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I. Researchers want ER docs to focus more on "excessive" force claims

A newly published study that calls for ER doctors to give more attention to complaints from injured suspects about "excessive force" and "police brutality" has been published in a prominent medical journal.

The authors, citing concerns by the ACLU and the World Health Organization about unnecessarily violent police behavior, argue that prisoners' injuries should be analyzed along guidelines similar to those used to assess child abuse and domestic violence, in an effort to identify cases of unwarranted use of force.

Critics with a law enforcement perspective, however, warn that what seems like a reasonable and impartial improvement in reporting protocol may, in fact, lead to inappropriate judgment calls that will harm officers and their agencies.

Authors of the study are Jared Strote, MD, associate professor in the Division of Emergency Medicine at the University of Washington Medical School; Erik Verzemnieks,
MD, with the Emergency Medicine Dept. at Johns Hopkins University Medical School; and Mimi Walsh, PhD, a strategic advisor in the Office of the Chief of Staff of the Seattle PD.

Their study, "Emergency Department Documentation of Alleged Excessive Use of Force," with Strote as the lead researcher, appears in the American Journal of Forensic Medicine & Pathology. An abstract is accessible free by clicking here. If you're interested in the full study, it can be downloaded for a fee there as well.

TRAINING VACUUM. Strote, with various support teams, has argued for years that ER physicians should play a more aggressive role in pursuing and documenting allegations of police abuse. His studies and editorials in medical journals have been reported since 2009 by Force Science News--along with sometimes fervent criticism of his research methods and conclusions by use-of-force and emergency-care experts.

Strote points out that while "patients' complaints of excessive use of force by police occur frequently in emergency departments," little if any education or guidance is given to ER physicians on how to document these allegations. This, despite the fact that doctors receive "extensive instruction" related to evaluating and reporting "other forms of potential abuse or assault," such as child abuse, elder abuse, and domestic violence.

To determine a sampling of current ER documentation of police-related injuries, Strote and his team analyzed a year's worth of excessive force complaints made to emergency personnel at the public hospital serving police cases in one major US city, Seattle.

COMPLAINANT POOL. Searching 12 months of police and medical records, the researchers identified 187 individuals who were brought to or came to an emergency department within 24 hours after a force encounter with Seattle cops. After eliminating those who were unable or unwilling to provide a "history" of their injuries and those who had only "psychiatric or nontraumatic medical complaints," 135 injured suspects were left.

The researchers then scoured police and medical records for one or more of the following cues in these patients' descriptions of their force encounters: "'assaulted,' 'beaten,' 'excessive force,' 'police brutality,' an intent to pursue legal action, a complaint that the force used was inappropriate for the patient's behavior, or reference to an action that is clearly not within common use-of-force guidelines (e.g., 'strangulation')."

In all, the team found a "patient complaint of inappropriate force" recorded in only 13 medical charts, roughly 10% of the final pool of subjects.

DEVIL IN THE DETAILS. The researchers found that important specifics were often missing in the physicians' documentation of the suspects' complaints, while certain components that the team thought "should be absent" were not.
"Notably," Strote writes, "no charts discussed" whether the doctor's physical findings were consistent with the subject's version of events. Nearly 40% failed to give a "complete description" of how the injury occurred, and more than 20% did not even give a "complete description of the injury" itself. True to the doctor stereotype, over 1 in 5 written descriptions was not entirely legible.

In reviewing police records, the researchers found 11 more subjects who had complained of inappropriate force but did not surface at all from medical records. These subjects evidently either failed to beef about their treatment in the ER, or attending doctors failed to record it.

By contrast, certain elements that the researchers considered no-nos were rife in the complainants' charts. In more than half, Strote reports, "subjective terminology (e.g., 'drunk' rather than 'altered')" was used. Nearly 40% of the attending physicians assigned "guilt" to the complaining patient, and nearly 54% accepted the "police description [of events] as fact" in their documentation.

Physicians, Strote writes, "cannot and should not assign guilt or innocence [to] the alleged offender." Yet "[p]atients brought in after law enforcement encounters are often altered and frequently disruptive" and doctors may "show intentional or unintentional bias against this population."

