Spring 2015

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Tactical Medicine: An Examination of Medical Training in Law Enforcement

Brian Woods Jr.

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Abstract

In recent years, there has been a trend towards making law enforcement officers more well-rounded first responders by increasing their required medical competencies. The required medical competencies of six law enforcement agencies of varying sizes in Northeast Ohio were examined by interviews conducted with a representative from each agency. Interview question topics included information on current training requirements and the types of medical equipment issued to officers. The study found that all six of the agencies surveyed offered medical training to officers as part of required continuing education, and all six agencies currently issued, or planned to issue in the near future, first aid kits to officers. Many agencies indicated that in recent years additional medical competencies had been added to their agency’s training, including the use of tourniquets, which all agencies surveyed use and the anti-overdose drug Naloxone, which two departments use. Results of the surveys indicate that medical training is now considered a core part of law enforcement training and that law enforcement agencies view responding to medical emergencies as part of their role as first responders.

Keywords: Law Enforcement, Medical Training, First Responders, Emergency Medicine

Introduction

Emergency medicine, as it relates to law enforcement, has experienced rapid growth in the past two decades, yet a widely accepted national protocol incorporating emergency medicine has yet to be developed for law enforcement. Nevertheless, certain specific medical competencies have become widely accepted by law enforcement agencies throughout the country in recent years, including the use of the tourniquet. Law enforcement officers are placed in a unique situation in regards to emergency medical care, in that they have two distinct roles in medical response.
Specifically, law enforcement officers can find themselves in a hostile environment akin to combat where a tactical medical response may be necessary, or an officer may be the first responder on the scene of a medical emergency, such as a cardiac arrest, where a more traditional EMS response is required. These vast responsibilities place law enforcement in a situation where there is no clear precedent for proper medical training. Law enforcement agencies across the country have looked to both military medicine and local emergency medical services to develop training programs to suit their officers.

The early beginnings of tactical emergency medicine can be traced to the Battle of Mogadishu in 1993. In that battle, a small contingent of Special Operations forces were engaged in a firefight for 15 hours that prevented medical evacuations for many of the wounded (Sztajnkrycer, 2010). Previous to this battle, the military had adopted the civilian approach to emergency medicine, whereby medics would stabilize wounded soldiers and evacuate them as soon as possible, much the same as EMS units stabilize patients and quickly move them into an ambulance to transports them to a nearby hospital. However, in the battle of Mogadishu, the wounded could not be quickly evacuated because of the intense fighting (Judge, 2012). Learning a hard fought lesson, the military moved to overhaul their medical philosophy and a subsequent in depth study examined the cause of combat fatalities during the Vietnam War (Sztajnkrycer, Peterson & Clayton, 2010; Judge, 2012). The resulting study found that 44% of combat fatalities could have been prevented if they were given immediate and appropriate medical care and that the lack of proper equipment was what led to many soldiers succumbing to survivable wounds (Cannon, 2013). This study into combat casualties also found that 60% of the preventable combat deaths were from hemorrhage in one of the extremities (Sztajnkrycer, 2010). What was particularly disconcerting about this figure was that a simple remedy for stopping death from
extremity hemorrhage had existed for centuries, namely the tourniquet. Using tourniquets to stabilize wounded soldiers dates back to the armies of Alexander the Great, and they continued to be utilized up until the Second World War, when they were blamed for tissue death in limbs, resulting in the need for amputations (Schmidt, 2014). The shocking number of casualties from hemorrhage in the extremities in combat caused the military to reevaluate the ancient technique of tourniquets, and today the U.S. military trains all soldiers in their use as part of their Tactical Combat Casualty Care (TCCC) training (Sztajnkrycer, Peterson & Clayton, 2010). Since the military adopted their approach to combat casualty care in 1996, there has unfortunately been ample opportunity to study its effectiveness in a real life setting with the wars in both Iraq and Afghanistan. By studying casualties in both wars, the military has found that tourniquets do save lives and that because of implementing new combat casualty care protocols, injured soldiers now have much higher survival rates than their predecessors in Vietnam (Sztajnkrycer, 2010).

The success of TCCC has not gone unnoticed by law enforcement agencies, and many law enforcement agencies across the United States have attempted to adopt TCCC training for their officers (Judge, 2012). However, wounds sustained in a tactical environment are not the only medical emergency faced by law enforcement officers. Survey studies have indicated that as many as 80% of law enforcement agencies respond to medical emergencies on a regular basis and that nearly 90% of law enforcement agencies are simultaneously dispatched to medical emergencies along with local emergency medical services (EMS). Research also indicates that in a majority of situations law enforcement officers arrive on the scene of a medical emergency before EMS, making law enforcement officers the first medical responder (Hawkins, Shapiro, Sever, Delbridge & Mosesso, 2007). While the traditional view of many law enforcement agencies has been one of simply strict enforcement of regulations and laws, law enforcement
agencies are more than that, they are first responders in the truest sense of the term and providing emergency medical care is as much a part of their job as apprehending criminals. The importance of quick medical care during an emergency is unquestionable; however, the extent to which local law enforcement agencies in Northeast Ohio prepare their officers for the two distinct types of medical emergencies has not been thoroughly investigated.

**Literature Review**

There is a growing body of research in the academic community on the successes of certain types of medical training in law enforcement, but little research exists on the current state of required medical competencies for law enforcement agencies. This gap in research may be due to the vast numbers and many differences in law enforcement agencies across the country. Data from the Department of Justice lists nearly 18,000 state and local law enforcement agencies across the United States (Judge, 2012). Each of these departments must abide not only by their state guidelines for law enforcement, but also by local laws and protocols. This creates a situation where there are almost 18,000 unique circumstances whereby the best type of medical training and equipment must be determined. While obtaining a universally applicable look at medical competencies may be impossible with such a vast and varied study subject, the author attempted to gain a general understanding of the current attitude towards medical training in law enforcement.

Since no specific research on the scope of required medical competencies could be found by the author, research regarding current trends in law enforcement medical training and critics of specific types of training and equipment were reviewed. Several articles have been authored on the effectiveness of law enforcement officers in giving pre-hospital care to individuals suffering from medical emergencies. Alonso-Serra, Delbridge, Auble, Mosesso, & Davis (1997)
found that 89% of law enforcement agencies mandate some form of medical training for all of their officers and that 50% of law enforcement agencies have their officers participate in medical care of victims on the scene. They also found that in 81% of cases, law enforcement officers arrived on the scene of a medical emergency before EMS, making law enforcement officers the first responders in many medical emergencies. A disconcerting finding of their research, however, was that only 2.5% of law enforcement agencies issued Automated External Defibrillators (AEDs).

