ALTERNATIVES TO
EMERGENCY
MEDICAL
SERVICES

ANTHOLOGY 2014

the rosehip medic collective
In Solidarity,

The Rosehip Medics

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Ken treatment programs, the people in these stories remind us of the effect that each person working within, outside, or against our healthcare system can have. In these pages, we read of actions and choices and solutions we would never have dreamed of by ourselves. Let’s keep working, and keep sharing our stories with each other. Providers, healers, patients, witnesses — together, we are so much stronger, more resilient, and more resourceful than we even know.

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Trauma and burnout in care providers is another theme that surfaces in several of the contributions we received. As Charles says, first responders and healthcare workers are "The keepers of our town's secrets," charged with the extremely difficult job of bearing witness. As we worked on this zine, one contributor added a fantastic resource to our constantly evolving conversation about self care and mental health of healthcare workers. The Code Green Campaign (codegreencampaign.org) works to raise awareness and support of first responders facing mental illness, including recognizing suicides of first responders across the country. One look at the barrage of stories on their website shows the necessity of changing the way we think of self care and support for our care providers. We hope our contributors' words serve as a call to rally behind one another and to care for ourselves and our fellow healers in addition to caring for our patients.

In the first Alternatives to EMS zine, we recognized the importance of supporting the healers in our communities as they further their education and training. We drew conclusions about the need to keep those people close to and involved in our communities as they go through the rigors of intense schooling, so that we do not lose our amateur healthcare workers as they drift away from us and into the world of healthcare professionals.

The stories in this zine have shown us another side of that same conclusion – the need to maintain ties with and between community-directed care providers so that we can continue to share and learn from each other's experiences. While it is easy to feel that we are alone in a broken system, reinventing the wheel each time we attempt to provide truly patient oriented care, these stories show us that we are far from alone and we can learn much from each other. We hope this zine acts as a reminder to seek out and maintain connections to one another, and to share lessons learned and moments of success and inspiration.

Finally, we are inspired by the creativity and ingenuity in the diverse stories we received. From unexpected sources of care in small-town EMS, to unplanned medic collaborations on city bridges, to patients banding together to support each other within bro-
Closing Thoughts

As we gathered these stories we were impressed by the diversity of voices and experiences we heard, but we also saw common themes emerge from them. In a field where many of us face isolation, those shared experiences seem worth highlighting. Here are our thoughts on a few of the many common threads throughout these stories – we hope you will add your own thoughts to them.

A common thread that weaves through the section on working within the system is positive experiences with rural EMS. These stories emphasize the familiarity that comes in small communities, where patients stand out as more than anonymous names or record numbers. Writers comment on the possibility for community-level EMS systems to give back to their responders through education, training and skill-building, and to recognize chronic emergencies – isolation, poverty, and lack of access to care – as the serious and present threats they are. We are curious about translating lessons learned from rural EMS into the smaller urban communities where many of us work as street medics. Though they are located within larger cities, many of the specific circles where we work are no larger in population than a small town. How can we bring these effective, individual-scale emergency response systems to the people we know and support in our own communities?

Another theme in this collection is the role of EMS as a safety net – sometimes functional, sometimes very dysfunctional – for individuals abandoned by society. One contributor writes that first responders “deal with the consequences of broken communities… our job is to pick up the pieces.” In doing that work, we see first hand how the systemic injustices in our society are connected to one another – malnutrition to poverty, poverty to health, health to environmental destruction… the list goes on. Repeatedly witnessing these struggles and the ways they are linked is a difficult role, but also one filled with possibility. The healers in our communities are uniquely placed to recognize these systemic oppressions, and their very concrete consequences. And also to build small, community-level solutions that can begin to fight them.

About this Project

Nearly four years ago, the Rosehip Medic Collective explored institutional Emergency Medical Services and existing alternatives in our original Alternatives to EMS zine. This project presented case studies, history and theoretical discussion of EMS and those working to build alternative models for emergency care. In creating that zine, we sought input from street medics, disaster responders, outreach workers and others—but mostly we critiqued different methods of providing emergency care and dreamed about what could come next. This project inspired us with the knowledge that alternative crisis response systems exist and function, and provide care that is patient oriented and community specific. And it sparked dreams of what else might be possible, and what sustainable community networks of care might have in common.

Since releasing that zine, we have been approached over and over by individuals who have told us their stories – stories of working within the system, of building alternatives, of filling unmet needs, of creating community resources, of burnout, of reflection, and of moments that helped them keep going. From the beginning, we knew we would need a sequel to our first zine – not another systems-level analysis, but a collection of these individual stories.

As so many of us run into similar barriers while providing and receiving care, we hope that by printing these stories we can share our lessons learned, celebrate our successes, and reduce the isolation institutional medicine produces. Our call for submissions for this anthology asked for stories of individual and group successes or learning moments in working towards community-directed care.
In line with Rosehip’s core values, we defined this as being care that:

- Believes consent and best practice are equally important
- Respects the parameters of care set by the communities with whom we work
- Supports all people’s rights to understand, access and direct their own health and wellness
- Embraces harm reduction and non-judgmental care
- Prioritizes self-care of providers

We asked also for stories of individuals and groups that have organized to confront, challenge, dismantle, or subvert harmful and oppressive healthcare systems – stories of broken rules, collaboration, re-appropriation of resources, insubordination, and lessons learned the hard way.

We received submissions from professional and volunteer disaster responders, street medics, nurses, EMT/Paramedics, outreach workers, village healthcare workers, herbalists, doctors, and people of other backgrounds and healing traditions. Some participants submitted written work, while others chose to be interviewed.

In this zine, we share the words of these individuals who have inspired us through their stories, their work and their vision. The anthology is divided into two sections – the first explores healthcare workers creating change and finding paths to patient directed care within the healthcare system, while the second celebrates moments of challenging oppressive systems, subverting ineffective care, and building alternative networks of mutual aid and support.
We hope these stories will serve as a reminder of the strength, resiliency, and resourcefulness within us all; whether we are, at any given moment, caregivers or patients, workers within or subjects of a broken system, these writings prove to us that, collectively, we have agency, knowledge, and power. Here’s to sparking more visions, dreams and possibilities.

Take care, give care,

The Rosehip Medics

treating violent injuries and working with people outside of our [radical/liberatory] communities. In the event of a social upheaval, these will be really good people to know (well-armed, organized, and with access to lots of resources). They’re frightening allies who have been neglected by my community. Also it allows me to do this work because I don’t want to work in the ER.” He also values being able to ‘siphon’ the money offered to him back to other groups and that “it’s engaging to be part of an underworld.”

Jason says that apart from his patients and the interviewer he has told no one about this part of his life. “I have to keep this secret and it sucks.” When asked why he agreed to give an interview about his nighttime calls, Jason says, “because I want people to understand how I got into this – because other people can do it.” He reflects, “I fell into it – I didn’t plan for it; it just kind of happened because my friend needed help. But people could plan it out without too much work. I think we could do something similar from an above-ground place too, with trac phones possibly.” He also sees his care for these gang members as falling within the context of providing accessible health care: “I’m a medic for my community. People call me all the time for all kinds of things. This is definitely not isolated.”
other man he treated was brutally beaten, with bruises all over his body (including the fragile abdomen). After assessing him, Jason says he was “pretty sure” the man was not bleeding internally, but he shared what kind of ‘red flags’ would indicate more serious internal injury (localized swelling/pain increase, change in Level of Responsiveness) and emphasized this would mean a NON-NEGOTIABLE trip to the ER. “I try to scare the shit out of people,” he adds.