In summary, Strote writes, "documentation for patients complaining of EUOF [excessive use of force] did not meet standards for other forms of alleged or suspected assault or abuse." Yet ER reports "may be the only objective evidence available in alleged EUOF incidents...if a formal complaint is later filed."

He acknowledges that "legally defined excessive force is rare," but it "clearly does occur, and patients with complaints...have been shown to have injuries consistent with their complaints...." However, there currently are "no legal or professional guidelines on how to document complaints of EUOF in the emergency department."

CORRECTIVE SUGGESTIONS. "Many authors have argued that incarcerated patients comprise a...vulnerable population" similar to abused and/or assaulted children, spouses, and elders, for whom "emergency physicians [can] play a critically important role," Strote writes.

"[S]imple educational interventions can dramatically improve documentation in such cases," he believes, citing "a notable absence" of instruction on "care for prisoners" in current medical education.

He believes "it may be useful to develop documentation guidelines similar to those for other alleged abuse presentations." These would include "complete and objective"
descriptions of injuries, "use [of] the patient's own words," and an identification of "potential inconsistencies."

Drafting these guidelines, he advises, "should be undertaken jointly by emergency medicine and law enforcement professional organizations to ensure consistent documentation that objectively and accurately describes histories and physical findings while not assigning guilt or innocence or other subjective judgments to either patients or police officers."

POLICE CONCERNS. Although Strote insists that better documentation will help to "protect" both the police and injured suspects, some law enforcement sources express concern about where his crusade may be headed. Thorough description of a subject's injuries and an accurate recording of his or her story may be a desirable goal, these sources say, but their concern is that in time this focus will morph into conclusions by physicians that injuries they see equate with evidence of inappropriate force.

"Things will be far worse if the rhetoric about better documentation transitions to a hospital or legal mandate requiring medical personnel to report suspected excessive use of force, as has been the case with child abuse, elder abuse, and domestic violence," attorney Michael Brave, a UOF instructor and litigator, told Force Science News.

"LEO force simply is not the same as child abuse or domestic assault, where injuries are not expected and may in fact be revealing in and of themselves. LEOs are entitled to use force within appropriately applied legal standards. This includes a sniper bullet to the eye. When weapons are used, they almost always cause injury whether misused or not. And ER doctors are rarely if ever present at the application of force to see the context in which it is provoked.

"When a medical doctor reports an alleged EUOF, it often has an undeserved aura of authority. Since the doctor has a medical degree, some people, including some prosecutors, judges, and juries take the doctor's statement as authoritative fact when, in reality, it should not carry that weight.

"I have deposed several ER docs in the past couple of years who put a statement of excessive force in the medical records, prompting litigation to commence, in part, based on that conclusion. At deposition so far, every such doctor has completely backed off of their statements. Part of the fun is asking them to define EUOF. Another fun part is asking them to relate the 'facts' of the incident."

Dr. David McArdle, a SWAT doc and emergency department physician in Colorado, told Force Science News: "There has been a great deal of discussion in our specialty concerning complaints from patients about possible misconduct by the police. However, emergency physicians do not know the circumstances surrounding the use of force sufficiently to label any injury as due to excessive force."
"In the heat of a trauma resuscitation, it has been shown that many physicians cannot even correctly identify a gunshot exit wound from an entrance wound. Much better forensic training is needed."

(Although McArdle is chairman of the Physicians Section of the International Assn. of Chiefs of Police, he made clear that he was expressing his personal views and not speaking as a representative of the IACP or its Physicians Section.)

FSI POSITION. At the Force Science Institute, executive director Dr. Bill Lewinski says: "We encourage doctors to be thorough in documenting UOF injuries. But their scrutiny should not extend to forming judgments about whether the force used by police was excessive.

"In officer-involved shootings where an offender is killed, we advise coroners and medical examiner, 'Don't take the body off the table.' That means report what you find at autopsy but don't try to reconstruct what happened to determine whether the shooting was justified. The same applies when an arrestee is being treated in the ER."

