

# Ethical Considerations in Embedding a Surgeon in a Military or Civilian Tactical Team

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## Abbreviations:

EMS: emergency medical services  
MOU: memorandum of understanding  
SWAT: special weapons and tactics  
TEMS: tactical emergency medical services  
TPS: tactical police surgeon

## Abstract

Tactical emergency medical services (TEMS) bring immediate medical support to the inner perimeter of special weapons and tactics team activations. While initially envisioned as a role for an individual dually trained as a police officer and paramedic, TEMS is increasingly undertaken by physicians and paramedics who are not police officers. This report explores the ethical underpinnings of embedding a surgeon within a military or civilian tactical team with regard to identity, ethically acceptable actions, triage, responsibility set, training, certification, and potential future refinements of the role of the tactical police surgeon.

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## Introduction

The concept of tactical emergency medical services (TEMS) was formed from the activity of specially trained combat medics during the Vietnam military conflict. In the early 1970s, the TEMS concept was adopted by the civilian sector, and was championed by the Los Angeles Sheriff's Department. Further support came from former US Surgeon General Richard Carmona, MD, who highlighted TEMS's promise of bringing immediate first aid from skilled EMS providers into the inner perimeter of a civilian police action utilizing a special weapons and tactics (SWAT) team.<sup>1</sup> Typically, EMS providers are stationed in the outer perimeter of a law enforcement action zone so that they are out of harm's way. TEMS, on the other hand, provides tactical training, gear, and membership in the "stack" of officers within the danger zone to provide on-site emergency care and stabilization for an injured officer. While it was met with initial enthusiasm, multiple issues have challenged the universal acceptance and feasibility of TEMS.

Among these challenges is that optimal realization of TEMS relies on individuals dually trained and certified as both SWAT operators and paramedics. Concomitantly, SWAT teams are increasingly specialized, more highly trained, and require increasing amounts of individual and team training time to meet the performance standards appropriate for such teams.<sup>2</sup> Moreover, a dually trained police officer who is also a paramedic may experience role confusion, degrading performance in either role.<sup>3</sup> In addition, medics from recent modern military conflicts who have entered civilian law enforcement have substantial medical experience and have diminished the need for a dually trained and certified paramedic as part of a civilian SWAT team.

As civilian medical care has also become increasingly complex, and required advanced EMS training, the dual role of the tactically trained paramedic is more difficult to support. This is especially true in low activity precincts. Accordingly, while many paramedics participate in tactical teams, they increasingly do so in an exclusively medical capacity and not as tactical officers. Complicating matters further is the blurred line between military

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and civilian trauma. Semi-automatic handguns that fire rounds at muzzle velocities approaching or exceeding rifle velocity (2200 feet/second) are now available; urban bombings create blast injuries, and inner city violence has reached epidemic proportions in some locales.<sup>4</sup> Concerns regarding nuclear, biologic, and chemical (NBC) weaponry have come to the forefront as well.<sup>5,6</sup>

The tactical police surgeon (TPS) potentially fills the need for advanced medical and surgical skill for stabilization of the injured officer, suspect, or innocent bystander. Such an individual is already trained in triage, resuscitation, emergency injury management and stabilization, critical care, and life-saving surgical techniques. Tactical police surgeon capabilities may exceed the abilities of a practicing paramedic as initially envisioned by the TEMS concept.<sup>7</sup> However, the advisability, viability, and sustainability of placing a highly-trained and multiply-tasked surgeon into such a role should be examined from a variety of perspectives. This report addresses basic and ethical issues that may confront a tactically deployed surgeon in the civilian arena.

