and public health communities have distinct approaches to violence prevention and have developed unique cultures, vocabularies, and entrenched biases that impede their collaboration. To move forward, violence and LE-UOF must be approached from a unified public health standpoint with the aim of improving health outcomes,[12] and tactical emergency medical services (TEMS) clinicians should help effect this change.

Violence Prevention Roles for TEMS Clinicians

TEMS developed largely within emergency medicine (EM) to respond to niche trauma care demands of high-risk, field-based situations that required experience at the intersection of LE, public health, trauma care, mental health care, and emergency medical care.[13] TEMS clinicians undergo training in hot and warm zone operations, tactical movement, and crisis de-escalation tactics to manage threats to public safety in disciplined, protocol-driven ways. TEMS clinicians also play key roles in EM, as emergency departments (EDs) are the sites of care for most individuals involved in LE-UOF incidents, although many ED personnel lack specific training in the treatment or reporting of UOF injuries.[14,15,16] Outside EDs, TEMS clinicians can motivate holistic, data-driven, scientifically informed approaches to LE interactions during crises and can advise agencies on how to improve UOF policies and protocols to mitigate excessive UOF and adverse outcomes.[3] Here, we discuss 4 foundational roles of TEMS clinicians: advisors, conveners, educators, and advocates.

Advisors. TEMS physicians have earned the trust of LE officers through years of training, shared experience, community service, and aligned professional ethics (see Figure). On the basis of this trust, they can serve as critical advisors across the tactical and strategic spectrum. At the tactical level, clinicians can advise and influence real-time LE behavior concerning UOF. At the strategic level, clinicians' diverse knowledge, skills, and backgrounds enables them to provide LE leaders with guidance on training, education, quality assurance, and accountability that can improve the outcomes of LE-UOF.

Figure. Virtues in Emergency Medicine and Policing[a]

Virtues in Emergency Medicine
1. *Courage*: "the ability to carry out one's obligations despite personal risk or danger."
2. *Justice*: fairness toward all people; a social responsibly to ensure "equitable distribution of benefits and burdens within a community or society."
3. *Vigilance*: a state of alertness and preparedness "to meet unpredictable and uncontrollable demands" in the service of patients.
4. *Impartiality*: an unconditional commitment to care for patients regardless of status, station, or individual characteristics.
5. *Trustworthiness*: honoring the dependence of patients on physicians in order to protect all patients.
6. *Resilience*: the ability to meet and overcome emergency challenges and recover personally and professionally in order to continue serving patients.

Virtues in Policing
1. *Courage*: "I will maintain courageous calm in the face of danger, scorn or ridicule; develop self-restraint; and be constantly mindful of the welfare of others." 2. *Justice*: "my fundamental duty is to serve the community; to safeguard lives and property; to protect the innocent against deception, the weak against oppression or intimidation and the peaceful against violence or disorder; and to respect the constitutional rights of all to liberty, equality, and justice." 3. *Vigilance*: "I know that I alone am responsible for my own standard of professional performance and will take every reasonable opportunity to enhance and improve my level of knowledge and competence." 4. *Impartiality*: "I will never act officiously or permit personal feelings, prejudices, political beliefs, aspirations, animosities or friendships to influence my decisions." 5. *Trustworthiness*: "Honest in thought and deed both in my personal and official life, I will be exemplary in obeying the law and the regulations of my department. Whatever I see or hear of a confidential nature or that is confided to me in my official capacity will be kept ever secret unless revelation is necessary in the performance of my duty."

a Adapted from the American College of Emergency Physicians[17] and the International Association of Chiefs of Police.[18]

Conveners. TEMS clinicians possess unique social capital that allows them to convene a broad network of stakeholders from LE, health systems, academia, and public health.[19] Since the Napoleonic Wars, prehospital and crisis clinicians have straddled the divide between what is best for an individual patient in a clinical care situation and what is best for society from a public health perspective.[20,21] The modern TEMS physician is comfortable with this tension and experienced in solving complex problems by mobilizing experts across a broad professional network. With a view to innovating public policy on UOF, TEMS physicians can bring together national medical societies (eg, the American College of Emergency Physicians, the National Association of EMS Physicians, the American College of Surgeons, the American Public Health Association, and the American Medical Association) and LE organizations (eg, the International Association of Chiefs of Police, the Major Cities Chiefs Association, and the National Tactical Officers Association), as they did with the implementation of tactical emergency casualty care as a national standard for trauma care in high-threat environments.[22,23]

Educators. TEMS physicians have years of education in anatomy, physiology, biology, and chemistry in addition to clinical experience managing patients with mental health problems and drug toxicity.[24,25] They can leverage decades of diverse experience in adult learning to create, implement, and sustain best practices for UOF. As clinicians, many TEMS physicians have experience caring for patients with delirium and agitation, exceptional pain tolerance, and incoherent delusions, and they understand the risk of positional asphyxiation to the prone patient.[26,27] Consequently, TEMS clinicians are uniquely suited to educate LE officers on the physiologic consequences of various UOF modalities (eg, chemical agents, nonlethal electric shock weapons, physical restraints). TEMS clinicians are also experts at crew resource management (CRM). In the ED, integrated team care for trauma and for cardiopulmonary resuscitation during cardiac arrest demonstrate the value of CRM.[28] Applying these clinically validated CRM tactics during UOF incidents can optimize de-escalation techniques, medication delivery, patient monitoring, and the use and position of restraints. Combined with clear identification of roles and responsibilities during team responses, education on these tactics could mitigate adverse outcomes, UOF incidents, and in-custody deaths.