Alonso-Serra, Delbridge, Auble, Mosesso, & Davis (1997) noted that in many medical emergencies, time is a critical factor in being able to provide life saving care to a patient. Since law enforcement officers are often the first ones to arrive on the scene, it is important that law enforcement officers be properly trained. According to their research this sentiment is supported by law enforcement agencies, with 60% of agencies believing that law enforcement agencies should take a role in the administration of emergency medical care, and the same percentage of agencies believing that not only would officers support additional medical training, but they would be willing and ready to undertake this additional medical training. Another important finding of their research was that a majority of law enforcement agencies believed that increased medical training and increased participation of officers in the administration of emergency medical care would improve the public image of law enforcement in general.

Similar research was conducted by Hawkins, Shapiro, Sever, Delbridge, & Mosesso (2007) when they surveyed law enforcement agencies across the nation using questions that were based upon those used in the 1997 study. This study found that the percentage of agencies that required medical training for their officers increased from 89% in 1997 to 91% in 2007 and that the percentage of departments that reported officers had participated in administration of
emergency care rose from 50% to 60% in the same time period. Additionally, the researchers found an increase in the percentage of law enforcement agencies that believed that law enforcement should take an active role in emergency medical care. As previously discussed, Alonso-Serra et al. (1997) found 60% of law enforcement agencies felt their officers should play a role in the administration of emergency care, but Hawkins et al. (2007) found that the number of agencies supporting such a role increased to 75%. This change indicated a shift in the view of leadership in law enforcement from a more traditional view of police as law enforcers to police as first responders. Perhaps one of the most encouraging results of Hawkins et al. research was the finding that 31% of law enforcement agencies were utilizing AEDs, which was more than a ten-fold increase from the findings of the 1997 study. They also reported, based upon their survey results that, more agencies would make use of AEDs if funds were available for equipping and training their officers, although some had concerns about liability from their officers using the devices.

Hawkins et al. (2007) also confirmed the findings of earlier research that a majority of law enforcement agencies, 89% based upon their research, were simultaneously dispatched to medical emergencies with EMS. They further confirmed that in 88% of cases, law enforcement officers arrived on the scene of medical emergencies before EMS, reinforcing the importance of medical training for law enforcement officers. Another interesting finding was that two of the law enforcement agencies surveyed, i.e. 1% of the agencies, also acted as the primary emergency medical response agency for their jurisdiction and required all of their officers to receive Advanced Life Support (ALS) training. While these departments do not represent a statistically significant proportion, they do represent a compelling anomaly in the field of law enforcement.

Along the same lines of the research discussed on the role of law enforcement in
emergency medical response, Mosesso, Newman, Ornato and Paris (2002) discussed the use of AEDs by law enforcement agencies across the country and how the use of these devices can lead to higher survival rates for individuals suffering from cardiac arrest. The researchers stated that every year in the U.S. between 250,000 and 400,000 people suffer a sudden cardiac arrest, with a vast majority of these incidents occurring outside of a hospital setting. Additionally they put this number in perspective by stating that the number of people who suffer from sudden cardiac arrest in a given year is “more than the number of people who would die suddenly if a fully loaded 747 aircraft crashed every day for a full year” (p.15). While the number of people who present with sudden cardiac arrest in a given year is staggering, luckily, 45 – 85% of them have a correctable cardiac arrhythmia such as ventricle fibrillation (VF). Individuals who suffer from sudden cardiac arrest as a result of a correctible heart arrhythmia can be saved if proper medical care is given within an appropriate amount of time, meaning the individual is given a shock to correct the heart’s rhythm within a sort period of time of the sudden cardiac arrest. When dealing with cardiac arrest, the rule of thumb is that time is crucial and delaying electric shock by even one minute can decrease the victim’s chance of survival. Even though as many as 85% of individuals who suffer from sudden cardiac arrest could be resuscitated, the current survival rate for individuals suffering from this condition is only 7%. However, with rapid defibrillation, survival rates can be much higher, and some studies indicated survival rates could reach 90% with immediate defibrillation.

The researchers argue that law enforcement personnel are optimally situated to provide defibrillation to individuals suffering from sudden cardiac arrest because officers have “an established role as guardians of public safety” (p.16) and often arrive on the scene of emergencies before EMS personnel. Mosesso et al. (2002) substantiated their arguments with
data collected by other researchers that indicated that when police officers were the first on scene in Allegheny County, Pennsylvania, survival rates for individuals suffering from ventricle fibrillation increased to 26% when police used AEDs compared to 3% when they did not. The researchers provided further evidence to support their assertions with data collected in Miami-Dade County, Florida where ventricle fibrillation survival rates nearly doubled from 9.6% before law enforcement officers were issued AEDs to 18.3% after AEDs were issued. They summarized their arguments this way: “‘early’ defibrillation, not ‘police’ defibrillation” (p.23) is the true goal, but law enforcement officers are uniquely situated to provide early and effective care in cases of sudden cardiac arrest.

In addition to the literature written on law enforcement officers being emergency medical responders, there has also been a number of articles written about the incorporation of military style Tactical Combat Casualty Care training into law enforcement, including Cannon’s (2013) article that argues there is an increasing perception of risk from gun fire, and particularly rifle fire, amongst law enforcement agencies across the country. Statistics from the Federal Bureau of Investigation have revealed that in recent years the number of law enforcement officers killed by gunfire has increased and accounts for 36% of line-of-duty deaths (LODDs). The treatment of wounds sustained in the line of duty from gunfire is more akin to military casualty care than traditional EMS response because when officers receive gunshot wounds in the line of duty it can be in a combat like environment where two adversaries are actively engaging in a fight to the death. EMS has little experience responding to this type of incident; therefore, EMS training does not properly prepare officers to handle this type of situation. In order to properly train officers, law enforcement agencies have looked to military training and TCCC. Cannon argues that the adoption of TCCC style training by law enforcement agencies is increasingly necessary
because of the threats faced by officers. He points to the North Hollywood bank robbery and subsequent shoot-out, where over 1,800 shots were exchanged between officers and the suspects, as an example of the type of situation law enforcement officers may face in the commission of their duties. Cannon also points to research conducted by the U.S. military prior to the adoption of the TCCC program that found that the majority of preventable combat deaths were a result of delayed medical care due either to hostile fire that prevented access to injured soldiers by medical professionals or to inadequate equipment to treat wounds. The research also states that death can occur from a potentially survivable wound in as little as 180 seconds, if not properly treated. Cannon uses these arguments to advocate for the adoption of TCCC or similar law enforcement specific tactical training to create a new image of law enforcement officers as a “hybrid warrior-medic” (p.712), that is prepared to provide appropriate medical aid to the level of a combat medic, but retains the ability to function as an enforcer of the law.