### The Military Surgeon or Medic

An appropriate introduction to the topic is consideration of the military surgeon. In many ways, such an individual parallels the TPS. The military surgeon serves as both a physician and potentially as a defensive combatant. Military surgeons or medics are expected to act in self-defense as well as in defense of the patients for whom they provide care, including opposing force injured combatants or detainees.<sup>8</sup> These imperatives are driven by both the 1949 Geneva Conventions<sup>9</sup> as well as the military Force Protection Program.<sup>10</sup> Careful note is made to identify that the military physician is not expected to be a primary combatant. Of course, such realities are principally operative in forward and far-forward operational theaters rather than in what are effectively tertiary centers of care. Nonetheless, there are ample data that opposing forces fail to uniformly follow the Geneva Conventions' principles when medically treating non-combatant physicians.<sup>11</sup>

### How Do Medical Ethics Interface With Military Responsibilities?

The overlap of medical ethics and military responsibilities primarily relates to medical and medical support personnel, but commanders need to be cognizant of these ethics as well. In particular, detainee or injured opposing force combatant care is a major area of ethical responsibility for medical and non-medical commanders in theater and has been amply explored during the Global War on Terror.<sup>12,13</sup> The front-line medical provider may be a General Medical Officer, a physician with little post-graduate training, who is relatively isolated at a forward or far-forward care station. As such, this individual is vulnerable to the exigencies and stresses of care for combat wounded as well as concerned with self-preservation. Further complicating this highly stressful situation is the relative lack of direct contact with senior and experienced supervisory medical personnel, as those individuals are generally placed to the rear. The Geneva Conventions and the US Army Field Manual specify physicians as non-combatants, but note that they may act in a combatant capacity in self-defense and in the defense of patients for whom they are providing care.<sup>9,14</sup> However, there is a history of physicians and other medical personnel acting in a primary combatant capacity.

The clearest example of the juxtaposition of medical and combatant roles is that of the Knights Hospitaller of St. John of

Jerusalem, who were known as "warring physicians" and embraced both roles in equal measure.<sup>15</sup> Prior to 1915, three US physicians were awarded the Medal of Honor for their combatant roles, *not* their physician roles.<sup>16</sup> Importantly, these examples raise the question of whether one can "stop" being a physician. More recently in Vietnam, one notes the "weaponization" of medicine. During that time, Special Forces Aidmen could choose to apply or withhold medical support from opposing force injured combatants or injured non-combatants. This practice came to a head in *US v Levy* (1967).<sup>17</sup> This case arose from the refusal of a physician to teach dermatology to Special Forces Aidmen, as he was convinced that they would unethically apply or withhold what he would be teaching them. His concerns regarding how others would act on the basis of the roles he would enable them to assume is known as secondary ethical responsibility. Ultimately, the physician was both dishonorably discharged and imprisoned.

Weaponization of medicine can take many other forms. These include care without consent, refusal to provide care, triage inequity, and the use of detainees, captured combatants, or captured non-combatants for medical research. The uneven provision of opioid analgesia to provide comfort as well as to hasten death from a non-survivable injury is another example. Lastly, providing field medical care as a means of supporting concealment and enabling Force Protection is another form of the "weaponization" of medicine. Therefore, interpretation of the ethical correctness of medical care may depend on the situation in which the care is provided as well as the intent that underpins that care.

### The Civilian Tactical Police Surgeon

The civilian TPS is not tasked as a combatant, and has a carefully prescribed role within the SWAT team. The role may be crafted as an agreement among a police department, hospital, medical school, and an individual; it also may exist entirely outside of a hospital or medical school, depending on the individual and the responsible police department. The agreement, commonly known as a memorandum of understanding (MOU), defines the boundaries of participation in a TPS role, as well as the expectations of each party that is signatory to the MOU. A primary combatant role is generally prohibited within the MOU as a result of liability and regulatory concerns, risk of personal injury, lack of appropriate training (i.e., not trained as a police officer), and the physician ethic to "do no harm." A physician discharging a firearm that results in a suspect injury would be well-explored in the media. Therefore, physicians who are not also police officers are generally not equipped with firearms, neither personal nor police department-issued. In the US, physicians in the TPS role generally function as if in the prehospital environment. Clearly, this role is different from that of the military physician who may be positioned far-forward in the military theater and attached to an active combat unit.