Advocates. Although advocacy is a core tenet of the physician's professional ethos, it is not a simple task in the context of UOF. In seeking to shape UOF policies, TEMS

clinicians should advocate for a data-driven, public health approaches to UOF policies and management of complex, high-threat interactions.[29,30,31] The President's Task Force on 21st Century Policing details 3 relevant advocacy priorities.[32]

1. *Create standards of care for UOF*. At the departmental level, TEMS clinicians can demonstrate to LE agencies the importance of crafting, validating, and implementing quality assurance processes to codify such standards. And, at a national level, TEMS clinicians can try to unite professional societies in health professions, law, public health, and public policy to help generate resources to match this requirement.

2. *Require and fund crisis response training*. Just as clinicians would not introduce a new airway device in EM practice without robust training and budget allocation, so TEMS physicians must advocate at all levels for funding for expanding and developing LEO training in UOF and crisis mitigation.

3. *Study outcomes*. Advocacy efforts should demand accurate data collection to inform public policy, develop departmental processes, craft realistic training, and support a public health approach to violence reduction.[32,33]

Models of Success

There is evidence that TEMS clinicians are increasingly influencing UOF policies across the United States, as leaders search for solutions to the complex issues of violence, LE use of force, and community security. In Champaign, Illinois, LE now successfully utilize a multidisciplinary behavioral health response team to reduce UOF incidents when engaging with individuals with mental illnesses and substance use disorders.[34,35] In Dallas, LE worked with TEMS clinicians to develop the Rapid Integrated Group Healthcare Team (RIGHT)—comprising paramedics, licensed clinical social workers, and police officers—to more effectively manage mental illnesses and substance use disorders when responding to calls about people in crisis.[36] Dallas is also addressing UOF incidents through the novel ABLE (Active Bystandership for Law Enforcement) Project,[37] a national resource for training, technical assistance, and research to nourish LE cultures in which officers intervene to prevent misconduct, avoid mistakes by police, and promote officer health and wellness.[37,38]

LE-UOF will continue to be required in certain situations. However, we can and must do better. Reducing violence, criminal or sanctioned, is a whole-community challenge that requires a whole-community set of solutions. Within the house of medicine, TEMS physicians stand at the ready to serve as trusted advisors, conveners, educators, and advocates. In these roles, they can truly help guide a diverse public health coalition to ensure that data, training, focused funding, and accountability drive efforts aimed at the most judicious and just UOF.

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POLICY FORUM: PEER-REVIEWED ARTICLE

How Should Exposure Risk to Tactical Personnel Be Balanced Against Clinical and Ethical Rescue Demand?

Mollie V. Williams, MD, MPH and Olaitan Ajisafe, MD, PharmD

Abstract

Chemical, biological, radiological, nuclear, and explosive devices can all be used to cause mass disruption and mass casualties. These incidents can occur naturally but are usually associated with terrorism and often require prehospital and hospital care for patients and various precautions for clinicians. It is important to consider for each kind of exposure how clinical and ethical demand for rescue should be balanced against field-based risk of injury, contamination, or death to tactical personnel. Chemical exposures typically require prompt extrication, decontamination, and medical management; biological and radiation exposures generally require donning personal protective equipment; and explosives could contain "dirty bombs" or secondary devices.

Hazardous Exposures

Chemical, biological, radiological, nuclear, and explosive (CBRNE) devices can all cause mass disruption and lead to massive numbers of casualties. These events, frequently referred to as CBRNE incidents, may be of natural or man-made origin. In the early phases of medical response to these incidents, prehospital personnel (first responders) and in-hospital personnel (first receivers) are the initial contacts for medical care of the victims involved in CBRNE incidents who are triaged at the scene or who self-present to a health care facility.[1] Difficult decisions often need to be made and should be informed by the ethical and clinical implications of possible courses of action that were discussed with highly trained personnel during the planning phases of disaster response.[2,3] The degree and duration of management efforts will often be determined by the type of exposure and the capacity of the health care delivery system. In this article, we discuss the inherent danger posed by such incidents to both prehospital and hospital personnel and the care dilemmas that arise as overburdened health care delivery systems must consider shifting from what some would argue is "crisis standards of care"[4,5] to "altered standard of care"[6] to allow for any contingency or crisis plan to be successfully implemented.[7]

Risks to Personnel

Chemical exposure. CBRNE incidents involving chemical exposure, though varying widely in their treatment, require immediate identification, decontamination, and prompt

initiation of medical management.[3] Death may occur within minutes if the causative agent is not identified and the appropriate antidote is not administered. Chemical exposures will often require prompt extrication, decontamination, and medical management to avoid increased morbidity and mortality due to exposure.[3] While not unique to chemical incidents, the challenge of caring for critically ill, contaminated patients who need immediate attention but who pose a risk for secondary contamination of the emergency department must be addressed. Secondary contamination can occur either when a patient is transported to the hospital but does not undergo the decontamination process prior to arrival or when an ambulatory person (the "walking wounded") self-presents to the emergency department.[8] The ethical dilemma for first receivers is to determine if the risk that the patient might pose to staff would lead to a potential loss of a valuable, highly trained human resource. It is important that hospital emergency management officials have decontamination protocols and trained teams in place to deal with this occurrence swiftly.[9]

Biological exposures. Biological and radiation exposures will likely require an appropriate level of personal protective equipment to avoid possible contact with and dissemination of the agent by rescue personnel and others involved in patients' transport and care.[10] The speed with which biological events can occur leads to an increase in the use of supplies, space, and staff. While some of these resources can be reused, stockpiled, adapted, or even substituted,[7] many health care workers, including physicians and nurses, are concerned about the risk to their own health and the health of their families.[11,12]