Similarly, Sztajnkrycer (2010) evaluated the appropriateness of the TCCC program in law enforcement by comparing the types of fatal injuries sustained by soldiers in combat to those of law enforcement officers in LODDs. In order to compare combat fatalities to LODDs, he examined the U.S. military research that led to the development of TCCC and the Federal Bureau of Investigation’s (FBI) Uniform Crime Reporting Law Enforcement Officers Killed and Assaulted (LEOKA) database’s data for a ten year period. LEOKA data includes short narratives of officer deaths, including the types of injuries sustained. From the LEOKA data, he compared the types of preventable deaths in law enforcement to those in combat. Sztajnkrycer found that in the adoption of TCCC, the military put a great emphasis on controlling hemorrhages in extremities with tourniquets because, prior to the adoption of TCCC, 60% of preventable combat deaths were from hemorrhage in the extremities. The military has had great
success with TCCC and the use of tourniquets, but Sztajnkrycer found that only two of 341 LODDs included in the study were a result of hemorrhage in the extremities. From this, he concluded that while tourniquets are a vital piece of equipment, the emphasis placed on their use in TCCC may not be appropriate for law enforcement because of the small number of LODDs due to extremity hemorrhage. The research also noted, however, that the LEOKA database does not include data on how many times tourniquets were used to save officer’s lives, so it is possible that the low number of officer fatalities from extremity hemorrhage is due to the use of tourniquets by law enforcement agencies.

Sztajnkrycer (2010) did note that the TCCC program has been highly successful for the U.S. military and there are many lessons that can be carried over to law enforcement. One of the successes of TCCC noted was the creation of Combat Life Savers. Combat Life Savers are combat personnel who are trained in basic first aid and some advanced medical concepts, such as needle decompression to treat tension pneumothorax, but who are not medics. In the civilian world, needle decompression is viewed as an advanced treatment and is generally reserved only for individuals who are trained to at least the paramedic level. He found that 25% of all individuals who survive potentially fatal wounds in combat survive because of the actions taken by Combat Life Savers.

The successes of the TCCC program have been admired by law enforcement agencies, and law enforcement officers could undoubtedly benefit from TCCC training. Based upon the LEOKA data analyzed by Sztajnkrycer (2010), he concluded that as many as 29 of the officers killed in the line of duty died as a result of tension pneumothorax, and had officers been trained in needle decompression, some of the officers killed could have been saved. While he recognized that TCCC training would be beneficial to law enforcement officers, he also
recognized that TCCC training is not completely compatible with law enforcement needs. Thus, he advocated for the creation of a new training program that fully takes into account the medical training needs of law enforcement officers.

To compliment the research conducted by Sztajnkrycer (2010), Judge (2012) examined whether law enforcement officers could benefit from military medical training. He started his work by exploring the creation of the military’s TCCC program after realizing traditional civilian style emergency medical response was inappropriate for combat scenarios. A specific example of difference between tactical casualty care and traditional civilian emergency care cited was the use of spinal immobilization. In civilian EMS, spinal immobilization is a common precaution taken whenever there is a chance of cervical spine trauma, such as blunt force or penetrating neck trauma. In a civilian setting, this emphasis is logical, as the risk of aggravating a cervical spine injury is high when moving a patient. However, immobilization of the cervical spine takes valuable time, and the military found in its study of combat casualties in Vietnam that only 1.4% of soldiers with penetrative neck trauma would benefit from cervical spine immobilization; police officers with similar injuries might also benefit from military style training rather than civilian training. Judges (2012) goes on to cite the success of TCCC in military and tactical settings, and offers the specific example of the 2009 Fort Hood shooting. During the active shooter situation, a responding police officer received a potentially fatal gunshot wound to the leg, but a nearby Army medic quickly responded and applied a tourniquet to the officer’s leg, saving her life. He offers this example as proof that certain elements of TCCC are applicable and useful for law enforcement officers. However, the author also states that while elements of TCCC are applicable to law enforcement, it is not universally applicable and more research needs to be conducted to craft a more comprehensive medical training program specifically for
law enforcement officers.

An initial attempt to adopt TCCC principles to law enforcement needs, called Tactical Emergency Medical Support (TEMS), has been adopted by some law enforcement agencies across the United States. In recent years, the state of California, updated state required training for all Special Weapons and Tactics (SWAT) teams to included TEMS training. Along the same lines, training similar to TCCC has been endorsed by both the FBI and the National Tactical Officers Association (NTOA). While these programs have been endorsed by well respected law enforcement agencies, little research has been done into the actual successes of such programs. Judge (2012) recommends further research into both TEMS and TCCC applicability in law enforcement, recognizing that some level of medical training is necessary in law enforcement, but realizing that the current base of knowledge is not significant enough to recommend specific guidelines for such training.

To expand the base of knowledge of the usefulness of TEMS in law enforcement, Vainionpää et al. (2012) analyzed 120 different situations in which the TEMS operations were conducted in the city of Helsinki, Finland over a five year period. In Helsinki, TEMS is considered to be part of EMS rather than law enforcement. Since TEMS is considered an EMS function in Helsinki, medical personnel are only permitted to enter the “cold zone,” where there is a low or no threat present, unlike law enforcement TEMS, where initial care is rendered in the “hot” or “warm zone.” The researchers found that integrating tactical medical response training into existing first responder agencies was preferable to the creation of separate TEMS teams, because specialty teams, like SWAT or TEMS, often take at least an hour to be called up and arrive on the scene. A delay of an hour during a medical emergency is unacceptable, as seconds count with most potentially fatal traumatic injuries. Since TEMS is an EMS role in Helsinki, the
researchers found that one of the key to successful medical intervention was rapid evacuation of victims from the hot and warm zones by law enforcement to a location where medical care could be initiated; reinforcing other literature that states rapid care of victims is a crucial factor. Another interesting finding was that serious injuries which required Advanced Life Support (ALS) treatment before transportation to a trauma center were rarely reported and only basic first aid training was sufficient to stabilize and treat most patients.

