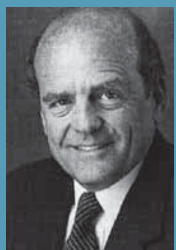


Tactical Emergency Medical Support (TEMS) at 20 Years

By Richard Carmona

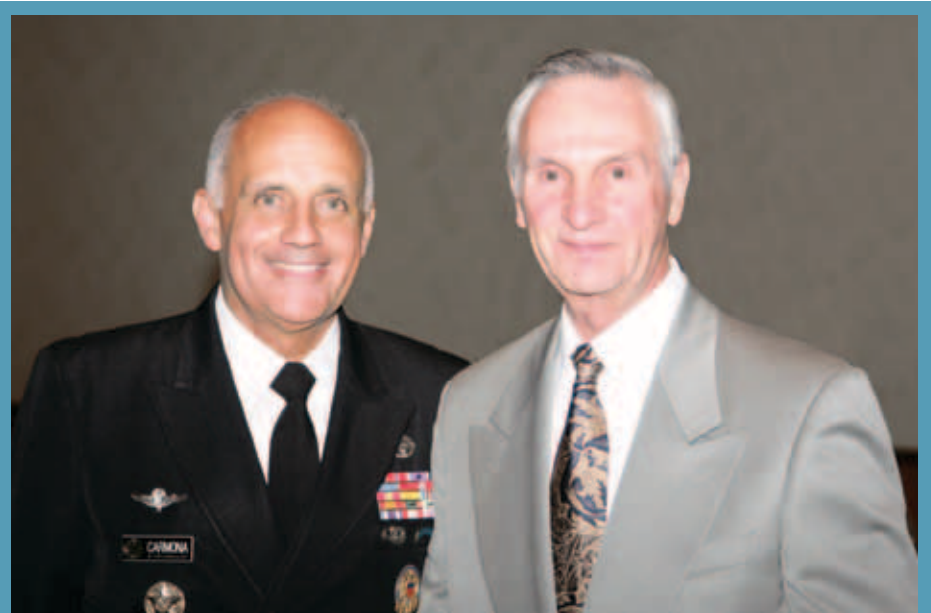
As an early member of the NTOA, I had the good fortune to be befriended and mentored by John Kolman, the founder of the National Tactical Officers Association (NTOA) and by all measures, the visionary leader who has contributed more to the evolution of law enforcement special operations than anyone in our history. For it was his vision to unite hundreds of disparate SWAT teams nationally through an organization, the NTOA, and a publication, *The Tactical Edge*, where we could learn from each other and move the profession forward collectively.



Commander David Rasumoff, M.D.

It was during this time in the mid-1980s that I had the opportunity to meet, teach with and befriend many operators nationally and then globally. One of them was the late reserve Commander (then-Lieutenant)

David Rasumoff, M.D. of the Los Angeles County Sheriff's Department's (LASD) SEB, ESD. David and I recognized early on that our respective teams were unique in having dual-trained operator medics much like the military special operations teams. These operator medics were not only there to take care of injuries and illness but also, and most importantly, to keep the teams healthy and operationally ready. They also assisted commanders in many areas, such as selection of appropriate safety equipment, gathering mission-specific medical intelligence, coordinating all medical support and monitoring the team's day-to-day health.



Vice Admiral, U.S. Surgeon General (ret.) and Deputy Sheriff Richard Carmona with NTOA Founder, Captain John Kolman (ret.)

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It was quite remarkable that the great majority of teams nationally had no formal internal or external medical support. In fact, most teams would just call 9-1-1 as needed or occasionally request pre-staged EMS units.

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With the advent of the NTOA, its training courses, *The Tactical Edge* publication and a few surveys¹, David and I were able to begin to characterize the status of medical support for tactical teams. It was quite remarkable that the great majority of

teams nationally had no formal internal or external medical support. In fact, most teams would just call 9-1-1 as needed or occasionally request pre-staged EMS units.

Considering the high-risk missions the teams were engaging in, Dave and I



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believed that it was inconceivable not to have some type of ongoing formal relationship with EMS and health professionals. Over the period of a year, our friendship and professional relationship grew. In 1988 we approached John Kolman and pitched the idea of an NTOA-sponsored curriculum and training in tactical medicine. John immediately embraced the concept and became our biggest proponent.

The NTOA and LASD SEB hosted the first national course on tactical medicine in 1989 in Los Angeles. David and I invited military and law enforcement operator medics from around the country. Our goal was to begin a dialogue with them on critical health and safety issues we all faced. From that meeting came numerous recommendations that guided our thoughts about a curriculum for what was eventually to become Tactical Emergency Medical Support (TEMS).

During the following year we planned our next tactical medical course, which was held in Tucson, Arizona in 1990 and sponsored by the Pima County Sheriff's Department and the NTOA. This course was also very well attended and successful.² At the Tucson course, Dave and I were approached by representatives of the Uniformed Services

University of the Health Sciences (USUHS) and advised that they were preparing to launch a one-week law enforcement tactical medicine course called Counter Narcotics Tactical Operations Medical Support (CONTOMS). We were invited to join the newly-assembling faculty.