Jason owns that he has never received formal training in most of the care he provides. As a Wilderness First Responder, with “lots of personal backcountry experience, in the bush,” he has learned to improvise his supplies—for instance giving himself and others sutures with fishing line or dental floss. He adds that a familiarity with yoga, body movement, martial arts and chronic usability issues has given him “a sense of what will become a severe chronic issue – the difference between internal bleeding, injured organs, and soreness.” He also learned a great deal working as a veterinary technician and as a disaster relief volunteer, where he “watched people who were really competent [in providing medical care] do it over and over for months.” He also refers to having a background caring for undocumented people and people on probation or with warrants.

After his initial treatment, says Jason, “I arrange follow-up visits every few days, then every few weeks.” Other than these visits and preexisting friendships, he keeps his distance: “I treat a lot of bad people...most of the people I treat are bad people, but they’re nice to you.” He doesn’t request monetary donation from his patients, beyond the occasional cost of materials and gas—though he says most offer him more. Jason says he accepts this extra money and gives it to community groups he cares about, saying “the shit that they give me is blood; I don’t want it. I don’t like these people because they’re destroying the community: That’s what a drug dealer does.” He believes strongly, however, that they still deserve care; “It sucks to be beaten up, robbed at gunpoint, have their house broken into.”

When asked what most drives Jason to keep on taking these nighttime calls, he responds, “Mostly I see it as really good practice; I am personally trying to prepare for collapse, to gain experience
Section One: Working Within the System

Working within the healthcare system can be a frustrating, alienating and isolating experience. As street medics focused on patient-oriented care, we see so much that is broken about our healthcare system, and sometimes feel we can’t do much to confront the problems. But every once in a while, as we strive to do our work in the best and most patient directed ways possible, we find unexpected sources of hope.

This section presents stories about working more or less effectively within the system – moments of revelation, of learning, and of witnessing systems that function in sometimes surprisingly positive ways. We look to these stories for ways of building space for our beliefs inside unfriendly systems, and ways of learning from each other how to provide care in complex environments. These authors remind us of the moments of possibility, when we are able to find the compassion and empathy that we so often see lacking.

These stories tell us about the moments of success that sometimes feel few and far between. The authors demonstrate how they find the strength to keep working, to break down social isolation, to recognize chronic emergencies, and to treat their patients like family. We share these experiences here as a source of strength to anyone working within a problematic system.
Finding Compassion in the Dark
by laurel peña

Compassion is as necessary for this job as a strong back. Both get destroyed by repetitive motions.

We call it the “Mike phenomenon” in my paramedic class, after a student who admitted to truly not caring about most of the patients who call when he is trying to sleep. He works 24 hour shifts in a city where heroin and meth have destroyed many of the community’s resources. Burnout is expected and turnover is high. I work in a quiet rural system with a supportive crew. But don’t I also have a moment just after opening my eyes when I can’t find compassion in the dark? We get up, we put our boots on, and we try not to let our patients know. We could have named it after any one of us – he just admitted it first.

EMS serves as the safety net. We pick up the people who have fallen out of the system. We also deal with the consequences of broken communities. When a community can’t deal with the illness of a member, we are called. Sometimes the threshold is high, for instance an elder being cared for at home who suddenly gets sick and needs more care than family can provide. Other times a person’s simple existence seems to be more than a community can deal with. The threshold is lower for the disenfranchised. And sometimes the community itself is so disempowered that it does not have the resources to deal with members in crisis, medical or otherwise.

Out of bed at 3 am, responding to an address my crew knows well. The man is having nightmares and is all out of his psych drugs. All I can do is drive him 2 hours to a hospital that will do absolutely nothing for him. It’s not even the sleep deprivation that gets to me – it’s the futility. The patient called because he was having an emergency, whatever that means to him. My job is to respond. I just wish I could get back into quarters feeling like I had actually done some good.

Someone has to pick up the pieces. It’s what we sign up for when we become EMTs. The problem is that we are so bad at it. It

3 a.m. House Visits
an anonymous interview

Jason is a street medic, Wilderness First Responder, martial artist, & community medical provider in his late 20s; he asked that both his name & certain details be omitted or changed, including the names of people and places.

Jason says he grew up dealing drugs and was friends with dealers. In high school, he was known as a troublemaker. “I did a shit ton of drugs too,” he adds.

Things had changed by the time he returned to his hometown in his 20s, but he liked to stay in contact with old friends. Among them, said Jason, “one of my friends from high school moved into being a big player [in drug trafficking networks].”

“One night, at 3 am my old friend calls me up & tells me he needs help; he tells me he’s just been stabbed.” Jason packed a bag and went immediately to see his friend. Arriving, he found his friend had indeed been stabbed, a clean but nasty wound—the friend had been applying pressure. After the immediate shock, Jason went to work cleaning and stitching up wounds. After finishing, he instructed his friend to “stop drinking,” to change the bandages frequently, and prescribed him some herbal infusions that might help speed the healing process. He proceeded to check on the friend every other night for a couple weeks. Jason says his friend was grateful “when he got injured, healed, & didn’t have to go to the hospital.”

Two weeks later, when this friend called Jason and asked to refer other injured friends to him, Jason said he’d “think on it.” A few days after that, he called his friend back agreeing with the condition that “you only tell people who you trust.”

Since then, Jason has received 7-8 such calls, “lots of knife wounds—to the shoulder, arm, foot—and blunt trauma. No gun wounds thankfully, though I’d like to learn to treat them.”

Over the first few calls, a kind of system emerged. Not knowing many of his late night/early A.M. callers, Jason asked only:
jeopardize their safety by disclosing this information to others without permission.

13. Provide support for them (if they want it) when they get out, if possible. That can look like: making them cookies, letting them crash in your spare room, whatever you want it to look like.

14. Set and maintain boundaries. This helps keep you healthy.

When talking with your friend, use your active listening skills. Don’t give them a fuck ton of advice unless they ask for it. While there are some mental health facilities that offer notfuckedup care, if your friend was incarcerated without their consent I can almost guarantee you that they are dealing with some level of trauma, so don’t make it worse by being a jerk! You don’t have to validate everything they say, but you can listen. Sometimes this is one of the most healing things of all.

is not our fault. We are not given the right tools and information. We are not empowered to make the right decisions. We are trained for the high-threshold calls - the ones where someone is in crisis and their usually sufficient resources are overwhelmed - the car wrecks and heart attacks. This is usually what gets people into the work, and the realization that it is a small percentage of what we do is often what gets people out of it.

“What percentage of the people who call you really need you?” my paramedic instructor asked one day. “I mean, sure, they all need you, but what percentage need the skills you are here to learn?” Ten percent was the number we agreed on.

Most of our calls involve the other two situations: the person the community is unwilling to care for, or the community unable to care for its members. In both cases the power dynamic is unbalanced. EMS forms its own little community and places itself outside and above the communities it serves. If the community is disempowered, or the individual patient disenfranchised from the community, the power dynamic is exaggerated.