Similar to Vainionpää et al. (2012), Waldman, Richmand and Shapira (2012) compared the U.S. military’s TCCC to Israeli medical response protocols. Waldman, Richmand and Shapira (2012) begin by comparing U.S. law enforcement’s approach to emergency medicine with Israel’s by highlighting that while the U.S. focused more on a civilian EMS response in the past, Israel has always adopted a military style medical response to tactical situations. The authors emphasize the importance of cooperation between tactical elements and medical elements in contrast to the Helsinki model. They argue that by creating combined units, effective medical care can be rendered to the injured more quickly compared to when evacuation before treatment is required. The researchers recognized that the creation of combined tactical/medical units can be difficult because there are times when the priorities of a medic and a law enforcement officer are conflicting. For example, during an active shooter scenario, the medic’s first priority is to begin treatment of the wounded, but the law enforcement officer’s first priority is to eliminate the threat. While these two priorities have the same end goal of saving lives, it involves two different approaches that must be balanced in a tactical situation. The authors suggest cross training law enforcement officers and medical personnel to enable both field to appreciate the demands and priorities of each other (Waldman, Richmand & Shapira, 2012).
Sztajnkrycer, Peterson, and Clayton (2010) discussed the creation of a Basic Tactical Casualty Care (BTCC) course by the Rochester, Minnesota Police Department. The department’s BTCC training is based upon the military CLS training, which is now taught to all U.S. Army recruits at basic training. BTCC was developed to fill the need for a law enforcement version of the TCCC program that was discussed above. Similar to TCCC, BTCC focused on the application of immediate care for critical wounds by training officers how to quickly assess wounded individuals and recognize the need for immediate care. After training officers to recognize potentially fatal injuries, they were also trained in the use of tourniquets and nasopharyngeal airways, and how to perform needle decompression. The authors noted from observing officers perform simulated drills that, in high stress situations, officers reverted to the type of training they had, which could be a positive, but also a negative. If an officer receives EMS training, as opposed to tactical medical training, the officer may begin administering medical care to an injured suspect before securing the suspect, which puts the officer and others in danger. The authors provide this example as rationale for the importance of the development of law enforcement specific medical training. Additionally, the authors point to the importance of ensuring that medical kits with essential items, such as tourniquets, be made small enough to be carried on an officer’s duty belt, providing the officer with ready access. It is important to ensure that officers carry essential medical items with them at all times, because a medical kit that is left in a vehicle, may be of no use to an officer caught in a tactical situation.

Information regarding the use of tourniquets specifically was given by Schmidt (2014). In the article, he details how the use of tourniquets dates back to the armies of Alexander the Great, but their use became taboo after the Second World War, when physicians believed that their use caused a need for amputation of an injured limb in many cases. However, the military
began issuing tourniquets once again in recent decades, and then civilian EMS followed suit. Schmidt showed the usefulness of tourniquets by discussing the Boston Marathon bombing in 2013, when civilians and medical personnel quickly utilized improvised tourniquets made of articles of clothing to prevent individuals from dying from hemorrhage. The author also discussed the Presidential committee to study gun violence after the Newtown Shooting’s recommendation that tourniquets be put in readily accessible public locations, much the same way as AEDs are (Schmidt, 2014).

The majority of literature related to medical training of law enforcement officers points to a growing trend towards more comprehensively trained and better equipped officers across the country. This current trend was highlighted by an article stating that New York State would be purchasing first aid kits for all law enforcement officers in the state. The new first aid kits included hemostatic bandages, a CPR mask, and a tourniquet. Additionally, the kits were designed to be fastened to the duty belt of law enforcement officers, so the kit could be carried with the officer at all times (Z-Medica®, LLC, 2014).

A review of literature regarding medical competencies in law enforcement also led to several anecdotal media accounts of instances where law enforcement officers made use of medical equipment or training to save the lives of victims of violent crime. In one instance, police officers in Washington D.C. responded to a reported domestic violence incident and found a victim who had been stabbed 15 times, with at least one of the wounds lacerating the victim’s femoral artery. Luckily, one of the officers who responded had received training in the use of tourniquets earlier that day, so the officers obtained a belt from an individual passing by the scene and made an improvised tourniquet with it. By using the improvised tourniquet, the officers were able to slow the victims bleeding until EMS arrived on the scene and took over.
(Miller, 2014). Further, in the study area of Northeast Ohio, two police officers responded to a reported assault and found the victim, who had been stabbed in the neck. One of the officers had previously served overseas in the military and had subsequently made his own first aid kit based upon the one he had been trained to use in the military. The officer retrieved a hemostatic bandage from his kit and used it to stop the victims bleeding until EMS could arrive. As a result of the actions of the officer, the police department he works for is considering purchasing hemostatic bandages for all officers to carry (Correa, 2014).

Interestingly, data was being collected for the present study, a local media report by Tom Meyer on WKYC surfaced regarding the medical training received and the medical equipment carried by a large Northeast Ohio police department. The report criticized the lack of training received by the large department, as well as the fact that the department did not issue any form of first aid kit or AEDs. The report stated that 45 local departments had been contacted to question whether or not those departments issue first aid kit; and 42 confirmed that they offer training or first aid kits, or both, to their officer. Meyer was also critical of the lack of training received by the department, stating officers receive twelve hours of medical training in the police academy but are not offered further training (Meyer, 2015a). Interestingly, the report was followed by a second report by Meyer that indicated the city which had been criticized had made new plans to provide first aid and CPR training to all officers and also begin issuing first aid kits once again (Meyer, 2015b).

**Methods**

The primary focus of this research was the required medical competencies of law enforcement agencies in Northeast Ohio. In order to obtain a representative data set, the researcher selected seventeen law enforcement agencies with jurisdiction within the Northeastern
counties of Ohio. Departments were selected to represent large, small, and medium size departments in rural and urban communities. Additionally, departments with varying types of jurisdictions were selected including municipal, county, state, and federal agencies. Once the seventeen representative departments were chosen, telephone numbers for each department were obtained and each agency was subsequently contacted by the researcher with an interview request. Of the seventeen agencies contacted, six granted the researcher’s request for an interview and interviews were conducted either in person at the law enforcement agency or over the phone with a representative from the local agency.

