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Reporting Use of Force Injuries by Law Enforcement Officers in the Emergency Department

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During the 1990s, public health scholars and practitioners observed an absence of medical research related to 3 of the 5 leading causes of premature death: suicide, homicide, and injury.¹ These premature deaths had comparable socially determined antecedents and clear policy implications for the broader society. In response, Surgeon General C. Everett Koop expanded the mission of public health and dedicated new resources toward the prevention and treatment of violence. By doing so, violence became conceptualized as a public health issue, rather than principally a matter of law enforcement.

Almost 20 years later, the synergy between public health and criminal justice systems has remained inconsistent. Efficacious violence prevention strategies in the medical field have been implemented by the Centers for Disease Control and Prevention.² However, there has not been sufficient cooperation in other areas of violence, such as intimate partner violence. One study found that 59% of surveyed physicians stated that they would *not* comply with mandatory intimate partner violence reporting if required, a view reinforced by the American Medical Association's opposition to mandatory intimate partner violence reporting.³ Although physicians are required by law to report child abuse, gunshot wounds, and stab wounds, there are no guidelines for them to report alternative expressions of violence, such as the perceived use of excessive force by police officers. To date, this area of violence prevention has received scant attention by physicians.

Hutson et al⁴ revitalized this issue by surveying 393 academic emergency physicians on the topic of excessive use of force by police officers. Here, 97.8% of respondents replied that they had managed cases in which they suspected or that the patient stated had involved excessive use of force by law enforcement officers, yet only 28.8% of respondents reported their suspicions. Furthermore, there was almost a total lack of training and departmental policy about potential cases of excessive force. This lack of response stands in contrast to criminological studies that estimate rates of excessive use of force. In 2002, an estimated 45.3 million people had face-to-face contact with police, with 1.5% of these events involving

police threat or use of force during the contact.⁵ Of the 664,500 (1.5%) persons against whom force was used, about three quarters characterized the force as excessive. Although police departments rarely report excessive amounts of force voluntarily, they do investigate complaints against officers and must respond to lawsuits alleging the use of excessive force. Data reported in the policing literature suggest that excessive force is used against citizens and that it is often underreported.⁶ Suspects who are injured or complain of an injury are supposed to be treated by medical personnel, often in hospital emergency departments.

When emergency physicians encounter patients who they suspect are victims of excessive force, it is unclear what they are supposed to do. Although it may be difficult for physicians to determine whether an injury has been caused by police abuse, these physicians are in the best position to assess the extent and severity of the injuries. When patients present with "suspicious" injuries that are inconsistent with the account told to the physician, then we propose that the physician report any inconsistency or concern to the police department's internal affairs office. This effort would take minimal training and follow-up.

It is neither necessary nor appropriate for physicians to assess intent as part of a medical examination; however, inconsistencies between reported events and manifest injuries may serve as sentinel events that highlight inappropriate and excessive responses by police. The most common complaint of excessive force involves blunt trauma inflicted by fists or feet.⁶ These injuries are easy to document, as is the version of the event told by the patient. The emergency physician could simply document her or his interpretation of the event on a form that is not included in the case notes. Internal affairs investigators could use these data to help determine what took place during the police-citizen encounter and whether the injuries to the suspect were consistent with his or her claims. At the ecologic level, epidemiologic investigations could use *International Classification of Diseases, Ninth Revision* coding, specifically E-codes 970-978, to compare municipalities and help identify both high-frequency and low-frequency outliers among them.

Beyond claims of excessive force with hands and feet, patients often present with comorbidity related to the employment of less lethal weapons. For example, physicians have reviewed police and medical records of use of neuromuscular incapacitating device (ie, Taser) to develop an epidemiologic injury assessment,^{7,8} and policy changes in law enforcement K-9 units have been associated with a significant decrease in the proportion of suspects bitten or hospitalized.⁹ This reveals clear precedent for violence prevention strategies.

In summary, suicide, homicide, and injuries share a commonality by being subsumed within the paradigm of “violence” and “violence prevention.” Likewise, police policies include a use-of-force continuum that mandates the level of force that is justified according to the level of suspect resistance. Our argument for training and policy is tempered by the understanding that the application of force in the real world is often chaotic and that approximately 8% of excessive force complaints are even sustained.¹⁰ Yet, these few cases of excessive force polarize the community and demonstrate why criminology would benefit from efficacious partnerships with public health.

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