The medic leaned over the drunk man on the gurney. “You can’t sleep,” he said. “If I can’t sleep, you can’t sleep.” He rubbed the man’s sternum with his knuckles, a technique to elicit pain used on unresponsive patients. The man groaned and opened his eyes, then closed them again. “Hey,” the medic said, and rubbed him again. When the patient tried to twist away, the medic grabbed a large nasal airway. “If you go to sleep, I’m going to put this up your nose.” One of my classmates was riding along and told this to me later as a funny story.

It’s these calls that we suck at. Often involving chronic health issues, behavioral problems, and/or lack of access to health care, we just don’t like them. It’s especially hard to care for these patients when there is no time to take care of ourselves.

The worst sound I’ve heard is the wail of parents who have been told their child is dead. The worst feeling came right after the code was called and there was nothing more to do. Clean up, get out of the way, go to the next patient. Nausea and vomiting. Probably food poisoning. Listen to the story, start the IV, push the Zofran.
Pretend to care.

How can we change the situation? The change needs to happen on a large scale – in our workplaces, and in the communities we serve. Healing people means healing the world; for instance, making sure everyone has access to good food and emotional well being. It’s not our job to make this happen, but placing my work in the larger context helps me keep going and not settle for picking up the pieces. It reminds me how my activism for forests and salmon relates to what I am doing right now, how the joy of planting a garden is linked to the sorrow and frustration of this chronic illness I am seeing.

Work wherever you can to change the system (perhaps by agitating for community paramedicine programs – but that’s a whole other article). Even more importantly, keep in mind the power structures present in every patient contact, and do your best to overcome them by treating everyone with compassion and respect. We also need to take care of our own minds and bodies and hearts in order to have the energy for compassion.

When I went out dancing after two days of ICU shifts, I felt burdens I hadn’t even been aware of fall away. I danced down the sorrow and frustration and the exhaustion, stomping it down into the floor of the bar. Then I let myself take joy in having a healthy body that could dance, feet that could walk out of the hospital at the end of the day, a heart that could speed up and slow down without concern. I hadn’t realized how cramped and slow I had been feeling, as if taking on the posture of my patients could somehow relieve their pain. I will have to learn how to cultivate joy in an intentional way so I can do this work for the long haul.

their phone bill, or complete some other time sensitive task for them. Sometimes it can be simple as letting their sweetie know where they are.

6. Ask (don’t insist!) if they’d like to be visited. If they don’t feel like being visited, accept their “no.” If it’s a soft no, let them know that it’s okay to change their mind later (like: cool, but if you change your mind, I’d still make time to visit you!).

7. If they’d like to be visited, ask if there’s anything you can bring them to make them more comfortable. Food, a particular blanket or stuffed animal, art supplies, whatever.

8. Call the day of your visit, and give them a time frame to expect you in, and set a limit for how long you will stay (this is healthy, and part of taking care of yourself!). Confirm you will try to bring the things they have requested if that’s part of your agreement.

9. During your visit/over the phone: if your friend feels comfortable discussing it with you, you can ask if they are getting their needs met. Ask if the doctor(s)/orderlies are listening to them and their experiences with their own body. Sometimes the medical “professionals” will ignore what the “patient” is saying about their prior experiences with certain meds, and the results can be disastrously fucked.

10. As a person on the outside, you have the power to advocate for people on the inside. You can call the facility where they are incarcerated and ask them to contact that person’s prior healthcare providers, probation officer, etc. and/or to advocate for them to be supplied with whatever they need to survive. It doesn’t mean it will work, but you can try. It’s better than leaving your friends to rot, yaknow?

11. Of particular note around meds and not getting one’s needs met: oftentimes trans people are denied their hormones while incarcerated, which can exacerbate any existing instability and be really really fucking upsetting.

12. Keep your friend’s incarceration confidential, unless you are given permission to do otherwise! There’s a lot of stigma around mental “illness” diagnoses/incarceration, so make sure you don’t
Imagine a world where the stethoscope connects the ears of one to the sounds of another’s heart and lungs. What the ears hear begins a journey only related to the translation of pressure waves to nerve impulses traveling through axons, cresting action potentials and the release of neurotransmitters. The journey begins at this phrase: “The heart beats.” The listener transforms to student, the student to journeyer.

In March of 2008, our EMS service fluttered into its first recognizable beat, a “lub-dub” generated on its own in a room of fourteen souls. Each affixed a signature below archaic language: “Be it resolved _______ authorizes itself to incorporate, conduct business meetings.” Our purpose was to improve the speed and access to emergency medical services in our town of 40 square miles. At town meeting, we stated we would reduce EMS response time and improve the level of care. In the years prior, EMS response times typically measured 30-45 minutes. The implicit contract bound the squad to the community in an equation that involved funding and improved medical care.

In those early days, I misunderstood the impact of the stethoscope on the listener. I invested time in the minutia of regulations, licensing, equipment, and raising funds, missing signs of vitality.

Few raised in our town pursue college educations. Our town has 70 miles of dirt roads and ten of paved in the rural hills of Vermont. We have no retail businesses. The few local jobs involve house cleaning, construction, and logging. There are almost 900 properties in town yet we have under 400 residents. The neighboring town,
who was only invested in his happiness, was a kind of talisman to him. I was sent home before the visit, so I don’t know how it went with his parents, but I told him he could keep talking to me in his mind, that I’d be his guardian angel, and any time he wanted to hurt himself, he should tell his imaginary me about it instead.

It was all so simple, what I offered. Contact, respect, and kindness. And in the offering, I found some equilibrium for myself. It’s funny, I was in such agony, but what I remember most from those eleven days is the people I reached out to. They remain vivid to me while the pain has long since faded. Because the reaching itself was an act of healing, an act of self-worth and hope. All of us were wounded in the place of bonding, of knowing our wellbeing mattered to those we loved. I left that sterile place, full of sledgehammer drugs, rigid authoritarianism and cheerful disrespect, much stronger than when I came, because I found a way to build a tiny island of what we all needed, however temporary: brief ties of mutual care, that overused, tattered, and resilient word, community.

Our food pantries are full. Buses painted with the white-and-black of Holstein dairy cows transport seniors to one hot meal daily. State law redistributes educational funding to a precise average for each pupil. Problems persist.

My ungloved handshake tells me more about a patient then
respect and room to mourn. Her parents wanted her to live with them when she was released, and the thought made her spiral down toward a desire to die. I told her she didn’t have to go home. She was over 21. She could defy them. She started talking with another inmate who was due to get out around the same time about getting an apartment together.

The Latino artist was the one I talked with longest. He liked to muse out loud about his next suicide attempt, partly defiant attempt to shock, partly his way of shouting pain without betraying vulnerability. Next time, he said, he was going to try an electric hair dryer in the bathtub. Most people reacted with tension, so I joked. In a relaxed and interested tone of voice I’d ask him how he would kill himself with different assortments of objects—an apple, a paper clip and a rubber band? A toothbrush and an envelope? He started seeking me out. When he frightened the art therapist with his comments about scissors, we laughed together. One time he called me aside and showed me a broken plastic knife. He said the staff wouldn’t let him have a dull butter knife, but loaded him up with plastic, which, when broken, had a razor sharp edge.

His parents were due to visit in a few days, and he became increasingly anxious and seemed more serious about self-harm. I told him that being an artist was really important, one of the most important things he could choose to do with his life. I told him his parents had worked that hard so that he would have a choice. I said he needed to tell them that he was an artist, that that was what he wanted to do with his life, not run the family business, and trying to please them was killing him. That they might not support him right away, but they would come around, that they loved him and wanted him to live and be happy.