### TEMS as a Bridge Between Military and Civilian Worlds

A TPS role may provide a bridge between the civilian and military surgeon's domains, and may be supported by prior police or military experience. However, there are multiple issues raised by embedding a surgeon in a tactical team. These issues include but are not limited to: salary support; time commitment; call or clinical activity coverage; liability insurance; disability coverage; training (team participation as well as safety); fiduciary responsibility; and the surgeon's role in determining officer suitability to participate in

the tactical team based on health and fitness, as well as post-activity debriefing. Clearly there are multiple opportunities for partnering between the medical and police communities, but such collaboration requires interest and recognition of the benefits that may accrue to both parties, and a balanced appraisal of the potential risks. Risk assessment for this role is hampered by a lack of guiding principles addressing physician behavior and responsibility in the context of a TPS role. In contrast, there is a well-defined set of responsibilities for a *non-tactical* police surgeon who may not be trained as a surgeon and whose primary responsibility is health and wellness screening, as well as serving on a police commission's disability board. In the UK, police surgeons also embrace a forensic analysis role at the scene—a responsibility assumed by forensic technicians and forensic pathologists in the US.<sup>18</sup>

Important for TPS “acceptable behavior” is the impact of the assumption of risk (personal and professional). Risk assessment must address the mitigation of on-scene risk for the TPS. Generally, one to two SWAT officers are tasked with ensuring TPS safety, but this strategy reduces available manpower for threat management. This is especially a problem during active shooting scenarios with an injured officer where the “best medicine” may be threat suppression or elimination.<sup>3</sup> Moreover, one or both of the SWAT officers protecting the TPS may be called to address another active threat, leaving the TPS to manage an injured individual without protection. It is apparent that risk, safety, and acceptable behavior interact with a host of issues.

### Ethical Principles and Specific Scenarios

Although multiple professional medical societies (including the American College of Surgeons, the American Medical Association, the American College of Emergency Physicians, the Society of Academic Emergency Medicine, the American Society of Anesthesiology, the World Health Organization, and the World Medical Association) have articulated codes of ethical conduct, none currently specifically address the embedded TPS. Therefore, one might turn to a local ethics committee for guidance, but it is similarly unlikely to have a readily available set of answers to inform the clinician, hospital, medical school, or police department. Instead, it is useful to explore the following scenarios and the issues that they raise.

#### *Scenario 1: How Does One Decide Whether to First Provide Care to an Injured Police Officer Versus a Concomitantly Injured Suspect?*

This is perhaps the most common scenario that the TPS will encounter. There are certain operational realities that may make this decision for the TPS. Since the TPS will be co-located with a contingent of police officers, the TPS will usually be closest to an injured officer and therefore might reasonably first provide care to the closest injured individual. This is particularly true if there are practical obstacles that prevent the TPS from gaining physical access to the suspect(s). Moreover, since the officer may be injured by the suspect (as opposed to environmental injury, such as falling through a floor), there is a time period between officer injury, suspect injury, and locale clearing to determine whether there are other suspects who would place the officers and physician at risk. Nonetheless, this scenario raises other concerns, especially if the physician witnesses the suspect injure the officer.

Triage theory holds that issues such as social worth or general behavior should not influence triage decisions; it is wrong for the TPS to withhold care in order to punish a suspect. Team training

and bonding and shared experiences will undoubtedly affect the TPS response to team member injury as opposed to suspect injury. Team bonding and the establishment of transactive memory is associated with highly effective performance during life-saving interventions such as cardiopulmonary resuscitation.<sup>19,20</sup> Such transactive memory is built and sustained during regular training exercises, as well as during team activations and their debriefing. However, the inner perimeter realities will generally render these factors moot, as the TPS will frequently be unable to access the suspect but will have more ready access to the injured officer.