We joined the USUHS CONTOMS faculty and donated our NTOA two-day tactical medicine curriculum and slides to the CONTOMS course. Coincidentally, the commander at USUHS overseeing the CONTOMS course was then-Colonel Craig Llewelyn, a legendary Army Special Forces commander whom I knew from my time in Army Special Forces. Craig was one of the original contributors to the Army Special Forces medical specialist curriculum in the 1960s. Since we were loosely modeling our law enforcement tactical medicine model on the military operator medic paradigm, we were fortunate to have a leader in Craig who fully understood and supported the concepts of tactical medicine. David and I continued to offer the two-day NTOA tactical medicine course around the U.S. while CONTOMS offered a five-day curriculum. Dave and I taught in both courses. These courses complemented each other and for many years were very well attended nationally. Both courses gradually added law enforcement, EMS, fire and medical faculty from around the United States as the demand grew.



TEMS is another excellent example of the translation of elements of military medicine to a community environment. Pre-hospital care, trauma centers, EMS systems and now TEMS have evolved from the battlefield to our law enforcement special operations teams in order to maximize operational readiness and care for the injured in sometimes austere environments.



In 1990, David and I began writing a regular column called "Inside the Perimeter," in *The Tactical Edge*.³ The column continues today, and through many authors has contributed significantly to uniting the tactical emergency medical community and establishing general standards. It was in one of our early articles that Dave and I coined the term "TEMS," the acronym for Tactical Emergency Medical Support.⁴

In the early and mid-1990s many departments and organizations began to offer their own tactical medicine courses. It rapidly became apparent that there were significant differences in quality among the many course offerings nationally and that some sort of uniform standards would be desirable.

In the mid-1990s, the International TEMS Association (ITEMS) was created with the intent of providing a specific voice and meeting place for TEMS. This organization attempted to achieve a national consensus on a TEMS curriculum as well as provide recognition to TEMS providers nationally who had excelled in any of several categories. Unfortunately, for several reasons, ITEMS lasted for a few years and then stopped operations.

The 1990s also gave rise to other organizations like Heckler and Koch, who provided their own version of a TEMS course; the International School of Tactical Medicine in Palm Beach, CA; and university medical



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centers like Johns Hopkins in Baltimore, MD, providing training to their emergency physicians in TEMS, as well as “medical control” to several federal and state law enforcement agencies. These are but a few of numerous organizations that contributed to the evolution of TEMS.

In the early 1990s, we provided the first presentation on TEMS to the National Association of EMS Physicians (NAEMSP) and had discussions with the American College of Emergency Physicians (ACEP) in an attempt to gather wider physician interest and support for TEMS.⁵ NAEMSP and ACEP have since formed TEMS advisory committees. We also began to reach out to our law enforcement colleagues directly via the International Association of Chiefs of Police (IACP) and the National Sheriffs Association (NSA).

As we transitioned from the 1990s to the new millennium, it was clear that TEMS had evolved as a national standard and was continuing to evolve commensurate with the expanding complex tactical challenges our nation faced. With the national and international collaboration of many individuals and organizations, TEMS has grown from an aspirational vision to an ever-evolving, widely accepted and essential component of police special operations.⁶

Most recently, the Center for Operational Medicine at the Medical College of Georgia, the NTOA and North American Rescue collaborated to define the practice of TEMS via a competency-based curriculum that is referred to as the “STORM” course (Specialized Tactics for Operational Rescue and Medicine). The refinement, improvement and evolution of TEMS continues.⁷ It is interesting to note that in one of our earliest articles (in 1990) in which we attempted to characterize the options for tactical teams providing TEMS, the approach we described then is still viable today.⁸

Since 1990, hundreds of TEMS-related articles have been published in tactical journals^{9,10} as well as peer-reviewed medical literature,^{6,11,12} and two TEMS textbooks are now in print.^{13,14} Subjects include, but are not limited to, administrative issues, prevention, specific clinical care, trauma care, integrating TEMS and tactics, medical/base station oversight, immediate action drills, “buddy care” and education and teaching TEMS.

TEMS is another excellent example of the translation of elements of military medicine to a community environment.¹⁵ Pre-hospital care, trauma centers, EMS systems and now TEMS have evolved from the battlefield to our law enforcement special operations teams in order to maximize operational readiness and care for the injured in sometimes austere environments.

Today the basic approach and platform for TEMS remains unchanged.⁸ The options to specifically apply TEMS in various environments continue to evolve based on new scientific knowledge, known and emerging threats and the tactics that evolve to prevent or respond to those “all hazards” threats.^{6,16,17}

TEMS exists and thrives today because of the passion and initial commitment of Dr. David Rasumoff and the visionary leadership of Captain (ret.) John Kolman, whose goal was always the health, safety and security of our officers and the public. ◀

About the author

Deputy Sheriff Richard Carmona, M.D.

is a 25-year veteran of the Pima County Sheriff's Department, where he served as a detective,

SWAT team operator, medic, training officer and team leader. He is also a combat-decorated former United States Army Special Forces medic and weapons specialist, the 17th Surgeon General of the United States and emeritus TEMS chairman for the NTOA.

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