Then I got him to promise he wouldn’t try to kill or injure himself for the next 48 hours, that he could come to me to talk at any time during that period, but he couldn’t hurt himself. I said it mattered to me that he be OK, and that he live the life he wanted. He tested the seriousness of my intention a little, but saw that I meant it, and I think he was shaking when he agreed. He kept his deal, and I think being asked to make that promise by a stranger

a narrative. Elderly Yankees raised in these hills rarely offer complaint unless one discusses roads, taxes, politics, and modernity. Of the six fingers lost from various hands in the last five years, none were re-attached. Not a Yankee amongst that lot called 911 for assistance.

Those few that do call for help delay dialing 911. They greet our squad with apologies. We hear phrases like: “I know you are so busy, but I didn’t know what else to do, the pain just won’t go away,” or “My doctor told me to call 911, I tried to argue but they said they would call if I didn’t.” My hand feels their thick callouses. My fingertips bounce on strong pulses, crooked fingers squeeze gently around my hand. Uniformly, hands are cold. Loose skin tells me of chronic dehydration. We listen to the story of the recent hours while we examine the house for medications, instructions, and discharge notes from hospitals.

To the body, we attach EKG electrodes. We measure the rhythms of breathing, and electrical heart activity. We put the stethoscope to our ears and then listen precisely to the corners of the chest.

Our emergency medical service has an EKG. Every member carries a stethoscope and the tools for rapid emergency assessments of sick and injured neighbors. In those first years, I begged for money. To raise money for the EKG, I carried it to the houses of cardiac patients. One man gave me 100 one-dollar coins. They sit now in my personal safe, money long replaced by my crisp bank check.

A student must learn to rapidly and accurately read the rhythm on an EKG. The student must know how the medications in a home hint at the medical history of those living there. The student must learn to see the gaps. The absence of medication in our hills may indicate that there is no family doctor. The student must learn to recall medication changes over the years. The patient with new onset seizures who is not taking any medications may be leaving us clues of liver failure, kidney failure, or financial problems.

Our founding document with its antiquated language obscured the names of fourteen students. I read the names of fourteen volunteers—fourteen people willing to rise from a warm bed to help
All of us were there because our most intimate relationships had been damaged, and there was nowhere else to take the intensity of our pain. And the new mother and I were also there because we needed someone else to take care of our children while we caught our breath, and an emergency was the only way to get access to respite parenting.

All of us needed for there to be thickly planted networks of neighborhood healing houses, places of crisis care, with an abundance of peer support, soothing teas, people to listen, and help finding ways to change and mend our relationships or let them go. We needed acknowledgement of the depth and importance of our losses. A friend of mine whose husband had also disappeared said, if they had died, people would bring us casseroles, and not expect us to function, but heartbreak gets no respect.

The first rule of this place we were in was take your meds. The second rule was no physical contact with other patients. It was forbidden to hold a hand or offer a hug. That was my starting point. Part sabotage, part guerrilla theater, I sidled up to my new friends and with exaggeratedly furtive whispers out of the side of my mouth, asked two of them to stand guard because I was going to hug the third. Throughout the day, I got them to join my conspiracy of contact, and it started to knit us into a band.

Rule number three was food may not be brought back from the cafeteria. New Mama couldn’t drag herself out of bed to go to meals. The only thing she could stomach, anyway, was chocolate milk, but the rules required her to go sit among the noisy crowds to get it. I started smuggling pints to her room in my pockets, and got some of the others to help. Each small carton was a declaration of kinship, proof that she was not alone, that we were on her side. Her wan smiles grew wider.

Although I still spent a lot of time sleeping off my exhaustion, and they made us go to silly, busywork activity groups, where we had to circle the stick figure faces that matched our emotional states, I sought out the people I’d connected with and kept trading stories. I validated the Christian girl’s sense of betrayal, said anyone would be upset. You don’t need lithium, I told her, you need

others. I failed to see how we would band together in a fraternity of scholarship. The synaptic bonds between members connecting us to each other, education, and new opportunities. On that founding declaration sits one name with a small heart atop the letter ‘i’ in Jessica, and her mother’s signature just above.

Jessica, home schooled by her mother, learned to write at the age of fourteen. She started reading at eleven. At eighteen, she had never been in a classroom except lessons offered at church on Sundays. She had never taken a test, received a grade, or faced a teacher sitting in a field of desks. This shunning of modern education spans generations. Together, mother and daughter took the first-level EMS course. Jessica, seized by the classroom and the education, learned that any paying job in EMS required a high-school diploma. At twenty-one, she deftly brought home a diploma from the regional high school 20 miles away. She then enrolled in a Massachusetts community college for an associate’s degree and paramedic certificate, a step that made her the first in her family to ever have attended college. Jessica’s mother follows her, earning her nursing degrees one step at a time.

The experience of achievement permeates the squad. One member, a heavy equipment operator, now works full-time at a professional EMS agency an hour west. One young woman earned her bachelors in nursing. Another member who already had a nursing degree and EMT earned a master’s degree in anesthesia. At present, our tiny service has three paramedics.

Of those founding members, only six are still active. Of those six founders, four are now paramedics, one of whom left the area for employment. During the years, members flow in and out as dictated by personal health, economic factors, and family pressures. Our membership level remains consistently at a dozen. Membership in our squad and funding for education has resulted in new careers for 50% of the members. New income, new education, new influences reflect back into our town.

Each person who volunteers with us finds his or her life changed. We, in turn, influence the community. The journey begins with the commitment to make a small change in another’s life.
ways to collectivize them in a world of privatized pain. What I saw all around me were emergencies that never needed to have gone this far. We were all of us imprisoned for lack of community.

There was the young, white, devoutly evangelical Christian woman who had become pregnant while at college, whose lover was East Indian, and whose mother, also devout, had forced her to have an abortion, which they both believed was a mortal sin. She was brought home to live with her parents and forbidden to ever mention the pregnancy or the abortion again. Her mother’s racism and fear of scandal in their congregation had taken precedence over what she’d always been told was God’s irrevocable law. Imposed silence and the spiritual abyss that opened up inside of her sent her reeling into a so-called psychotic break. When I met her, she was loaded to the gills with lithium, and unable to cry. She needed help to integrate the immense moral contradictions, grieve her lost child, and build a sense of sovereignty from the ruins of what felt like the ultimate violation.

There was the young Latino man, a first generation child of immigrant parents who worked themselves ragged to build a business he could inherit, their whole lives pinned on making him a successful small businessman or even a professional. But he was an artist, and the weight of their expectation, their complete incomprehension of his passion for applying inks to paper, and his inability to disappoint them and tell them his truth, felt like such a tiny, no-exit room to him that he’d attempted suicide five times. The staff was jittery around him, eyeing him sideways, and he liked to yank their chains with offhand comments about sudden death.

And finally, the new mother, bedridden with post-partum depression, made deeper and more complex by her husband’s affair while she was pregnant. On top of which, on September 10th he’d been on a business trip to New York, and they had stayed up half the night talking on the phone, trying to mend, so he overslept and missed his flight, which ended up hijacked and crashed in a field in Pennsylvania. In the face of massive death, personal betrayals had seemed suddenly small, but still, she couldn’t get out from under her heavy heart.