Radiological and nuclear exposures. Radiological and nuclear incidents are infrequent in occurrence, but, when they do occur, they tend to be greeted with panic and fear not only by the public but also by medical personnel.[13,14] Victims without life-threatening injuries should undergo complete decontamination prior to the initiation of treatment. In the case of severely injured individuals with life-threatening injuries and contamination, the decision about whether to initiate decontamination prior to treatment or to forgo decontamination and risk secondary contamination of the facility and staff is a difficult one to make for emergency medicine physicians, trauma surgeons, and hospital administrators.[15] Explosives can also harbor the inherent risk of "dirty bombs" or secondary devices meant to increase the morbidity and mortality of those individuals attempting to secure the scene of the incident and even those who are involved in rescue and care.[15] Each of these incidents carries with it an inherent danger to both the prehospital and the hospital personnel.

Decision Making During CBRNE Incidents

Each CBRNE incident involves incident-specific decision-making dilemmas as well as decisions about the care of individual patients. In these austere environments, the medical decisions made by both prehospital personnel and clinicians can be drastically different from the usual preexisting protocols and plans.[16] In following the standard of care, one must first determine what another physician with similar training would do in a similar situation.[17] In CBRNE incidents, however, the level of care provided could possibly differ from the standard of care or be conceived of as altered, opening the door to legal implications. The term *altered standards of care* was originally coined by the Agency for Healthcare Research and Quality during a meeting on mass casualty events that it convened in 2004.[6] Later, Schultz and Annas[4] and Koenig[5] would use the term *crisis standards of care* (adopted by the Institute of Medicine,[18] now the National

Academy of Medicine) to indicate that the level of care being provided was appropriate for the present circumstances and available resources.

According to Hick et al, in crisis care, "inadequate resources are available to provide equivalent care—care is provided to the level possible, given the resource gap. Increased risk of morbidity and mortality because of a lack of resources defines the care provided in this phase; this risk can be minimized by implementing resource use strategies."[7] The authors identified 4 factors that would likely affect the execution of any crisis care plan: space, staff, supplies, and special considerations,[7] all of which are interconnected and necessary to the care of the injured and critically ill during disaster. Whether resources are material or human, it is important to anticipate decisions that will need to be made during times of scarcity. Decisions about reallocation of resources, such as ventilators and other life-supporting devices, and about prioritizing critical interventions and palliative care are both clinical and ethical in nature and should motivate fairness and equity.[7]

Implementation of crisis standards of care is guided by 2 overarching theories: utilitarianism and virtue ethics. The utilitarian principle of doing the greatest good for the greatest number of individuals is in line with public health initiatives. Virtue ethics is based on 7 traits attributable to physicians responding to terrorist events. According to Larkin et al, the virtues of "prudence, courage, justice, stewardship, vigilance, resilience, and charity"[19] allow clinicians to respond flexibly to challenges they are likely to experience during terrorist attacks rather than rely solely on preexisting protocols and plans to triage and treat victims. Virtue ethics, however, could lead to scarce resources being quickly consumed on a patient who is likely to have a poor outcome if charity takes precedence over stewardship and justice. By contrast, utilitarian ethics will apply those scare resources where the greatest chance for survival exists.[20] Decisions guided by either of these theories will often differ from decisions that would have been made in an ideal environment with normal or unlimited resources[21] and may have severe legal implications.[20,22]

Several government agencies offer practical guidance on care in disaster situations. These documents clearly outline the definitions, tools, guidelines, and frameworks for developing standards of care for use during disaster situations, including contingency planning, strategies for addressing shortages, and ethical bases for medical decision making during the disaster as well as during the pre-event planning phase.[6,23] However, these documents provide very few answers to ethical questions or scenario-based suggestions and no general consensus on how to ensure fairness, reliability, and equity of resource allocation; on health care personnel's duty to service during disaster; and on clinicians' and society's reciprocal duties of care.[2]

In conclusion, regardless of the type of disaster event, prehospital and hospital personnel will be unable to determine the duration of the event, the number of resultant casualties, or the amount and types of resources (human and material) that will be necessary in the earliest phases of disaster response. Such uncertainty will lead to the need for preexamined policies and emergency management plans, which help to prepare health care and disaster response leadership for the difficult decisions they will need to make as they pertain to surge capacity, resource allocation and reallocation, triage, decontamination, and clinicians' duties to provide care during times of disaster.[7,24]

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POLICY FORUM: PEER-REVIEWED ARTICLE

Why Care-Based, Not Carceral, Approaches to Suspects With Mental Illness Is Key to Whether We Trust Professional or State Authority Ever Again

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Abstract

Many police officers, prosecutors, defense attorneys, judges, and parole boards have reformed how their court- or carceral-based work with patients who have mental illness proceeds. This article discusses how policies and protocols have evolved to help court and carceral workers meet mental health needs of people in their custody and considers which virtues and values should guide clinically, ethically, and legally relevant deliberations and conduct.

Sean Moore

On January 6, 2017, police officers in San Francisco responded to a neighbor's complaint about Sean Moore, a man diagnosed with bipolar disorder and schizophrenia.[1,2] During this intense encounter, Moore was shot by an officer in the abdomen and groin. Subsequently, "Moore's family and lawyers claimed that officers should have been able to recognize ... Moore's mental health symptoms and handled the situation differently."[2] Daily and nightly, police officers encounter citizens with mental illness who express troubled, troubling, and sometimes threatening behaviors.[3] About 1% of calls for police intervention involve an individual (eg, a missing person or criminal suspect behaving erratically or threatening harm to self or others) struggling with serious mental illness.[4] People with untreated mental illness are 16 times more likely to be killed by police than other suspects.[5] The stakes are high, ethically complex, and controversial.