Data was collected with the use of a fifteen question survey that included demographic questions, such as number of officers employed, the size of the population the agency serves, and the average education level of officers, as well as specific questions on required medical competencies. Medical questions included in the survey covered topics such as the required medical competencies of officers, the types of medical training officers receive, if officers carry first aid kits, what the contents of the kits are, and if medical training counts toward continuing education requirements (Appendix A). After the data collection, it was analyzed using Microsoft Excel to compare the types of training required by different size departments, as well as to note the common medical competencies required by a majority of agencies throughout Northeast Ohio. Departments were defined as “large” for the purpose of this study if they had more than 100 officers. Likewise, “medium” size departments were characterized as having between 25 and 100 officers, and “small” departments were classified as those having less than 25 officers. Of the agencies surveyed for this study, two departments fell into each of the three categories of agency size.
Results

In the process of data collection for this research, seventeen law enforcement agencies with jurisdiction in Northeast Ohio were contacted. Of the seventeen agencies contacted, six agencies agreed to be interviewed by the researcher, which resulted in a response rate of 35%. Based upon the interviews conducted with representatives from the law enforcement agencies, required medical competencies for law enforcement officers appears to be a blossoming field. A majority of the agencies surveyed had recently offered new types of medical training to officers, or planned to offer new training for officers in the near future. This trend towards more well rounded training for law enforcement officers is consistent with the growing body of literature, which indicates a desire by the law enforcement community in the United States to become better prepared to respond to a variety of circumstances.

From interviews conducted by the researcher, several law enforcement agencies throughout Northeast Ohio had recently adopted training in the use of tourniquets, and a number of others had recently purchased new first aid kits for officers that included tourniquets but were awaiting the development of a proper training program to instruct the officers in the use of all the items in the kit. Overall, 100% of the agencies surveyed either had regular medical training for officers, or had training scheduled for officers in the near future.

In addition to questions regarding specific medical competency requirements, the survey included demographic questions about each law enforcement agency. Demographic questions included the number of officers employed by the department and the population of the jurisdiction of each agency. The number of officers employed by the agencies surveyed ranged from a low of fourteen officers, to a high of 1,500. Concurrently, there was a also wide range in the population of the jurisdictions of the agencies, ranging from 5,000 to well over 100,000.
Additional demographic information questions regarded the average number of years of service for officers in each agency. Two agencies could not determine an average number, but of the four that responded, years of service ranged five to 22 years. The required education level for new officers was another factor taken into consideration; 83% of agencies surveyed required at least a high school diploma or GED, while one agency required some college credit.

Additionally, both small departments surveyed required that new officers obtain an Ohio Peace Officer Training Academy certificate before they were considered for a position with the agency (Table 1). Similarly, the average education level of veteran officers and leadership for each agency was obtained by the researcher. Two-thirds of departments reported that most veteran officers had at least some college or technical education, while one medium size department reported veteran officers generally have an associate’s degree, and another medium size department reported most veteran officers have a bachelor’s degree (Table 2). Likewise, one-third of agencies surveyed reported leadership have at least some college or technical education, while 50% reported leadership for their agency generally have a bachelor’s degree.

Additionally, one medium size agency reported that all leadership in the department has post graduate education (Table 3).

<p>| Table 1 – What is the minimum education level for new officers/agents/deputies in your agency? |
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<table>
<thead>
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<th></th>
<th>Total</th>
<th>Large Dept.</th>
<th>Med. Dept.</th>
<th>Small Dept.</th>
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<td>High School Diploma/GED</td>
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<td>Some College or Technical Education</td>
<td>17%</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<td>Military Training</td>
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<td>0</td>
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<td>Associates Degree</td>
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<td>Bachelors Degree</td>
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<td>Post Graduate Degree</td>
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<tr>
<td>Other</td>
<td>33%</td>
<td>0</td>
<td>0</td>
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* Require Previous OPATA Certification
Table 2 – What is the average education level for veteran officers/agents/deputies in your agency?

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<thead>
<tr>
<th></th>
<th>Total</th>
<th>Large Dept.</th>
<th>Med. Dept.</th>
<th>Small Dept.</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Diploma/GED</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Some College or Technical Education</td>
<td>67%</td>
<td>2</td>
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</tr>
<tr>
<td>Military Training</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>17%</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>17%</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Post Graduate Degree</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3 – What is the average education level for leadership in your agency?

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Large Dept.</th>
<th>Med. Dept.</th>
<th>Small Dept.</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Diploma/GED</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Some College or Technical Education</td>
<td>33%</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Military Training</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>50%</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Post Graduate Degree</td>
<td>17%</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The types of medical competencies required by law enforcement agencies had relatively little variability across the various agencies. One hundred percent of the agencies surveyed required officers to be trained in cardiopulmonary resuscitation (CPR), basic first aid, and the use of automated external defibrillator. The universal nature of these required medical competencies is due to the fact that all law enforcement offices in the State of Ohio must have completed the Ohio Peace Officer Training Academy (OPOTA), which requires that graduates are competent in CPR, basic first aid and the use of AEDs (Fiatal, 2012). In addition to State required medical competencies, two departments, one medium sized and one small, required officers to be trained in the use of the anti-overdose drug Naloxone, commonly known in the law enforcement community as “Narcan.” Further, one medium size agency required officers to be specifically
trained in proper blood borne pathogen safety, or body substance isolation (BSI) procedures (Table 4; Figure 1).

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Large Dept.</th>
<th>Med. Dept.</th>
<th>Small Dept.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>100%</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Basic first aid</td>
<td>100%</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Trauma care</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Use of Naloxone (Narcan)</td>
<td>33%</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Use of AEDs</td>
<td>100%</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Emergency Medical Technician</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Paramedic</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tactical combat casualty care</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency delivery of infants</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>17%</td>
<td>0</td>
<td>1*</td>
<td>0</td>
</tr>
</tbody>
</table>

*Body Substance Isolation

While the required competencies for all officers were fairly consistent across the various agencies, the types of medical training offered by departments varied more widely. All departments surveyed offered, or planned to offer in the near future, basic first aid training for all
Additionally, 83% of agencies offered CPR training to enable all officers to retain their CPR certifications. Two-thirds of agencies offered training in the use of AEDs to officers and one-third of agencies offered training in the use of Naloxone. Furthermore, one small agency offered TCCC style training to officers, while one medium size department offered increased training in trauma care to officers. Half of the agencies surveyed offered medical training in areas that the researcher had not included as specific categories in the survey. These other types of medical training included two departments, one large and one medium, that offered specific training in the use of tourniquets, a medium department that offered training in BSI procedures and a small department that offered crisis intervention training for officers (Table 5; Figure 2).

