

# TACTICAL ANATOMY by Dr. James S. Williams, MD

The topic of “what’s the best gun or ammunition to carry” always seems to come down to the answer, “The most important thing is shot placement.” Sadly, this concept has not been emphasized enough in law enforcement firearms training, which tends to emphasize good shot placement...in the wrong place.

How many of us have qualified, under department or academy auspices, on the B27 silhouette, whose highest value aiming point is at solar plexus level, well below the heart? And which rewards a hit that would have merely shot off the opponent’s cuff link or Bluetooth with 60% value? And how many of us have shot at targets ranging from the FBI “Q” to the IPSC (International Practical Shooting Confederations) or IDPA (International Defensive Pistol Association) cardboard silhouettes that gave a mere lung shot the same 100% value as a hit that would have gone heart-into-spine?

Dr. Jim Williams is a pleasant breath of fresh and realistic air in this critical area of law enforcement training. If we wanted a top expert from the medical world to guide us in these matters, we’d probably ask for an Emergency Room physician with lots of gunshot wound experience, who saw the patients fresh from the shooting instead of the next day on the stainless steel table in the autopsy room. Who was able to debrief the guy who took the hit and ask him what it felt like, what he did thereafter, and how his injury affected his ability to continue fighting. Hell, maybe even a doc who had been shot *himself*. It would be a bonus if that expert had been through extensive firearms training (both law enforcement and advanced private sector), and had also debriefed a great many people who’d had to shoot other people and picked their brains about their observations during the gunfight itself.

That set of particulars perfectly describes James S. Williams, MD.

A police surgeon and a currently serving, longtime ER doc, Williams is a solidly credentialed professional whose “BTDT cred” (“Been There, Done That”) is instantly apparent to police audiences. He has taught for national seminars of the International Association of Law Enforcement Firearms Instructors, the American Society of Law Enforcement Trainers, and the International Law Enforcement Educators’ and Trainers’ Association. I’ve not observed him at the first, but have taken his training at the latter two. As then-Chair of the Firearms Committee for ASLET and as a member of the Advisory Council for ILEETA, I’ve also been privy to attendee reviews of Dr. Williams’ presentations. He was *very* well received, and what stood out from the student critiques was that the cops who had been in gunfights – who had actually had to shoot men, and some of whom had actually been shot – kept saying that Williams’ approach to the topic was the best and most realistic that they had ever experienced.

That says a lot.

Prior to his presentations at the national level, I had invited Dr. Williams to lecture at classes taught through my school, Lethal Force Institute, whenever it was possible. We got the same sort of reviews from cops and soldiers who had “been there and done that.”

Williams is thoroughly conversant with all the “stopping power theories”: the penetration theory, the energy dump theory, the permanent wound cavity theory, and all the rest. He distills them succinctly into a program that teaches the officer to direct his or her shot to the internal parts of the

offending organism that must be shut down to save innocent human life, including the officer's own. He teaches the use of "external anatomic landmarks" as aiming points, much the way the surgeon marks the skin of the patient at the first point where the scalpel will cut.

Dr. Williams' approach validates the three points of aim that have long been taught by established private sector schools such as Thunder Ranch and Lethal Force Institute: deep brain, center chest, and pelvis. The center chest, containing the heart and the great vessels, becomes "the mediastinum zone of incapacitation" in the Tactical Anatomy program. It is here that the officer should aim at a violent offender armed with a remote control weapon such as a firearm. To shut the offender down to where he cannot flick his trigger finger, in a fast moving situation that takes into account degradation of marksmanship under stress, this gives the cop the highest probability of a neutralizing hit.

The pelvic shot, which Williams refers to as the "lateral pelvis zone of incapacitation," is actually a much larger target than the cardiac area, and is *extremely* likely to take away the offender's mobility if the pelvic girdle is seriously fractured. A hit here anchors a man who has been staying up and fighting through chest hits, and thus makes a follow-up head shot much more likely to succeed if it must be taken. It instantly denies mobility to an attacker coming at the officer with a contact weapon such as a knife or club.

The commonly described "head shot" is not guaranteed to work: the face, the jaw, and the notoriously bullet-ricocheting internal helmet of skull bone that physicians call the cranial vault, are not the optimum targets. Deep brain, the area that controls autonomic response, is the target of choice when a sniper must neutralize a hostage taker without a reflexive pull of his trigger, or when a street cop must shut down a gunman who has been shot to pieces but is still firing at police. Dr. Williams teaches this as the "brainstem zone of incapacitation."

Dr. Williams' book is the cornerstone of a carefully-constructed Tactical Anatomy training program that goes all the way up to certifying Tactical Anatomy instructors within a law enforcement agency. It encompasses unassailable logic supported by the collective experience of the medical community, the law enforcement community, and the combat military community alike.

Strongly recommended.

■ Massad Ayoob, Director, Lethal Force Institute