For us, that commitment is to measure vital signs, understand medical histories, and treat what we can while waiting for an ambulance to come from two towns away. We treat trauma, cardiac crisis, circulatory crisis, respiratory crisis, neurological crisis, and illness. Yet it is through education and opportunity that our volunteers most give back to our neighbors.

Jessica and all of the others can describe the neurological pathways of hearing and the anatomy of the ear. Each of them can draw a heart; illustrate the flow of blood, the major cardiac vessels, the electrical pathways. Most members, paramedic or not, can perform a quick interpretation of an EKG strip. When we listen to the four corners of a chest with our stethoscopes, we have a robust understanding of the people we serve. Through the veneer of poverty, isolation, and cultural pride we hear the lub-dub of a beating heart that we endeavor to protect.
June, 2002. I was in the depths of a very bad breakup and I wasn't eating or sleeping much. Two months earlier, my partner of six years had left without saying goodbye, committing a series of betrayals on his way out that devastated my trust in others and in my own judgment. I felt desperate to escape my overwhelming emotional pain. I'd just returned from a major academic conference, where I'd had two seizures in a single night, each time waking to ask where he was, my missing husband. One nurse said doubtfully that I had no ring and no tan line. In the two sunny months since his departure, it had faded.

Now I was back home and it was late at night and I couldn't feel my feet. I didn't know what was happening to me, didn't know my shallow breathing had deprived my extremities of oxygen, so I went to the ER, thinking about my numbed arches and toes, not my broken heart. I don't really remember the full sequence of events. I was exhausted, it was one in the morning, and they had only one option on offer. Either I got in an ambulance and went to a suburban psych ward, or I went home to the same hyperventilation that had made my legs vanish out from under me, back to single parenting through alternating bloody anguish and black despair. I wanted something, anything to change, and I was too tired to think, so I let them put me in the ambulance. When I got to the facility, they said I had to take a massive dose of Remeron or go back home. I slept for three days, the heavy hand of the medication forcing my eyelids back down each time I struggled toward alertness.

But on Day 4, I woke up and started talking to my neighbors, and because I'm an organizer and a healer, I listened to their stories and I organized, doing what I do with all my struggles, trying to find
circumstances. Many people fall apart from much less.

It is easier to be compassionate to people when you know what hell they’ve been through, even when they are behaving poorly and may even be heaping abuse upon you as you try to help them.

I’ve seen people spend years, maybe even decades, digging themselves into a deep, dark pit of addiction and homelessness and criminality and sickness, decide they want something better for themselves and finally change; seemingly moving on without looking back.

There’s people nobody believed were capable of changing who proved everyone wrong by not letting the tragedies of their past taint and define their present and future. These people inspire me to continue rooting for the underdog.

I grew up and was born in a small town. Coming from that background, I like the pace of living here. Still, without the riveting night life provided for me down at the fire hall I don’t think I would be as happy here. There really aren’t many other places to go.

Monday: Once a month; old men mumble the well worn verse of Robert’s Rules. I can’t understand what the president is saying more then half the time.

Thursdays: In-house trainings; the juniors try to show off how much they know.

“T’ll kick all your asses once I’ve been in the Marines four years!” says one scrawny 19 year old. The conversation digresses to a slew of slurs that I am embarrassed to say I didn’t stand up to.

This week we deployed the porta-pond, I’m repeatedly frustrated that we don’t ever practice medical skills.

There have only been three other active EMTs in the company since I’ve been here. The others have been out of commission with injuries. We get a little over a call a day and I’m still not cleared to run on my own yet.

Sam was the head of EMS when I got here and hasn’t said a word of encouragement to me yet. We have ridden calls where the only words she’s spoken have been direct answers to my questions. She’s really warm to kids, but I don’t know what it’s like to be her. Nor do I know how to work with her...

The other woman Jess is new to town too, also unemployed. She’s been the main person to teach me much of anything. I’ve been really impressed by her bedside manner; she shoots the shit with everyone including the cops...

Driving down the street, a cop went by. I think it was Harry. My boss, chief of the EMS is a cop. Am I supposed to wave? Am I expected to wave at the other cops? At the Fire department Christmas party they wanted to thank all the police on the department. So they gave them donut seeds (Cheerios). Weird... I don’t think I get to make cop jokes yet.

For me it’s all been a lesson in passing. I have a lot of privilege and am used to being read as white, male, and straight. But I’m queer, Jewish, and an Anarchist. More importantly in this case
I’m an outsider. Sometimes it feels like I have a slightly secret identity. Running from a house meeting to a call on the ambulance; my double life. I want to fit in, to gain the respectability, local knowledge, and cultural currency that has already proven useful for our campaigns. I want the damn credit on my taxes... even if it means hanging out with the “Good Ol’ Boys.”

Most importantly though, I’m volunteering for the experience. The concrete medical skills so that I can contribute to the community and ultimately help people. Also I am learning the nuances of local culture, how folks relate, what they struggle with.

“If it wasn’t for the gas points,” the Chief said, “I probably wouldn’t be able to keep driving my truck.” A good portion of the company, many of who have lived here and been part of the community their whole lives are either unemployed or work at the factory. Multiple people work third shift.

As Earth Firsters and Radicals in general we are often faced with the dilemma of when no-compromise politics means more diverse, non-Anarchist communities. How and what do we let slide without totally selling out? Being vegan while people talk about hunting? A feminist where men and women are demeaning women? Queer in a place where that might be just a swear word?

All of this exists in a context where I want the people I am working with to respect me and teach me the lifesaving skills they volunteer to help their community.

Learning where change is possible, where to push and where not to...

Justifying these compromises; promising myself that once I earn respect I will challenge people in ways that are effective. Is that what it feels like to work within the system?

On the scene of an accident the patient’s blood pressure jumps 10 points as the State Trooper comes in to get a statement.

Even while learning to do the medical skills better and faster, I can return to what we value as Street Medics: compassionate care, communicating with our patients, explaining what we are doing as we do it...

Riding with a patient from a different accident to the hos-

cult as it may be at times, we try to treat them all with unconditional positive regard. We are paid, to some extent, to root for the underdog. We take our role seriously: everyone needs an advocate.

“We are all in the gutter, but some of us are looking at the stars.”
— Oscar Wilde

We all have low-points in our lives. Many of us have had periods of extreme depression or excessive drinking due to whatever crisis we were in (a breakup, the death of a loved one, financial woes, etc). Most of us can tap into our personal and social resources to get through it and move on. But not everybody does: some people enter a vicious cycle of crippling self-loathing and self-destruction that doesn’t end for a long time, if it ends at all. Some people seemingly had no chance to begin with.

Imagine, for instance, that as a child, your parents passed you around to provide sexual favors to their “friends” in exchange for money or drugs. Imagine if you grew up living in motel rooms watching your prostitute mother have sex with strange men; or going on drug-fueled crime sprees with your father instead of going to school. Imagine if, as a child, your punishment for mistakes was being burned with cigarettes.

Hopefully, you can imagine how enduring such experiences might lead somebody to having little confidence in or allegiance to a society that maybe they never really understood or fit in with; and how those experiences might cause somebody to mask their emotional scars with substance abuse and antisocial behavior. You can also, I hope, imagine how carrying those experiences around with you might seriously interfere with your ability to be a functional person by societal standards.