<table>
<thead>
<tr>
<th>Table 5 – If so, what types of medical/first aid training is made available to officers/agents/deputies?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>CPR</td>
</tr>
<tr>
<td>Basic first aid</td>
</tr>
<tr>
<td>Trauma Care</td>
</tr>
<tr>
<td>Use of Naloxone (Narcan)</td>
</tr>
<tr>
<td>Use of AEDs</td>
</tr>
<tr>
<td>Emergency Medical Technician</td>
</tr>
<tr>
<td>Paramedic</td>
</tr>
<tr>
<td>Tactical combat casualty care</td>
</tr>
<tr>
<td>Emergency delivery of infants</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

*Use of tourniquet
*Body Substance Isolation and use of tourniquet
*Crisis Intervention
In the same way that the types of medical training offered to officers varied widely between law enforcement agencies, so did the types of medical equipment issued to officers. All of the departments issued tourniquets, or planned to issue tourniquets in the near future, to at least some of their officers. Curiously, one large department only issued tourniquets to officers who had undergone additional tactical rifle training. This department also currently only issues individual first aid kits to officers who have undergone additional tactical training, although they have plans to issue first aid kits to each patrol vehicle in the near future. Along this line, 83% of agencies surveyed either currently issue, or plan to issue, first aid kits to officers. An unexpected finding of the researcher in regards to first aid kits was the report from one large agency that it had experienced problems storing first aid kits. This department reported that first aid kits were kept in the trunk of patrol vehicles, and that over time moisture had collected in some kits and
ruined some of the equipment. Additionally, this large department reported problems with keeping all the first aid kits up to date and replacing items that had been used by officers.

Another commonly issued medical device for law enforcement agencies in Northeast Ohio is the AED. Half of the agencies surveyed had AEDs available for officers to use, one large agency, one medium agency and one small agency. Similarly, one small agency and one medium size agency planned to issue the anti-opioid overdose drug Naloxone to officers in the near future. A third of agencies surveyed also issued medical equipment that was not specifically included in the survey, with one medium size department and one small department also issuing CPR masks to officers (Table 6; Figure 3).

| Table 6 – What type of medical/first aid equipment are officers/agents/deputies issued by your agency? |
|--------------------------------------------------|-----------------|-----------------|-----------------|
|                     | Total | Large Dept. | Med. Dept. | Small Dept. |
| AED                  | 50%   | 1            | 1            | 1            |
| Individual first aid kit | 83%   | 2*           | 1            | 2            |
| Tourniquet           | 100%  | 2*           | 2            | 2            |
| Trauma Kit           | 0%    | 0            | 0            | 0            |
| Naloxone (Narcan)    | 33%   | 0            | 1            | 1            |
| Obstetrics Kit       | 0%    | 0            | 0            | 0            |
| Other                | 33%   | 0            | 1*           | 1*           |

*One agency only issues tourniquets and IFAKs to officers who undergo optional rifle training
*CPR Mask
Of the agencies that reported issuing first aid kits to officers, two-thirds reported that the kits were similar to the U.S. military issued Improved First Aid Kit (IFAK). The IFAK generally contains a tourniquet, an elastic bandage, adhesive tape, a combat dressing, a nasopharyngeal airway, gloves and other bandages (U.S. Army, n.d.). Other items included in first aid kits were blankets by one large department, ammonia inhalants by one large department and CPR masks by one large department and one medium department.

The survey given to the six law enforcement agencies included an additional question about all the types of medical equipment that an officer would be authorized to use by the department. A majority of agencies answered that generally officers are authorized to use whatever they are trained on by the department or through OPATA training. However, 50% of the agencies surveyed stated that they would be willing to craft additional policies regarding
officers who had received additional medical training. For example, if an officer were to receive an emergency medical technician certification on their own time, one large department and two medium size departments indicated they would be willing to craft new policy to be consistent with such officer’s additional training and certification. Additionally, one large department stated that officers would be authorized to use any medical equipment on which they had been trained, in whatever capacity. The representative from this large department also stated that officers often build their own personal, ad hoc first aid kits with equipment individually purchased or obtained from local paramedics.

In regards to additional training received by officers, another area of study was whether law enforcement agencies had any personnel trained at the emergency medical technician (EMT) or paramedic level. Of the two levels of training, paramedics are more highly trained and are able to perform more advanced medical procedures, in addition to making use of a broader range of medications, compared to EMTs. Both large departments surveyed reported having personnel who were trained to the paramedic level, but no medium size or small agencies reported having any personnel trained to this level. Similarly, both large departments surveyed reported having officers trained as EMTs, as did one small agency.

Another area of study addressed by the survey was whether or not the participating law enforcement agencies coordinated with emergency medical services to provide for tactical medics. Interestingly, all agencies surveyed reported some level of coordination with EMS and/or other law enforcement agencies for tactical teams. One large agency reported conducting regular exercises with a variety of response agencies, including local EMS and even federal agencies. Two agencies, one large and one medium size, reported coordination with local fire departments to provide tactical medical personnel, while two small agencies and one medium
size agency reported participating in joint SWAT teams that provided medical personnel. Interestingly, one of the joint SWAT teams had more than just tactical medics; they also had a SWAT doctor. This doctor was a local surgeon and tactical operator who occasionally accompanies the SWAT team on operations and has detailed medical files on all members of the SWAT team in case of injury during an operation.

Continuing education requirements are common in many professional fields, including law enforcement. In Ohio, a certain amount of continuing education is required for law enforcement officers. This type of training is often sponsored by law enforcement agencies to ensure that all officers meet minimum continuing education requirements. One hundred percent of agencies surveyed offered some form of medical training as part of sponsored continuing education requirements for officers. Types of training offered by agencies included basic first aid, use of AEDs, use of Naloxone, CPR, and use of tourniquets. In addition to required and/or department sponsored training, many departments also encourage officers to undergo additional continuing education. Of the agencies surveyed, 67% reported that participating in out-of-department medical training, such as EMT or paramedic certification, would count toward department continuing education requirements.

Perhaps the most interesting result of this research came from the responses to the question “When hiring new officers/agents/deputies, is previous medical training such as Basic Life Saver (BLS) certification or EMT/Paramedic education a factor that is taken into consideration?” Half of the departments surveyed replied that such training would be taken into account when hiring new officers, while the other half replied that it would not be considered an advantage when hiring officers. What was particularly interesting was how the size of the department factored into the responses to this question. Both large departments surveyed
reported that previous medical training would not be a factor when hiring new officers, as did one medium size agency. Conversely, both small departments and one medium size department reported that previous medical training was a desirable trait when hiring new officers (Figure 4).