Court and Carceral Reform

Courts. Across the United States, prosecutors continue to examine criteria and protocols for filing criminal charges against persons with mental illness. Moreover, many jurisdictions sponsor mental health courts to process cases in which there is evidence that mental health care is warranted as an alternative to typical criminal justice processes that generally lead to incarceration.[6] In jurisdictions without mental health courts, judges may factor in a defendant's mental illness at the time of sentencing.[7]

Judges may also place convicted offenders with mental illness on probation so that they can receive residential or outpatient mental health care instead of being incarcerated. In a few cases, defendants may be deemed incompetent to stand trial and remanded to forensic psychiatric care units.

Incarceration and detention. Of people experiencing incarceration, approximately 20% have experienced some form of serious psychological distress in the past 30 days, and, when diagnostic criteria are expanded to include anxiety and other symptoms, approximately 55% have experienced an indicator of mental illness in the past 30 days.[8] Many federal and state prisons and local jails have tried to respond more fully to the health needs of people who are incarcerated. Judges and parole boards, for example, may release detainees with histories of severe mental illness when there is evidence that residential or outpatient mental health care would be an appropriate alternative to continued incarceration.[9]

Clinicians' Roles

Behavioral health clinicians (eg, nurses, psychologists, psychiatrists, social workers) are key to helping officers, prosecutors, defense attorneys, judges, and parole boards help individuals with mental illness navigate their lives.[10] Clinicians who train police officers focus on helping officers interact with people with mental illness constructively and humanely to de-escalate tension and minimize the need for arrest.[11] Prosecutors consult clinicians when making decisions about whether to file charges against suspects whose mental illness might have influenced their alleged criminal behavior. Defense attorneys consult clinicians about what constitutes evidence that clients' mental illness influenced their alleged criminal behavior in order to argue during their clients' trial or sentencing that the mental illness should be regarded by the court as a mitigating factor that facilitates plea negotiation, reduced sentence duration, earlier probation eligibility, dismissal of a charge, referral to a mental health court, or, in rare cases, a not-guilty-by-reason-of-insanity defense. Some carceral officials consult clinicians to help them respond to detainees' mental health needs, and parole boards consult clinicians about care alternatives to continued incarceration.

Five Virtues of the Best Practitioners

Both clinical and legal responses to citizens, suspects, defendants, and detainees with mental illness should be anchored in evidence and ethics.[12,13] Five focal virtues identified by Beauchamp and Childress[14] should be expressed through clinical, legal, judicial, and carceral workers' deliberations and decisions about people with mental illness.

Compassion. Compassion presupposes sympathy, has affinities with mercy, and is expressed in actions intended to alleviate another person's suffering.[15,16] Expressing compassion toward criminals or those alleged to be criminals can be a challenge for many clinicians, even the most experienced. That said, compassion is a cornerstone of professionalism, and keen awareness of how psychological symptoms can manifest in the conduct of a person with mental illness is a cornerstone of emotional intelligence. Ideally, the San Francisco police officers who approached Moore would have been trained to identify his mumbling and nonsensical language as symptoms of psychosis and responded without lethal force.

Discernment. Discerning professionals' decisions and actions are informed by "sensitive insight, astute judgment, and understanding."[14] Decisions unduly influenced by fear and

racial bias are to be guarded against by anyone responding to the needs and vulnerabilities of people with mental illness. Inequitable numbers of police shooting victims are people of color like Moore.[17] Clinicians and officials charged with the care and custody of people with mental illness must cultivate awareness of and practice resistance to pervasive racial bias in US health and carceral systems.[18]

Trustworthiness. Trust requires reliance upon another person's character and competence and belief in the beneficence of their motivations. Whether as agents of a state or representatives of a profession, clinical, legal, judicial, and carceral workers have fiduciary responsibilities to express respect for the needs and vulnerabilities of those in their care or custody. Such workers are now not widely assumed to be trustworthy simply because of their roles or authority[19]; they must demonstrate trustworthiness in their actions consistently and reliably over time.

Integrity. Consistent, reliable expression of virtues and values over time generates integrity. Clinical, legal, judicial, and carceral workers who possess integrity must also challenge unethical conduct by colleagues. For example, integrity is key in the growing "active bystander" movement among police departments to train officers to intervene when a colleague mistreats a suspect who is mentally ill.[20]

Conscientiousness. An individual who acts conscientiously makes a good faith effort to determine and act upon what is right. Clinical, legal, judicial, and carceral workers must make conscientious, deliberate, consistent efforts—not casual or sporadic efforts—to treat people with mental illness respectfully and humanely.

Four Ethical Values of the Best Practitioners

The 4 core moral principles of Beauchamp and Childress[14] are worthy of reiteration here.

Autonomy. Respect for autonomy implies that self-governance should generally be free, undeterred by others. However, when people with mental illness lack insight into their illness, lack capacity to make decisions about their actions or health interventions, or pose a threat to themselves or others, clinical, legal, judicial, and carceral workers must balance respect for the autonomy of a person with mental illness with other ethical values, such as nonmaleficence, beneficence, and justice. For patients experiencing incarceration, further restriction of their autonomy related to their health and welfare deserves careful consideration, and respect for these individuals' autonomy should be expressed to the greatest extent possible (eg, under some circumstances and when feasible, by honoring their refusals of interventions or, if needed to keep the individual or others safe, by using force that is the least intrusive and least restrictive). In Moore's case, this might have meant initiating civil procedures for a psychiatric inpatient stay as an alternative to arrest, incarceration, or use of lethal force.