“If you’re going through hell, keep going.” — Winston Churchill

There’s only so much that any person can endure. Each of us has a breaking point. I believe the horrors some of the people I’ve described have suffered could cause any of us to end up in similar
Rooting for the Underdog
by Brenton Gicker

Brenton Gicker has worked for White Bird Clinic (www.whitebirdclinic.org) for 8 years and CAHOOTS for 5 years. His views do not represent those of White Bird Clinic or CAHOOTS. He can be reached at beg977@yahoo.com.

“Men make their own history, but they do not make it as they please; they do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted from the past.” — Karl Marx

Working for CAHOOTS (Crisis Assistance Helping Out On The Streets, a program of White Bird Clinic) people often ask how we are able to tolerate the bad behavior of some of our clients and still provide them with respect, patience, and compassion. They are usually referring to homeless alcoholics and other addicts we serve, not necessarily the many other people we assist with their medical and emotional needs.

They are referring to our “problem clients”; homeless people who are chronically intoxicated and belligerent. These aren’t necessarily people who are temporarily homeless while they work through bad circumstances, such as a foreclosure, a disabling accident, bankruptcy from hospital bills, etc (though many homeless do fall under that category). These aren’t necessarily people who are homeless as a result of mental illness (though many homeless fall under that category too).

These “problem clients” are the ones who “give the homeless a bad name”; the one’s who “choose” to be homeless (or, more accurately, have resigned themselves to it); the drunks and aggressive panhandlers; the one’s you find passed out on the lawn or fighting in the alley; the one’s who spend their SSI checks on liquor when they haven’t eaten in days.

Working on CAHOOTS, we know these people well. Diffi-
We were just two friends bumping into each other commuting home from nursing school and medical school, stopping to help someone who needed it. Yet everything we did was from our street medic training, not our professional lives. We didn’t diagnose or fix or make much progress, still though we made sure he knew that he mattered to us. We don’t think we dramatically altered the course of anyone’s life through this moment of convergence. The act of stopping and making connection with each other, our patient, and the third bystander was fundamental to our commitment as medics, affirming the fundamental importance of taking the time to prioritize caring for one another.

Medicking Isolation
by Taiga

Taiga is a member of the Rosehip Medics who volunteers as an EMT in rural New England.

When my pager screeched on the icy winter’s afternoon, I recognized the address. It was a nondescript call: 70 year old male feeling ill; no specifics. I first heard about this address over a year ago, when I joined the rural volunteer ambulance in this tiny northern New England town. The old man who lived there was known as a “frequent flyer,” one who regularly called 911 for minor to nonexistent ailments. Of all the regular patients in this economically depressed, elderly community, Rick had a reputation for calling us out of loneliness or boredom. I’d been warned that I’d end up at his place sooner or later.

Our ambulance service is a one-truck operation covering two rural towns in one of New England’s poorest counties. It is unstaffed and volunteer-run, with crew members carrying pagers and responding to calls whenever they are able. In the time I lived there, the crew had nine members who responded regularly – a handful of others responding every once in a while and showing up to our firehouse meetings to grumble and debate the service’s operations. We are far enough from definitive care, along bad enough dirt roads, that staff at the nearest hospital call our town, “where cardiac patients go to die.”

This is a part of New England where self-sufficiency is prized, where many families have lived for generations, and where people only call 911 for critical emergencies. As I was warned when I joined the crew, we don’t get small calls. So Rick was the exception: the old man who regularly calls us for what seems like nothing. As I pulled on boots, jumped in the car and edged down the icy road, I hoped we weren’t all heading out in this weather to a false alarm.

Katherine, an experienced crew member, radioed the fire
station that we were responding, and I headed straight to the scene while she picked up the ambulance. Mary, another new EMT on the crew, met me on scene, outside a dilapidated farmhouse. Paint peeled from the clapboards, and the torn screen door was patched with plastic and plywood. Inside, a small, gray-haired man sat in a worn brown armchair. The living room was faded and mostly empty, with dirty patches of carpet scattered across a sagging floor, but Rick grinned at us from his enveloping seat as we introduced ourselves.

“Hi Rick, I’m Mary, remember me from last time? Now what’s going on today?” Mary asked, as I set jump kit and oxygen tank on the floor.

“Well, I got up to go in the other room, and I didn’t feel good, and I sat back down here...” was the vague reply.

“You didn’t feel good? Can you tell me more about that?” Mary questioned.

“I just didn’t feel good. I don’t know. I can’t describe it.”

“And it happened when you stood up?”

“Well yeah, I got up to go in there, but I felt sick, so I sat back down.”

“Are you having any trouble breathing? Did you feel short of breath at all?”

“No, none of that...”

“Did you feel dizzy? Or nauseous?”

“No, no, nothing like that.”

“Did you lose your balance? Or have any chest pain?”

“No...”

“But you didn’t feel good.”

“Yeah, I felt funny.”

Mary sighed at the ambiguous answer.

“Okay, is it alright with you if I take your vitals?” I asked, lifting my blood pressure cuff and pulse oximeter.

“Sure...” He extended his arm willingly, from many instances of practice. When his vitals were normal and a patient history yielded no clues, Mary and I looked at each other in confusion. We asked more questions, but Rick appeared alert and oriented, showed
O\nIVER: I could see the situation from halfway across the Steel Bridge- someone is on the ground, people are with them, but something is wrong. I biked carefully, my heart going faster, thinking about how I will approach this scene. I slowed down, telling myself to focus on the bridge and not crash my bike trying to see ahead. I pulled up and immediately saw Annah and relaxed. Annah and I have sat through a hundred meetings and half a dozen street medic trainings together. We’ve walked in the streets of tense protests together. We call each other for medical advice, each of us with a different set of clinical skills. We are occasional medic buddies, friends, and we can work together under any stressful circumstances. I knew whatever intervention had already happened was good; there was a plan. Instead of rolling up to a crisis I had rolled into a trusted friend’s plan to help a stranger in need. What more could a street medic want?

The patient was not talking, but he had been. Annah had helped him into rescue position, another passerby stopped to help; it was just a waiting and watching game. No one had called 911 or wanted to. We settled in and waited, watching the patient breathe through his many layers of clothes, bundled up against a cold dry day. We would check his level of responsiveness every few minutes and we kept our distance. We stayed calm, smiled at each other, and didn’t need to say, “I’m so glad you’re here.” The other bystander gathered that we knew each other and knew some first aid. Our instant team expanded to include him, and our ease with each other and the situation kept him calm.

Slowly the person on the ground responded to our words with grunts, then slurred words: “Keep off me! Who the fuck are you?” We gave him even more space, and slowly he calmed down and we came closer to chat. We exchanged names and explained why we were there.

We learned that this was not his first seizure.
He had just shot up with friends.
Where are the friends?
The friends had run off.
A Tale of Accidental Medic Buddies
by Annah and Oliver

Annah and Oliver are members of the Rosehip Medic Collective in the Bridge City.

Annah: As I biked across the Steel Bridge, I saw a standing figure beside someone sprawled down on the ground over two cement steps. They did not look in good shape. I stopped to check in with the bystander to find out what was going on and if he wanted any help. He did.