#### *Scenario 2: What is the Responsibility of the TPS in Providing Care to Inadvertently Injured Bystanders?*

This is a scenario that is less likely for the TPS, as there is often a time delay between the initiation of an unplanned SWAT activation (such as a barricaded suspect with hostages) and the arrival of the tactical team and the TPS. In general, inadvertently injured bystanders will have already been evacuated by patrol units and EMS providers. However, in certain scenarios, patrol and EMS providers will not be able to safely reach injured bystanders to provide first responder medical care and evacuation. In such circumstances, it is appropriate for the SWAT team to provide safe access for the TPS to reach the injured bystander when feasible. For instance, it may not be reasonably safe to reach the injured individual on foot if the suspect has a high-powered optically-enhanced rifle. In such events, armored tactical vehicles would enable the TPS to safely reach, extract, and care for the injured bystander. Importantly, the vehicle also provides significant protection to members of the tactical team.

Other scenarios such as high-risk warrant service occur with a completely assembled team. The scenario is more difficult when one of three events also occurs: (1) a tactical team member is injured; (2) the suspect is injured; or (3) a hostage is injured. In any of these scenarios, the TPS is faced with challenging ethical decisions that need to be made with regard to the order of care. These permutations raise issues with regard to TPS responsibility to different groups. Is the TPS primarily responsible to the tactical team or is the TPS equally responsible to all individuals present on scene? Should the TPS weigh the relative merit of providing care to the injured bystander compared to the injured suspect, and if so, using what metric? Since the suspect and the bystander(s) are not physically co-located (in general), the TPS will be unable to render an immediate triage analysis in a side-by-side fashion. Moreover, the previously identified inherent delay in safe scene entry to where the injured suspect is located may only allow for initial evaluation and treatment of injured bystanders.

Access to an injured hostage may be more readily available. If so, one must decide whether the TPS should make entry with the tactical team to evaluate the injured hostage prior to managing injured bystanders, or whether the TPS should initially address a “freshly” injured and accessible hostage. Hostages may be injured by the suspect (more likely), or inadvertently injured by the tactical team. “Iatrogenic” injury should not change decision-making but will likely engender a powerful emotional response from tactical team members, potentially clouding logical scene triage decisions. Therefore, one can reasonably argue that the TPS should address the most accessible individual first—generally an injured police officer—provided that doing so does not compromise the overall mission nor create a new safety threat.

*Scenario 3: Can a TPS Be Objective and Participatory in Injured Suspect Management if the TPS Injures the Suspect in Self-Defense or in Defense of an Injured Patient (Tactical Team Member, Hostage, or Bystander)?*

Given that the TPS is generally not trained as a combatant, may not be armed, and, when unarmed, is protected by one or more members of the tactical team, this scenario is believed to be rather uncommon. However, actual experience identifies that events do occur where a TPS is left unprotected to render care to an injured officer. Nonetheless, one survey documented that 67% of physicians functioning in a TEMS responder role were armed.<sup>21</sup> Since a key tenet of providing care to a seriously injured combatant is to relieve that individual of any weapon(s) and to make those weapons safe, the TPS will have ready access to weaponry that would be available for self-defense or patient defense as needed. Less injured officers are expected to provide initial self-care and to continue to return fire as needed as part of overall mission support. Clearly the TPS needs to be expert in removing, clearing, and making safe the entire spectrum of weapons utilized by their tactical team. Whether or not the TPS should be specifically trained to a particular level of expertise with any or all of the tactical team's weapons is unclear, but it would make intuitive and rational sense to do so, given the potential need to protect oneself or one's patients. One might anticipate that the police officers on the tactical team would want the TPS to be trained to perform to a similar standard as they so as to help ensure safe firearm use, no matter how rare that need might be.