The final subject of data covered by this research was whether or not representatives from the surveyed agencies would like to see additional medical competencies encouraged by their respective agencies. Two-thirds of agencies reported that they would like to see additional medical competencies added to department training, while one-third felt that the current required medical competencies were sufficient for what officers need. After receiving a “yes” answer, a follow-up question asked representatives to explain their desire for additional medical competencies. The most common response for agencies was the desire to increase required medical competencies was they wished to increase the level of first aid training received by officers. One department also reported their desire to increase the amount of trauma training received by officers. Another medium size department reported they wished to have each officer carry a first aid kit on their person, rather than limiting them to patrol vehicles. The most intriguing response to this question came from a small department that would like to institute a cross-training program between law enforcement officers and paramedics to enable officers to get more in depth medical training.
Discussion

For a majority of the history of policing, the job of law enforcement officers was to simply do what their title implies, enforce laws. However, over time the law enforcement field has developed into a civil service profession that emphasizes services to the community. With this new emphasis comes new responsibilities, including the necessity for increased medical competency requirements for officers. Based upon interviews conducted by the researcher and information gathered from a growing body of research on the subject, there appears to be a emerging trend in Northeast Ohio and across the United States towards making police officers true first responders, rather than simply enforcers of the law.

Law enforcement officers are uniquely situated to be effective medical first responders because their profession requires them to be out in the community. Most medical emergencies do not happen in the presence of trained medical professionals, so when an emergency does occur, the time it takes for help to arrive can be critical. As discussed previously, during sudden cardiac arrest, a delay of just one minute can prevent a patient from being resuscitated, and studies have consistently shown that law enforcement officers are able to respond to the scene of a medical emergency before EMS can arrive (Mosesso, Newman, Ornato, & Paris, 2002). This example highlights the positive impact law enforcement can have on the community by assuming a first responder role.

Fortunately, most law enforcement agencies have embraced the first responder role; however, not all law enforcement agencies are fully prepared to act in this capacity. During interviews conducted for this research, representatives from several agencies indicated that at least some of their required medical competencies were recently added. For example, more than one agency indicated that they began training officers in the use of tourniquets within the last
year, and two other agencies indicated they had recently obtained tourniquets and would be training officers in their use in the near future. Additionally a review of anecdotal media reports showed that while many officers are well trained in medical response, the proper equipment is not always available. In the media report discussed above of the Washington D.C. officer who responded to a domestic violence incident where the victim was badly lacerated from a knife wound, the officers used a belt to fashion a tourniquet to save her life. Similarly, another report was found of officers using crime tape to form a tourniquet that prevented a victim of violent crime from dying from hemorrhage (Miller, 2014; Meyer, 2015a). Fortunately, these types of instances seem to be the exception rather than the rule, as all the agencies surveyed indicated that they either currently issue medical equipment or plan to issue new equipment in the near future, once all officers have been properly trained in the use of the new kits.

While all the agencies surveyed issued, or plan to issue, medical equipment to their officers, and all the agencies offer some form of medical training to their officers, two-thirds would advocate for their officer to have additional medical training. The general feeling in these agencies was that the current level of training is adequate, but the types of training received could be improved upon and made more encompassing. One department even expressed the desire for all of their officers to be cross-trained as paramedics so they would be better able to respond during medical emergencies. From conducting interviews with individuals in the law enforcement field, it was clear to the researcher that the idea of more in depth medical training for officers is a relatively new idea in law enforcement, but one that is openly embraced by many agencies.

The most common impediment to implementing increased medical training in law enforcement is funding. This assertion was supported by both the finding of the researcher and
existing literature. Comprehensive first aid kits are often expensive, costing upwards of $100 per kit. Supplying such a kit for every officer in a large or even small department becomes quite expensive, even without including the cost of training the officers. Additionally, such first aid kits do not last forever; often items in first aid kits have a shelf life of several years, so new kits need to be purchased to replace expired ones and replacement equipment needs to be purchased to replace items used by officers in the course of their duties. As officers become competent in more types of medical response, new and more expensive items need to be purchased for the officers. An example of this are AEDs. All law enforcement officers in Ohio are required to learn how to use an AED during their state mandated training; however, only 50% of departments surveyed issue AEDs to officers. Alternative sources of funding, such as grants, have been used by several departments to purchase medical equipment for officers, but more funding is desired by agencies in order to better train and equip their personnel.

As mentioned earlier, law enforcement’s interest in medical training is two-fold. Medical training is important for officers because they act as first responders and are often the first to arrive on the scene of medical emergencies. However, medical training is also important because law enforcement officers may find themselves in a situation akin to combat where they must quickly respond to save the lives of other officers, civilians, or even themselves. A majority of research related to medical competencies in law enforcement focuses on tactical medical response. Tactical trauma care has been highly emphasized in law enforcement because in the rare situations when police need it, this training is life saving. However, this emphasis can detract from other medical training that is more useful to civilians, like the use of AEDs. A balanced solution is necessary that includes appropriate amounts of training in both areas. Actually, there is significant overlap between tactical medical response and traditional
emergency medicine. For instance, the use of tourniquets has been demonstrated to be life
saving to both law enforcement officers and civilians in need of medical attention.

These competing types of medical training demonstrate that an individualized and
comprehensive medical training program should be developed for law enforcement officers.
Such a training program should be based on the types of medical emergencies that law
enforcement officers are likely to encounter, as is commonly suggested in the literature.
However, such research should not only focus on the injures that officers sustain in the line of
duty, but also on the common civilian medical emergencies that law enforcement officers must
respond to, such as cardiac arrest. A focus on tactical medical training is undeniably important
for law enforcement, as they may find themselves in combat like situations as part of their duties;
however equal emphasis should be placed on medical training to prepare officers as first
responders.

Of the agencies surveyed for this research, one-third reported that they believed that the
current required medical competencies were sufficient for the needs of their officers. The most
common rationale for this sentiment was the belief that EMS units in the jurisdiction often
respond to the scenes of medical emergencies in a short enough time that the current level of
medical training for officers was sufficient to initiate care and stabilize patients until EMS
arrived on scene. This is a valid sentiment, as research has shown that in most locations EMS
arrives on the scene of emergencies shortly after law enforcement units (Mosesso, Newman,
Ornato, & Paris, 2002). In most cases, the interval between the arrival of law enforcement and
the arrival of EMS units does not provide sufficient time to initiate or perform complex medical
interventions, such as intubation, but research on the use of AEDs by law enforcement clearly
shows increased rates of survival when law enforcement initiates medical care (Mosesso et al.
Whether this success can be transferred to other medical intervention requires further research. However, increased medical competences among law enforcement officers will likely lead to better performance in the role of first responder by law enforcement officers.