As a small but telling example of how things can be distorted in the "minefield" of medical interpretation, Lewinski notes Strote's characterizing a suspect's report of "strangulation" as something "clearly not within common use-of-force guidelines." Lewinski says: "What the patient describes as 'strangulation' may in fact have been an entirely proper application of LVNR [lateral vascular neck restraint], which can be a trained and legitimate use of force not at all outside of proper guidelines.

"Documentation of injuries, if it's accurate, objective, and thorough, may in the long run help an officer by supporting his account of resistance," Lewinski says. "But doctors need to resist stepping out of their domain of expertise to pass judgment on an encounter they know nothing about first-hand."

INTERESTING FACTOID. In their study, the Strote group cites a US DOJ special report from 2005 that found that among those who experience force in police encounters, "83% consider it excessive."

II. Force Science grad probes the dark mind of the active killer

Potential victims who plead for mercy from an active killer only spur him to greater violence and likely doom themselves, while those who act aggressively against him have the best chance of stopping his slaughter, according to an exploration of the dark psychology of rapid mass murderers by a NYPD firearms trainer.
Lt. Daniel Modell, training coordinator with that department's Firearms and Tactics Section, is a rarity in the police world: a 19-year veteran cop with bachelor's and master's degrees in philosophy. He's also a graduate of the Force Science certification course.

In a paper published recently in the journal Law Enforcement Executive Forum, Modell expresses his theories on the subculture and pathological mentality of active killers, distinguishing their differences from others who commit multiple murders, challenging myths about their nature and motivations, explaining their copy-cat competition with other active killers, and suggesting tactics most likely to work against them for officers or civilians.

"[T]he explanations [of active killers] most often proposed are plainly inadequate," Modell writes. He argues that these individuals are not driven by the same dark forces as serial killers or murderous ideologues, nor are they motivated by vengeance or a sudden "snapping" in a moment of insanity, as is commonly believed. Their "bloodlust signals a more savage pathology," he asserts.

In his interpretation, active killers view the world as sharply divided between victims and victimizers; victims are failures, victimizers are successes, "victimization finds its most dramatic expression in acts of physical violence," and "greater victimization means greater success."

Over the course of a lifetime, the active shooter has "consistently [and] chronically" been a victim, developing "a self-contempt immeasurable by rational standards," Modell writes. In the active shooting, his one, all-absorbing moment of glory, the offender feels himself transformed temporarily into a victimizer.

When he sees his victims fleeing in terror, crying, cringing, pleading, "yielding without resistance--as he always has, he sees in their faces, their postures, their bearing everything that he has ever been.... In killing them, he kills himself...kills the failure and the loathing." Potential victims who act like victims invite his lethal contempt.

Psychologically, however, this "momentary transcendence" into victimizer cannot be sustained, Modell observes. "Bravery is not known to [the active shooter]...his is not a soul made for battle." So when law enforcement--or even an aggressive, unarmed citizen--aggressively confronts him, "the active killer crumbles."

In Modell's words, "[H]e is conditioned by a lifetime of conceding, cringing, and yielding. Swift, aggressive action exploits [this] conditioned behavior. In his brief role as victimizer, he will attack a victim; he will not attack--not effectively, in any case--those who adopt the posture and action of victimizers in his peculiar interpretation of that term." Most, when the prospect of confrontation occurs or seems inevitable, commit suicide, he notes; those who don't, want to.
The bottom line for law enforcement, Modell concludes, is to "respond and engage the killer without delay," employing solo-officer entry and search if necessary, rather than the "affected orthodoxy of cumbersome team formations." For civilians, "when necessity or obligation calls, attack"; tackling the suspect has been enough in a number of instances.

"The active killer does not lie in wait to battle responding law enforcement," Modell writes. "No law enforcement officers have been killed responding to active killer incidents in the United States. Few have even been injured."

To access a free abstract of Modell's article, "The Psychology of the Active Killer," click here, where the full text can be purchased for $4 as well.

[Our thanks to active killer researcher Ron Borsch, whose statistical compilations have been reported in past transmissions, for alerting us to Lt. Modell's paper.]