Nonmaleficence. Nonmaleficence means avoiding, or at least mitigating, harm. When feasible, clinical, legal, judicial, and carceral workers should do their utmost to avoid harming those in their care or custody. Avoiding abuse, traumatization, or retraumatization of people in custody is key for officers. Prosecutors and judges should avoid knowingly discounting documentation of defendants' mental illness. Parole boards should not ignore parolees' mental illness when rendering decisions about whether to revoke parole and reincarcerate people who violated conditions of their parole due to their mental illness.

Beneficence. Beneficent actions are those intended to benefit others. Examples of beneficence include prosecutors who actively seek a mental health court in which an alleged offender will be tried and judges and parole boards who consider care-based alternatives to incarceration.

Justice. Clinical, legal, judicial, and carceral workers should be dedicated to equitable treatment of people with mental illness and primarily constructive rather than primarily punitive responses to behaviors symptomatic of mental illness that could lead to arrest, prosecution, conviction, and incarceration. Ideally, someone like Moore, whose severe mental illness attracted police attention, would receive competent and comprehensive psychiatric care as opposed to being met with a punitive or lethal response.

Conclusion

Clinical, legal, judicial, and carceral workers' skill in managing crises is key in their encounters with people with mental illness. In both theory and practice, professionals should aim to act in the interests of those in their care and custody by expressing the virtues and values considered here.

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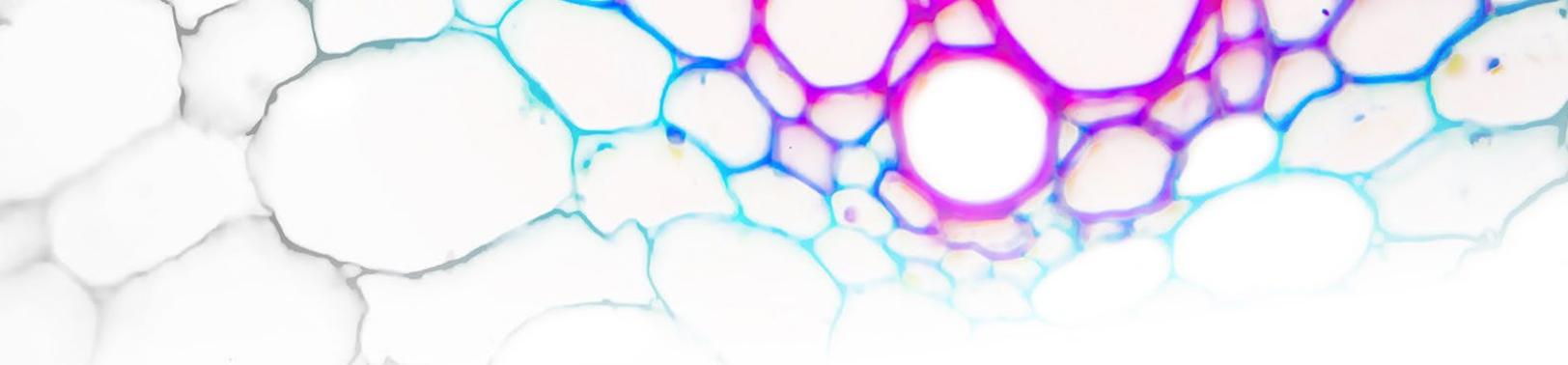
MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Tactical Emergency Casualty Care and the Art of Practicing Nonmaleficence in Harm's Way

Jeremy Ackerman, MD, PhD

Abstract

This exploration of the author's training and experience as a tactical physician underscores the benefits of physicians' work with law enforcement personnel in field-based operations that are ethically complex. The article points in particular to physicians' roles in assessing potential risks and benefits—especially of use of force—to promote community safety.

An Accidental Tactical Physician

I had no plans to become a tactical physician, yet, here I am, with body armor, gas mask, weapons, and badge. I have now deployed with my team for more than 50 operations, including service of high-risk warrants, protection of well-known public figures, mass gatherings, and riots. What I have learned and experienced underscores the benefits of physicians' roles in the field, especially in helping officer colleagues balance potential harms of use of force against securing community safety.

Unlike many physicians who practice tactical medicine, I had no prior emergency medical service, law enforcement, or military experience. Instead, I started by looking for a police officer to collaborate on a firearm injury prevention project. The police department had resources that we, hospital emergency medicine physicians, needed for our project, and we hoped an enthusiastic officer would help. Our project moved forward, and in return I began working with officers from a Special Weapons and Tactics (SWAT) team. I quickly realized I needed to improve my own firearm skills and tactical knowledge. I understood little about law enforcement and tactical team functioning and needed my team members to teach me. Over the next year, I trained regularly with the SWAT team—*my* team. I had to participate fully in the training to learn my role as a tactical physician so as to gain my team's trust. My trauma and emergency department experience did not apply directly in the field, particularly when I was faced with ongoing potential threats. I learned the established protocols of tactical emergency casualty care (TECC),[1] which are designed for this setting. I earned the nicknamed "Doc," which, in the tactical world, expresses not only a professional qualification but also trust and respect. By my fourth mission, I could don my body armor unassisted, and I had streamlined my medical pack to fit the cramped and now comfortably familiar space of our armored truck.