One of the most compelling results of this study was the responses gathered from the question “When hiring new officers/agents/deputies, is previous medical training such as Basic Life Saver (BLS) certification or EMT/Paramedic education a factor that is taken into consideration?” Half of the agencies surveyed replied that such previous medical training is considered a positive factor when considering applicants, while the other half stated they would rely on other factors. The most intriguing aspect of the answers to this question were the trend that appeared based upon the size of the department. Both small agencies reported that an applicant with previous medical training was more desirable as a potential employee than someone who had not received such training, while both large departments replied that such training would not be a factor when hiring new officers. This phenomenon may be due to the fact that large departments must hire more individuals in order to maintain their workforce, while small agencies can be more selective in their hiring. For example, one large department reported that hiring is largely based upon the civil service exam, and that previous medical training would not be factored into civil service scores. Conversely, agencies with fewer than 25 officers do not have to hire large numbers of new officers on a yearly basis in order to maintain an adequate workforce. Therefore, they may be afforded more latitude in making decisions about hiring new personnel. Conclusive results regarding department size and hiring practices cannot be determined based upon the limited nature of this study; however, it may be a worthy topic of future investigation.
Limitations

The most limiting factor of this research is the sample size. Even if a 100% response rate would have been achieved, the study would still have had a limited scope and with a response rate of 35% the applicability of the study is further limited. With over 120 different law enforcement agencies in the geographic study area, the representativeness of six agencies is not known (USA Cops, 2015).

Additionally, the study is further limited by the inclusion of chosen representative departments, rather than randomly selected agencies. With the limited time frame for completion of the research, the researcher chose to choose a limited number of representative departments rather than a large number of randomly selected agencies, which would have yielded more statistically valid results. Further research into this topic is recommended using a larger sample size and greater geographical area.

Conclusion

Based upon this limited scope study of law enforcement agencies that have jurisdiction in Northeast Ohio, local law enforcement agencies are generally well trained and equipped to respond to medical emergencies and assume the role of first responders. All agencies studied currently offer, or plan to offer, medical training for officers and all agencies currently issue, or will issue in the near future, medical equipment for officers. All law enforcement officers in the State of Ohio are required to have certain medical competencies, and most law enforcement agencies surveyed train officers in skills beyond what is mandated by the State.

The role of law enforcement officers as medical first responders is a growing topic of study, and more law enforcement agencies are embracing the role of true first responders. Although, more study is needed into the current state of preparedness of law enforcement
officers to respond in a medical capacity, this study indicates that in Northeast Ohio law
enforcement agencies are well prepared to take on this role and will most likely be expanding
their required competencies in the near future.

Acknowledgments

The researcher would like to thank the Canal Fulton Police Department, the Massillon
Police Department, and all law enforcement agencies that took part in this research for their
willingness to share information about department training and for taking time out of their busy
schedules to sit down and have a conversation with the researcher. Enough thanks can never be
given to the law enforcement officers who sacrifice on a daily basis to keep their communities
safe, so the researcher would like to thank all law enforcement officers for their watchful service.
References


Survey Questions

1. How many officers/agents/deputies are employed by your agency?

____________________________________________________________________

2. What is the population of the area your agency serves?

____________________________________________________________________

3. What is the minimum education level for officers/agents/deputies in your agency?
   a. New hires
      __ High School Diploma/GED
      __ Some College or Technical Education
      __ Military Training
      __ Associates Degree
      __ Bachelors Degree
      __ Post-Graduate Degree
      __ Other (Please explain)

      ____________________________________________________________________

      ____________________________________________________________________

   b. Veteran employees
      __ High School Diploma/GED
      __ Some College or Technical Education
      __ Military Training
      __ Associates Degree
      __ Bachelors Degree
      __ Post-Graduate Degree
c. Leadership

__ High School Diploma/GED
__ Some College or Technical Education
__ Military Training
__ Associates Degree
__ Bachelors Degree
__ Post-Graduate Degree
__ Other (Please explain)

4. What is the average numbers of years of service for officers/agents/deputies for your agency?

__________________________________________________________

5. What types of medical competencies are required for officers/agents/deputies in your agency? (check all that apply)

__ CPR
__ Basic First Aid
__ Trauma Care
__ Use of Naloxone (Narcan)
__ Use of AEDs
6. Is any medical training made available to officer/agents/deputies in your agency?

   YES    NO

   a. Is so, what types of medical/first aid training is made available to
      officers/agents/deputies by your agency? (check all that apply)

      __ CPR
      __ Basic First Aid
      __ Trauma Care
      __ Use of Naloxone (Narcan)
      __ Use of AEDs
      __ Emergency Medical Technician
      __ Paramedic
      __ Tactical Combat Casualty Care
      __ Emergency Delivery of Infants
      __ Other ( please explain )
7. What type of medical/first aid equipment are officers/deputies/agents issued by the agency to carry with them while in the field?

__ AED
__ Individual First Aid Kit
__ Tourniquet
__ Trauma Kit
__ Naloxone (Narcan)
__ Obstetrics Kit
__ Other (please Explain)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8. If offices/agents/deputies are issued a first aid kit what are the general contents of the kit?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

9. What types of medical/first aid equipment are officers/deputies/agents authorized to use in the field?

__ AED
__ Individual First Aid Kit
10. Does your agency have any officers/agents/deputies trained to the
   a. Paramedic Level?
   b. EMT Level?
   c. Is so, approximately how many of each? _________________________________

11. Does your agency coordinate with local Emergency Medical Services to provide tactical medical personnel? If so, with what agency (local fire department, local EMS, private EMS) do you coordinate?
   a. What type of training do these tactical medics receive? Do they take part in practical exercise? If so, what types?
12. Does medical training, such as an officer attending an EMT/Paramedic course on his or her own time, count towards continuing education requirements?

YES  NO

a. If yes, does your agency offer medical course for continuing education?

YES  NO

What type? ______________________________________________________

__________________________________________________________________

__________________________________________________________________

13. When hiring new officers/agents/deputies, is previous medical training such as Basic Life Saver (BLS) certification or EMT/Paramedic education a factor that is taken into consideration?

YES  NO

14. Would you like to see additional medical competencies instituted or encourage in your agency?

YES  NO

Why?_________________________________________________________________

__________________________________________________________________

__________________________________________________________________

15. Do you have any additional comments?

________________________________________________________________________

________________________________________________________________________