Equally important is whether the physician can objectively render care to an injured individual if the physician has created the injury—in self or patient defense. There are little data to inform the TPS or others on this particular topic. However, since the TPS would generally be the sole advanced medical or surgical care provider in the inner perimeter, care should proceed based on access to injured individuals and their prioritization according to standard triage principles. While one may anticipate psychological factors that may be overwhelming in this rare situation, they may alter physician decisions in ways that cannot be accurately anticipated. Team training and modeling of this circumstance may help to offset the psychological impact, and help ensure that the TPS is as well-equipped to appropriately respond to care needs as possible.

**Where Is The Border Between Physician And Combatant?**

In the setting of firearm (lethal and less-than-lethal) use, one may ask where the border lies between physician and non-physician. It is clear that physician behavior may vary, but a behavioral change does not equate to changing one's identity to that of a non-physician. In many ways, a physician's professional identification is also his or her core personal identifier. It is important to explore whether a physician embracing a combatant role necessarily relinquishes his or her obligation to function as a physician from the perspective of professional obligation.

Tactically deployed physicians are garbed and outfitted with body armor and communication devices identically to all other tactical team members so as to not call undue attention to themselves as potential targets. Two elements do readily distinguish civilian tactical team physicians: the lack of weaponry and the presence of a gear bag. Therefore, a shifting role does not require a shift in external identifying badging or other identifiers such as the familiar Red Cross on military medic helmets in World War II. Along these lines, if a physician did discharge

a firearm (lethal or less-lethal) in self-defense or in defense of an active patient, it would have to be done as part of a sound tactical medical plan. According to the Tactical Combat Casualty Care doctrine, often the best medical care is firepower superiority to end the threat and then allow unimpeded appropriate medical care. If the physician must participate in self or active patient defense, then doing so embraces rather than negates this professional obligation. Nonetheless, it must be explicit that under no circumstances is a physician to use his or her medical skillset to inflict harm, nor to aid tactical officers in gaining strategic advantage (i.e., offering medical care as a ruse to enable tactical team entry). Such actions would be categorically viewed as inappropriate.

It is unclear whether there is likely to be any professional impact (deleterious or otherwise) for a TPS who acts in a defensive fashion that results in suspect injury. This would hinge on whether the actions were clearly defensive as opposed to whether the actions were not clear or not immediately clear to an external observer. Professional impact may include but is not limited to loss of employment, suspension or revocation of medical licensure, and degradation of professional reputation. The effect on the TPS's surgery practice may be significant, as that TPS's activity would undoubtedly be examined in detail in the lay press and this may sway potential or current patients away from that physician's practice. It is not anticipated that lay press exposure would augment an individual's practice. Similarly, the legal inquiry for a volunteer TPS who is not employed by the police department is likely to be both lengthy and complex, and require substantial amounts of time away from clinical care and academic activity. To date, no such events have occurred.

One method of potentially mitigating such events is to have the physician act as a combatant only under the explicit direction of a tactical team officer. Civilians are generally expected to follow clear directives put forth by police officers, and the TPS would be no exception. Another mechanism is to have a motion-activated helmet camera that records what the TPS sees, ambient sounds (including verbal commands), and the TPS's response to a given situation. Newer tactical helmets have side rail mounting systems that readily support such technology. Since most communication system exchanges between tactical team members as well as the team and the command post are recorded, the TPS's need to act in self-defense or defense of a patient may be supported in this way as well. Lastly, each team should have a specified protocol and action plan for the circumstances that support the TPS engaging in a defensive combatant role and the mechanisms to allow that engagement.