In this article, I discuss physicians' work with law enforcement personnel in field-based operations, with special attention to the role of physicians in assessing potential risks and benefits of tactical teams intervening to promote community safety.

Trigger Discipline

One role of tactical physicians was impressed upon me by a memorable mission to arrest a suspect with a particularly long and violent criminal career. At the mission briefing we learned that he was heavily armed and had posted threats to police and others on social media. I watched my team enter his home, emerging a short time later with the suspect in our custody. One of my officers walked past me and said, "Doc, with you out here, it's easier to keep my finger off the trigger."

Firearm safety rules always include some variation of "ALWAYS keep your finger off the trigger until ready to shoot."[2] Known as *trigger discipline*, this rule is key in civilian, military, and law enforcement firearm training. We know from countless "accidental," "unintentional," or "negligent" shootings that a finger on a trigger is almost always the proximal cause of harm. We also know that even well-trained, experienced firearm operators can neglect trigger discipline when stressed or threatened. My officer's remark made me more fully appreciate how my role in mitigating risk of harm to bystanders, suspects, officers, and communities extends far beyond providing care.

Warm and Hot Zone Demands

In addition to serving arrest and search warrants or responding to hostage and barricade situations, tactical teams also assist security details for high-profile events (eg, National Football League Super Bowl games). When assigned as a quick response unit for an event, our role is primarily to respond to a potential mass casualty incident (MCI), such as a terrorist attack or the presence of an active shooter, and to prevent further deaths or injuries. In every mission, we divide the scene into zones—the hot zone where the threat is, the warm zone where the threat could go, and the cold zone (which is probably safe). When my team is making an arrest or serving a warrant, I remain in a protected location: the cold zone. But when my team responds to a potential MCI, there is no safe place; I need to move with my team into the warm or hot zone.

Anyone in the warm or hot zone is vulnerable. Our team moves rapidly to secure these zones and to stop ongoing threats. Conventional emergency medical services will not go into the hot zone where the threat is or the warm zone where an active shooter or new threats could emerge at any time. Concern for securing the safety of the scene from ongoing threats is a common reason why medical response is delayed in MCIs.[3] The principles of TECC dictate that only minimal and immediately lifesaving interventions be performed in the warm zone, where emphasis is placed on rapid evacuation to the cold zone. Because these situations are dynamic, zone classification can change rapidly and the TECC priorities shift as a result. Because in the hot zone the priority is stopping the threat, when I am working with my team as part of a quick response unit for an event, it is essential for me to be armed. Review of relevant law and department policies had taught me that I could only be armed in the role of helping to stop threats if I became a sworn officer. I balanced the obligation I felt to serve my team and the public on the front line against the risks inherent in committing to enter warmer zones, and I enrolled in the police academy.

Nonmaleficence and TECC

For many, the idea of an armed physician serving as part of a tactical unit conflicts with the dictum "first, do no harm." As scholars have noted, this dictum is not actually a part of the Hippocratic Oath and conflicts with how modern medicine is practiced.[4] An armed tactical physician dramatically exemplifies the fine balance of risks at the heart of how modern medicine must be practiced. Any health intervention carries at least some risk of iatrogenic harm; such risk can only be avoided entirely by avoiding any intervention. Weighing the risks and benefits of intervening is done in policing as well as medicine. In addition to providing medical care, part of my role as a tactical physician is to augment my team's capacity for ethical reflection and serve as a sort of medical conscience. To that end, I help the team weigh potential risks and benefits of actions' effects on bystanders, suspects, officers, and communities, just as I do so often with patients and their loved ones.

Fundamental to TECC is that, within a hot zone or a warm zone, the greatest threat arises not from victims' injuries or conditions but from the potential for additional deaths and injuries. A point at which risk of injury or death warrants use of force, including deadly force, must be assessed on a case-by-case basis. Just as an oncologist might escalate or stop an intervention based on a patient's responses, so tactical teams must dynamically assess the appropriateness of using any kind of force—including discharging a firearm—based on the situation, as specified in the International Association of Chiefs of Police Code of Ethics.[5] As members of tactical teams, physicians working in warm zones have responsibilities, just like other team members, to be trained and prepared to properly use force if needed and to be prepared and skilled in contributing to deliberations about prospective risks and benefits of using force.

Harm's Way

The number of deaths caused by iatrogenic harm (including errors) in health care[6] is staggering compared to the number of deaths caused by law enforcement personnel.[7] Beyond the raw numbers, the critical ethical point is that all members of a tactical team subject themselves, their colleagues, and those whom they seek to serve and protect to the consequences—positive and negative—of tactical and ethical decisions they make in the field. Obviously, I'm not saying that physicians should ever intentionally place themselves in positions that necessitate use of force without providing benefit. What I am saying is that being armed and being skilled in wielding a firearm is key to being a good tactical colleague and to contributing to the creation of an environment in which early critical medical assessment and intervention can be done. Although still debatable, the use of force by any individual—even a physician—in self-defense or in defense of others has long-standing legal and even religious support.[8,9] Physicians entering warm zones looking to provide care must assume the risk of possibly needing to take life to preserve life.

When I completed police training, I earned a badge and became an officer sworn to serve and protect our community. I bring my experiences to students and colleagues who are in both law enforcement and health care. Although I hope I never have to use my weapon in the field, I appreciate that it enables me to provide care—at dire times and under austere conditions—to patients for whom such care would otherwise be inaccessible.