Collapsed haphazardly on shallow steps was a person I presumed houseless, his belongings in a backpack 5 feet away, not aware of the two strangers around him. He was alone except for the other biker who stopped before me. He was breathing. I could see his chest rising and falling. He did not respond when I hit the ground next to him with my palm and announced my presence loudly. I did it again and he responded with a moan. I spoke with the other person who stopped, a social worker with no medical background. We decided in that moment not to call 911. With my brief assessment I didn’t sense any immediate threat to life, and wanted to wait a bit more to see if the man lying on the sidewalk would come to. Maybe he had a seizure? Maybe he was high? I didn’t know. I told the man my name and that I was a medic and would like to help him. He appeared dazed, still lying there, and replied by moaning, and almost incoherently asking me several times who I was.

At that point I called Oliver’s phone for medic buddy advice and he did not pick up. Serendipitously, two minutes later Oliver appeared, crossing the Steel Bridge on his bike. He pulled over, and we said hi like we were planning this all along. I filled him in on what had happened so far. I was immensely relieved to have a medic buddy I knew and trusted, and felt ready to continue assessing the man on the ground who may or may not need emergency care.
Section Two: Working Outside the System

In the first section of this zine we presented stories of care workers attempting to act in accordance with their radical roots and in line with their commitment to care for and validate each patient. Through resiliency, creativity, and communication, they manage to build networks of support or temporary spaces for alternative approaches to care.

The authors of the following stories express similar motivations, and employ different means and roles; in particular the roles of patient and medic are not always so distinct. Patients provide support to other patients, and medical providers in need turn to one another for help in dealing with the stress and grief of witnessing illness and death. When emergencies become commonplace, apathy, isolation, and chronic illness all in turn become emergencies.

We are all responsible for bearing witness. Some of us reabsorb the trauma and ignore its effects on the body and mind—including burnout, chronic illness, PTSD, and anxiety. There are also models for processing trauma as a form of resistance. Connecting with others and letting people know they are seen and that they matter is strong medicine in and of itself. Can we validate each other’s present truth while holding onto our boundaries and letting go of other people’s baggage? Holding space cannot overshadow the place of urgent medical needs and care, yet it can and should exist alongside it in larger ways than it typically does.

The stories that follow are about aiding others simply because care is warranted. These approaches, anchored in respect for individual autonomy and mutuality, are revolutionary in that they affirm self worth and restore hope. Through what Aurora Levins Morales calls ‘brief ties of mutual care’ we can build longer bridges and create supports flexible enough to hold us together. Our stories of reaching out to give and receive help offers us glimpses of successful communities of care.

Treat ‘em Like Family
an edited interview with Charles

TAIGA: You said in your email that this Anthology corresponds with some work you’re doing. But what are you doing?

CHARLES: I’m attending Paramedic school. And for almost 9 years I’ve been on the local fire department as an on-call and then part-time volunteer. I guess part of going to paramedic school has forced me to reevaluate all the steps, all the medical and legal issues, the way we’re supposed to present ourselves and talk and the kind of information we need to give them. And it’s also forced me to reflect on the behavior of my coworkers while we’re on the truck.

Five years ago I worked as non-emergency transport. Grandma fell down at the nursing home, and 9-1-1 ambulance brought her into the hospital, but then they would call us to bring her back home. Or Uncle Phil got a dialysis appointment, but he’s got no legs—his diabetes has taken his legs in addition to his kidney. So we pick him up, take him to his appointment, and after his appointment, they call us and we take him home.

Between these two settings, 9-1-1 and a non-emergency company, I interact with a lot of different patients in a lot of different ways. I work in a small town where people never see beyond the horizon. People don’t really understand radical politics, and radical thinking, and I find myself on more than one occasion wanting to, you know, you just take this herb or that herb, soap... ‘That cut’s pretty bad, but you don’t need stitches; you soak it in a strong tea of oregon grape leaves and calendula flower. It’ll close up, it won’t hurt, it won’t scar, it’ll heal up real good.’ But I can’t say that, I have to go through all the motions.

But every once in a while my professionalism flips. One case that I’ll probably never forget was a 14 year old girl who had been fighting with her mother. And over the course of a 45 minute trip where I picked her up at one hospital and took her to the children’s hospital in Cleveland, I gave her information that no one’s
ever given her. ‘Why am I going to a children’s hospital?’ No one ever bothered to explain that to her. ‘What is this diagnosis that’s laid on me?’ No one’s ever bothered to explain that to her. ‘Is magic real? Can I trust my intuition? Is there a bigger world out there that I can’t see? I feel these things going on inside my mind and I’m really angry about them, but I don’t necessarily feel that they’re really me.’

And I would find myself saying, ‘I really shouldn’t be talking to you about this cause I could get in a lot of trouble. I’m not supposed to talk about magic. We’re not supposed to talk about feelings.’

‘No no—no one’s ever told me this stuff. I always thought it was a put-down that they sent me to a children’s hospital. No one ever told me I’m not done growing yet. Explained to me what it means to be a child biologically.’

I can still see her face when I picked her up; walked into the isolation room there in the hospital, there in the psych room where there’s no cabinets, there’s no chairs; there’s just a bed. She was sitting there, curled up in a ball with her dyed red and black hair hanging in her eyes, and she looked at me like ‘oh god—it’s another one.’ And by the time I dropped her off 45 minutes later, she was beaming; she was radiant. Because here’s this random-ass guy who got it. I didn’t treat her like a child; I treated her like family. I talked to her in the way that I wanted someone to talk to me when I was 14 and I didn’t have a clue what was going on in the world around me, and why these things were happening and why people were reacting to me the way they were reacting to me, and why my parents acted the way they were acting. I wanted someone to sit down with me, and say, ‘it’s okay. It’s really confusing right now, but it will get better.’

Bringing street medics and radical thought to patient advocacy and actually explaining [care] to patients, has had on more than one occasion a really positive impact working with drug addicts and the chronically poor, the geriatric patients and the psych patients. I always end up with the psych patients, the crazy people and the old people. They’re always like, ‘oh give those to Charles; he seems to handle them better.’ Or homeless people—‘he seems to handle them
better’—cause I treat them like human beings and they don’t know how to do that anymore. They’re all burned out on it. I treat them all like they’re my family.

You know, I picked this one guy up at the rest stop one time. He was a traveler he had left one gathering and he was on his way up to California. He wasn’t homeless, he was just without a home. You understand that there’s a difference. They couldn’t grasp the notion of someone not having a home. They didn’t know what that means. As soon as I saw the guy I was like ‘this guy’s not homeless; he just doesn’t live here. He doesn’t have a house; he’s a traveler, yeah I’ve got that.’ They were like, ‘we don’t know what to do with him.’ The security guard up at the hospital gave him a jacket and I gave him 20 bucks. We found him a place to stay at a halfway house shelter for the night. And the next day I happened to be in town, and saw him out on the highway and he was catching out. There was nothing wrong with him. He was just moving through the world in his own way and somebody got worried. Wanted to make this big thing out of it. This semi-policing is the way EMS in general is set up right now.