**How Does Military Unit or SWAT Team Responsibility Impact Triage Decisions?**

Since the TPS is in general not a police department employee, team integration is essential. Such integration is enabled by regular training as a unit, and requires adjusting SWAT training to incorporate the TPS into team movement, rescue scenarios, and police officer training in basic first aid and emergency medical care principles and procedures. In this way, the police officer SWAT members learn how to help themselves, one another, and the TPS in the event of team member, suspect, or bystander injury. As a result of the negotiations required to generate and complete the MOU, regular (at least monthly) team training, and team activation and deployment, durable and meaningful interpersonal bonds develop. Moreover, there is an

expected behavior set that accompanies integrating into a team. Deviation from the “normative” set of behaviors within a team dynamic, especially in a high-stress and potentially lethal environment, may incur censure in a variety of forms.<sup>22,23</sup> In a hostile environment, where one’s life may rest in another’s hands, departure from the expected team dynamic may be disruptive, dangerous, and divisive. Such team training sessions offer a superb opportunity to maximize the TPS’s likelihood of maintaining team cohesion while respecting professional ethical standards. Such sessions allow the team to practice multiple permutations of the scenarios outlined above, explore triage and treatment decisions, and discuss team member observations (successes, failures, and misgivings) during the debriefing that occurs immediately after each sequence is completed. Such sessions enable triage decisions that the TPS renders when a SWAT member and anyone else is concomitantly injured.

Given the above, one might wonder whether treating a suspect who is more grievously injured than an injured officer would critically damage the TPS’s role, position, and viability within the tactical team. The parallel within the military scenario is quite apt with injured same-force and opposing-force combatants presenting simultaneously to an aid station or definitive care facility.<sup>24</sup> This scenario occurs quite commonly, and is resolved, in general, using standard triage decision-making; nonetheless, conflict does occur. However, the military physician is generally not embedded within a tactical team and does not risk disrupting that specific team dynamic. This seemingly obvious but critically important difference cannot be overstated. Recognition of this difference again raises the question of whether the TPS may or should ethically treat an injured SWAT member before all others.

One approach to answering this question would determine and rank the strength of the duties with which the TPS is faced. There are duties to one’s self, one’s family, one’s team, one’s employer and society that are readily identifiable and binding in different ways. These duties are accompanied by duties based upon the unique skillsets derived from a profession and the discharge of those duties to individuals in need. Since the SWAT members act on society’s behalf, and in so doing, derive benefit from (emergency inner perimeter care) and provide benefit to (protection while providing care) the TPS, it may be that there is a more binding duty between each of the TPS and the SWAT members than there is between the TPS and any other on-scene individuals regardless of injury. This argument should not be

interpreted to mean that the TPS would treat an injured team member with a clearly minor injury (e.g., a sprain) before treating an injured suspect or bystander with a truly life-threatening injury. Instead, the articulated principle may inform a TPS in the circumstance when there is concomitant injury and equal access.

### Should A TPS Be A Sworn Police Officer?

It is readily apparent that having the TPS be a salaried employee of the police department would establish a fiduciary responsibility to the department and its members. If the TPS also satisfied the requirements to be a police officer, then concerns with regard to training, firearms, salary, injury compensation, and professional responsibilities would be substantially minimized, and in some circumstances, eliminated. However, there is no substantial precedent upon which one may rely, nor is there generally sufficient available time to appropriately train a physician in a way that would satisfy state regulatory agency requirements. One solution is the establishment of a new police officer designation, a Medical Police Officer. Such an individual would be a practicing physician who would undergo an abbreviated training program in law enforcement with the training focused on tactical teamwork, applicable laws and regulations, and firearm use, as well as an expanded curriculum addressing forensic medicine. This individual could be employed by the police department, and have all of the authorities and responsibilities of a police officer, confined to those required to support tactical team activities. This individual would not participate in routine patrol activities, but would be required to maintain skills and knowledge bases appropriate to the discharge of tactical team duties. No such program currently exists, but creation of such a program could readily be explored as one means to enhance safety, training, and efficacy of the TPS role.

### Conclusions

The role of the Tactical Police Surgeon is complex. The complicated ethical principles that guide the TPS regarding acceptable and ethical behavior are often affected by safety and physical location concerns. While standard triage rules generally apply in most circumstances, the bond that develops between a TPS and the tactical team may appropriately influence certain triage decisions in special circumstances. Further refinements in TPS training and certification may better enable support of the tactical team as well as the forensic aspect of team activity.

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