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VIEWPOINT: PEER-REVIEWED ARTICLE
Crisis Intervention Team Program Leadership Must Include Psychiatrists

Mark R. Munetz, MD and Natalie Bonfine, PhD

Abstract

Crisis intervention team (CIT) programs are partnerships between police and mental health community members developed with little involvement from psychiatrists. This article argues that psychiatrists should be one of the CIT program leaders to facilitate the transfer of persons in crisis from law enforcement to mental health care, make admission and civil commitment decisions, offer real-time telemedical support to officers or co-responders in the field, and collaborate with first responders in integrating responses to 911 and 988 calls.

Origins

In 1987, a young Black man with a history of mental illness and armed with a knife was shot and killed by Memphis police officers when he refused to drop his weapon. Following public outcry and substantial community planning, the Memphis crisis intervention team (CIT) model emerged in 1988. CIT involves partnerships among police, mental health professionals, individuals living with mental illness, and their families to prepare volunteer police officers selected to become CIT officers. Trainings include 40 hours of the following content: overviews of mental illnesses and substance use disorders, local mental health service systems, contact with families of and individuals recovering from mental illness, verbal and nonverbal de-escalation strategies, and role playing. CIT programs motivate community safety and officer safety and enable prearrest diversion program development and implementation.[1,2,3,4]

Yet CIT programs have developed with little involvement from psychiatrists. This article argues that psychiatrists should be one of the CIT program leaders to facilitate the transfer of persons in crisis from law enforcement to mental health care, make admission and civil commitment decisions, offer real-time telemedical support to officers or co-responders in the field, and collaborate with first responders in integrating responses to 911 and 988 calls.

CIT Infrastructure

While CIT continues to evolve, concurrent efforts to improve and transform crisis response systems are underway: the Substance Abuse and Mental Health Services Administration (SAMHSA) offers a toolkit of crisis care best practices,[5] the National Association of State Mental Health Program Directors and partners host the Crisis Now website with resources,[6] and both the Treatment Advocacy Center and the National Alliance on Mental Illness recommend that clinicians, not police, respond to crises.[7,8] Recent federal legislation established 988 as a dedicated alternative to calling 911 for crises involving a person with a mental illness,[9] which must be implemented by telecommunication service providers by July 16, 2022.[10,11] Finally, in 2021, $35 million was added to the federal Mental Health Block Grant to be distributed annually by SAMHSA to support states' crisis service integration, infrastructure, care, and implementation costs.[12]

Clinicians (eg, clinical social workers, psychologists, and counselors) have been key to CIT programs' successes. CIT police officers develop relationships with CIT trainers, who include clinicians in crisis centers, hospital emergency departments (EDs), and other mental health services organizations. CIT programs can help transform community safety cultures by forging solidarity among advocates and encouraging trusting relationships among police officers, clinicians, and families of and individuals with mental illness.[13] In the rest of this article, we try to show why psychiatrists' integration into CIT leadership would enable integration of clinical knowledge into CIT training and help more fully integrate CIT operations into crisis responses.

Psychiatrists' Roles

One reason for a lack of psychiatric leadership in CIT programs could be an overall shortage of psychiatrists in the US health care system. Yet as the number of community psychiatry fellowships increases nationally,[14] more psychiatrists may be exposed to and prepared for CIT responsibilities. In addition, a CIT program in Albuquerque, New Mexico, is now a potentially scalable model for how to embed psychiatrists directly within law enforcement to coordinate CIT responses and consultation to community partners.[15]

Psychiatrists can help teach CIT courses that train first responders to recognize a person with mental illness and should assist in CIT program development and implementation, especially in communities that lack psychiatrists. Police officers, specifically, can benefit from direct contact with psychiatrists in CIT program curriculum development, role play planning, and site visits. Trust among officers, psychiatrists, and other clinicians can make case work, field work, and quality assurance run productively and efficiently. Psychiatrists, specifically, can help in the following ways:

1. Implement early intervention programs to coordinate needed specialty care (rather than criminal justice system involvement) in cases involving, for example, persons with first-episode psychosis.
2. Implement evidence-based interventions (eg, assertive community treatment or assisted outpatient treatment) for individuals who should be treated as patients instead of as suspects or perpetrators.
3. Guide postcrisis evaluation, treatment, referrals, and care coordination for patients.
4. Facilitate information sharing as appropriate and educate stakeholders as appropriate about patients' postcrisis care needs, especially in cases in which

involuntary commitment or compassionate force protocols in clinical settings are needed to keep a patient or others safe.[16]

5. Give advice about state and federal policy that governs transportation and transfer of patients from correctional to clinical care environments.

6. Help CIT first responder colleagues navigate field-based or secondary trauma experiences.

Collaboration Promotes Safety

Because crises are complex and require individualized but well-coordinated responses, it's important to acknowledge that CITs might be only one part of an effective overall response to an incident in a community. For example, some crisis call responses require CITs to be augmented by mobile mental health crisis teams,[17] which typically include 2 clinicians (or a clinician paired with a specially trained person living in recovery from mental illness, referred to as a peer). Co-responder models tend to incorporate a CIT police officer and a clinician or peer in the field together[18] to respond to a call or follow up on a prior response to a call.[19,20]

Compared to police-only responses, having clinician partners in the field facilitates interagency collaboration and communication, improves de-escalation success, and increases the likelihood of a preferable outcome for an individual experiencing crisis.[21] Many crises can be resolved on scene, but some require transportation of patients to a crisis assessment center or hospital ED and therefore involve emergency medical system (EMS) personnel, such as paramedics or emergency medical technicians (EMTs), and nurses. Additionally, EMS personnel often work for fire departments or other local government units, are responsive to a medical director official, and follow well-established emergency response protocols that streamline transfers of patients to hospital EDs. For example, EMTs in the field are supervised remotely, make decisions based on protocols, and initiate transportation of a patient to an ED. Like emergency physicians' work with EMS personnel,[25] psychiatrists can help supervise field-based decision making to optimize CIT programs' contributions to effective crisis responses, by using innovative video technology either in real time[26] or to create a network for continuing education (eg, CIT ECHO) to respond to people in crisis.[27] Moreover, psychiatrists can help forge community trust and collaborative responses to 911 and 988 calls as implementation of 988 call centers, as well as service integration of 911 and 988, continues in the United States.