*TAIGA: I’m interested in a couple things you said. Just now you used the term ‘policing’ of people’s lives and identities through EMS. That’s a great use of that word. I wonder if you could talk more about that word, how you see that working...*

*CHARLES: Well, on the one hand the way the city is set up right now, and the way EMS in general is set up. The police come when things are really ugly and really angry. They break things, they break people, they break doors, whatever. And then they call us to come and pick up the pieces. Especially when they’re confused. They always say ‘you need to either come with us or go with the squad.’ On only one occasion has anyone ever said they’ll go with the police. Every other time they go with us. It’s because the cops don’t want to deal with them. My department, the full time staff in my department are union. The police are also union. These guys are all friends. So often as not, the firemen act a lot like the police.

advocacy is everything and we have to remember that. We have to be a better patient advocate. I need that to inform what I do on the truck, it’s what it’s all about. It’s not about the bottom line or the billing. It’s not about getting to the next call and it’s not about good trauma. It’s just about our patients. And remembering that it’s about our patients. Whether that’s at a protest or at a bottom line bar or a 4th of July festival or a nursing home, they all deserve our full attention.

Anybody that makes a transition from Street Medic to emergency or public safety should know that it’s a hard crossover. I’m the strangest person most of these people have ever met. Which is weird because I’m not the strangest person I’ve ever met. If they were to go to a protest, a big summit and work at one of the clinics and had to work with some of the community, they’d run out of there screaming. They don’t know how to even begin to interact with those people. It took me a little while at the G20 as a street medic to get back into remembering to be particular about pronouns and not making assumptions about anything. It’s a different world.

*TAIGA: Do you have anything else you’d like to talk about or suggest that we think about?*

*CHARLES: Don’t let the bastards grind you down. I know that’s a really overused phrase. I know what I know, I think what I think, I feel what I feel. Being surrounded by people who don’t, it’s just so hard sometimes to remember who I am when I’m submerged in that climate.

Don’t be afraid to stand up to the Assistant Warden at the prison. Tell him he’s not in charge. Tell him, “I’m not a prisoner and I’m not your employee, you can’t talk to me like that.” Don’t be afraid to tell the family “I’m sorry but you can’t let Grandpa go on like this. He’s gonna fall and you’re not going to be there, and you’re going to have a dead grandpa.” I don’t care how mad they get. It’s the patient I’m most concerned with. It’s not the bystander or the family’s feelings when they don’t want to hear what I have to say.
They understand what they understand: heterosexual, normalized, mainstream, thought process. This is what’s right. Anything that doesn’t fit inside of that, they don’t get. You’re weird, you’re a freak, whatever. We don’t have a lot of transgender people living here or really a lot of GLBT people in general. We have a couple of gay guys and a couple of lesbians in town, but not many. We’re a very small town. We had a woman who was working on the squad who was openly lesbian; she didn’t last very long. I actually ran into her today and she’s getting along extremely well but it’s really sad. She basically got kicked out of the department.

What it is, is they want things to be simple. And if it’s not simple it’s too complicated. And that makes them upset. We have a lot of military veterans in the department. They don’t like having their buttons pushed, and if someone gets in their face, they respond the way the police do. I don’t know. I don’t know if I’m answering your question. A lot of it upsets me. The way I see these guys treat people.

AIGA: I’m curious if you have things that you would say to other people working on ambulances in relatively small towns or working within EMS and feeling frustrated.

CHARLES: Yeah I have a big one. Something that has haunted me nine years. Every person I pick up is a member of my family—every single person I pick up. I don’t care if they’re a junkie. I don’t care if the others are saying, it’s her again...we’re so sick of picking her up. This is the 15th time. They’re my family. I love them in a way that isn’t possible for a lot of these guys because they can’t get past the judgmental stage.

We picked up this guy the other night with an overdose. He was an IV drug user and he got a hold of some morphine pills and overdosed on them. The performance of the paramedics on duty was lackluster at best. Their attitude was as apathetic as I have ever seen. And he died because it wasn’t a top quality performance on their part. They weren’t fighting for this guy in a significant way.
I’ve seen a lot of people die. I never ever imagined that my life would be filled with death in that way that it has become, and every single one of them sticks with me. I remember asking the question seven or eight years ago: what do you do with the stress and the grief and the sadness of watching somebody die? Where do you put it? And I’m asking this question of nurses and doctors and paramedics, some of them have been doing it longer than I’ve been alive. And I haven’t found any here (and very few anywhere else) who have told me any different than their standard answer which is: oh, it doesn’t involve me; I don’t feel anything; I don’t have any emotion when it comes to this stuff. It’s just part of the job; just part of what I do. And for a long time I lived with that. I went with that. And it didn’t work so well. It haunted me.

I evaluated a lot of really negative, personally destructive behaviors on my part. And I was talking to a [street medic friend] about it, ‘cause I had a series of really bad calls. I asked, ‘How do you deal with it? These guys say it doesn’t affect them.’ And she said, ‘the minute it doesn’t affect you, you need to get out of this business; the minute that they’re no longer human and you think that they’ve become meat bags, you’re doing it for the wrong reasons.”

And that made it better. I started to realize that most of the guys who said, ‘oh this doesn’t bother me’, had fasting blood sugars of 400-500; they weighed 350 lbs; they drank too much; they were on their fourth marriage; they smoked too much. They had all the classic symptoms of repressed grief. They just didn’t admit it or accept it. They mistakenly assumed that the natural coping mechanism of grief is compartmentalizing.

I get it, because I can do that with the best of them. Rolling up on six dead bodies in a van on the highway and then stopping to get a cup of coffee on the way home afterward. That’s all fine and good. But it was only when I looked back with clear eyes: it wasn’t eight hours later, me and two guys that were on the truck that night were at each other’s throats screaming at each other. Because we had witnessed a horrendous thing. Six people were dead.

Things were said. “They were immigrants from another country, they were computer programmers, they weren’t from here, they were passing through town, it was a freak accident, now they’re all dead, let’s just go on with our day.” And I was like, wait a minute, it is okay, and it has to be okay to stop and recognize that we witness horrible things. We are the keepers of our town’s secrets. We need to recognize that we are the ones who know these deep dark secrets, honor those secrets I guess, and honor the passing.

There was a little old lady. We barely got to the door, got her on the cot, got her down to the truck, and then she died. Then she stopped breathing. And I can’t tell you how many times they die once we get them on the cot, or once we get them in an ambulance.

Talking with [the same friend] about this, because she’s one of the few people I can connect with in this way, I realized that our job is sometimes not to save life. Because like [another friend] told me once when I ran up on a guy full of bullet holes: “sometimes when they fall, if they were to fall backwards on the best surgical sheet surrounded by the best surgeons in the world, they’re still gonna die.” So we can’t save them all, we can’t even save most of them. The ones who are gonna die are gonna die. Our job is bearing witness. And we have to be okay with that. We have to accept the fact that we’re not gonna save them all but at the same time give it everything we’ve got every single time. We can’t be thinking, ‘oh yeah, he’s just an IV drug user - who cares?’ or ‘we have to try harder for this one ‘cause they’re a kid.’ Everyone is somebody’s child. Everyone is family and we have to treat them like family.

And sometimes I do this. Sometimes I remember this and I act accordingly. Other days I can’t. On my best days I do, but it’s constant work.

Every life is sacred. I don’t care if they’re an IV drug user, or a 98 year old grandmother, or a four-year old child, or the 54 year old nurse. Every single one of them is a unique opportunity, a unique expression of life. We have to recognize that specialness, honor that uniqueness. You have to be okay with that. Give it everything you’ve got, but accept that sometimes there’s just not enough to give. Because sometimes they’re going to die.

One woman, her heart had completely died I guess; I don’t know what happened, but she stopped breathing on her cot. Her