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VIEWPOINT: PEER-REVIEWED ARTICLE

What Law Enforcement Can Learn From Health Care About Moral Injury

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Abstract

A career as a public servant carries risk of moral injury. Law enforcement and health care personnel must subordinate some personal values in service to the public. *Transgression* and *betrayal* are primary mechanisms of moral injury, which this article explains. Identifying which value system (eg, personal, professional, or social) is affected by moral injury can inform efforts to mitigate it, help support personnel who have experienced it, and preserve public servants' connection to the broader missions of their professions.

Moral Injury Among First Responders

Health care and law enforcement are professions that work in service to society, which entrusts professions with privileges in return for technical and ethical expertise.[1] Transgressions against foundational values or unexpected erosion of professional standards integral to members' professional identities can generate deep conflict, which is recognized in health and service fields (eg, public defense, social work, education) as *moral injury*. Sharing lessons learned across medicine and law enforcement can help both fields promote healing.

Individuals sustain moral injury by 1 of 2 mechanisms: transgressions of deeply held moral beliefs[2] or betrayal by a legitimate authority in a high-stakes situation.[3] In addition, individuals work within several value systems: personal, professional, and social. One can sustain moral injury due to transgression or betrayal of values in any of these systems. Understanding both mechanisms of injury and which values system has been violated can inform appropriate solutions. Moral injury via encroachment on social values is a topic unto itself, beyond the scope of this article, though germane to issues that are politicized (eg, mask wearing) or influenced by racism and inequity (eg, in health care). What follows are descriptions of individual and professional value system moral injuries and strategies for responding to both.

Moral Injury

Professionals in medicine and law enforcement must subsume their personal values to the professional values that benefit the society they serve.[4] Such situations increase risk for moral injury. Transgression of foundational professional values, such as the oaths physicians or law enforcement officers swear, and betrayal by authority arise from systems issues within one's field or one's organization. The COVID-19 pandemic offered

ample illustrations of such betrayals of health workers—by health systems that decided who qualified for ventilators and rationed personal protective equipment and by society, which failed to enact basic public health measures.[5,6] The US Capitol riots of January 6, 2021, involved similar betrayals of law enforcement officers, as being unable to protect those in their charge transgressed officers' general professional values.[7] Specifically, leaders' failure to authorize reinforcements was described by the union representing Capital Police officers as being "betrayed."[8]

Healing

Helping individuals better understand how to manage a discrepancy between their personal beliefs and their professional obligations is appropriately addressed via individual solutions—mentoring and role modeling by more seasoned colleagues, for example. A physician might talk with senior colleagues about how best to choose a specialty or design a practice that minimizes conflict with their beliefs, and a law enforcement officer might learn to reframe his or her role as ensuring safety rather than opposing protestors' messages. Experience of *professional* moral distress and injury, however, can only reasonably be managed through systemic changes. Recognizing moral injury and using accurate language to describe it are the first steps toward resolution and prevention. Health care is beginning to reckon with moral injury in the wake of the COVID-19 pandemic and offers approaches that are easily generalized.

Train for these incidents. Critical incident training typically consists of practicing technical skills. What is practiced less often, if at all, are the building blocks of an ethics skill set. Most ethics training consists of contemplating what is the right thing to do. Spending more time learning and practicing how to follow through on what one knows is right is an essential step in reducing the risk of moral injury in difficult situations. Such training only occurs over time, with repeated practice, and with seasoned guidance in the following:

- Developing awareness of situations or events that have potential to disrupt personal or professional moral values.
- Learning which factors are critical in responding to potential moral disruption.
- Developing and practicing response actions.[9]

Leaders must use their positions to advocate for better, more efficient systems that facilitate high performance. It is difficult for those at the coalface to both care for those they serve and to advocate for system change. When a leader asks, "What do you need to be successful today?," and then follows through with delivering it, workforce distress drops because clinicians or officers are less constrained in pursuing their missions. They are better able to get patients the care they need or better able to protect the most vulnerable when they have the right tools and resources, facilitated by responsive leaders. It is important for the workforce to support leaders who are strong advocates.

Maintain health care workers' connection to the bigger picture of the profession. Even as clinicians work within the constraints of process, procedure, performance metrics, regulations, and legislation, organizations can maintain clinicians' connection to the bigger professional picture by deliberately refocusing organizational culture on the *why* of the work as opposed to the *what*. Organizations can help do the following:

- Reconnect workers with the reasons for choosing their particular profession.

- Focus on workers' purpose rather than their tasks.
- Restore or reinforce a sense of community among colleagues.

Law enforcement, like health care, reflects social values and priorities. It is inevitable that, at times, social values and priorities might conflict with personal values of individuals working in these fields, putting them at risk for moral injury. But it is possible to mitigate moral injury risk through clarity about professional purpose and standards, understanding how to voice and elevate challenges, supporting good leaders, and strengthening professional integrity individually and collectively.

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