

CHICAGO ACTION MEDICAL

# STREET MEDIC HANDBOOK

CONTAINING A LARGE COLLECTION OF  
HIGHLY ESTEEMED FIRST AID TIPS  
AND TRICKS, NAMELY:

**SPREADING CALM,**

**PATIENT ASSESSMENT,**

**NOT DYING,**

**BUDDY ROLES**

SELECTED BY EXPERIENCED STREET MEDICS

FOR THE USE OF PUBLICANS

AND PROTESTERS IN GENERAL,

ADAPTED FROM ROSEHIP MEDIC COLLECTIVE AND OTHER SOURCES

---

**EDITED BY E. MACK.**

---

PRICE ONE SHILLING

---

CHICAGO: TYPESET BY E. MACK,  
ROOSEVELT ROAD.



# About this Handbook

December 2013

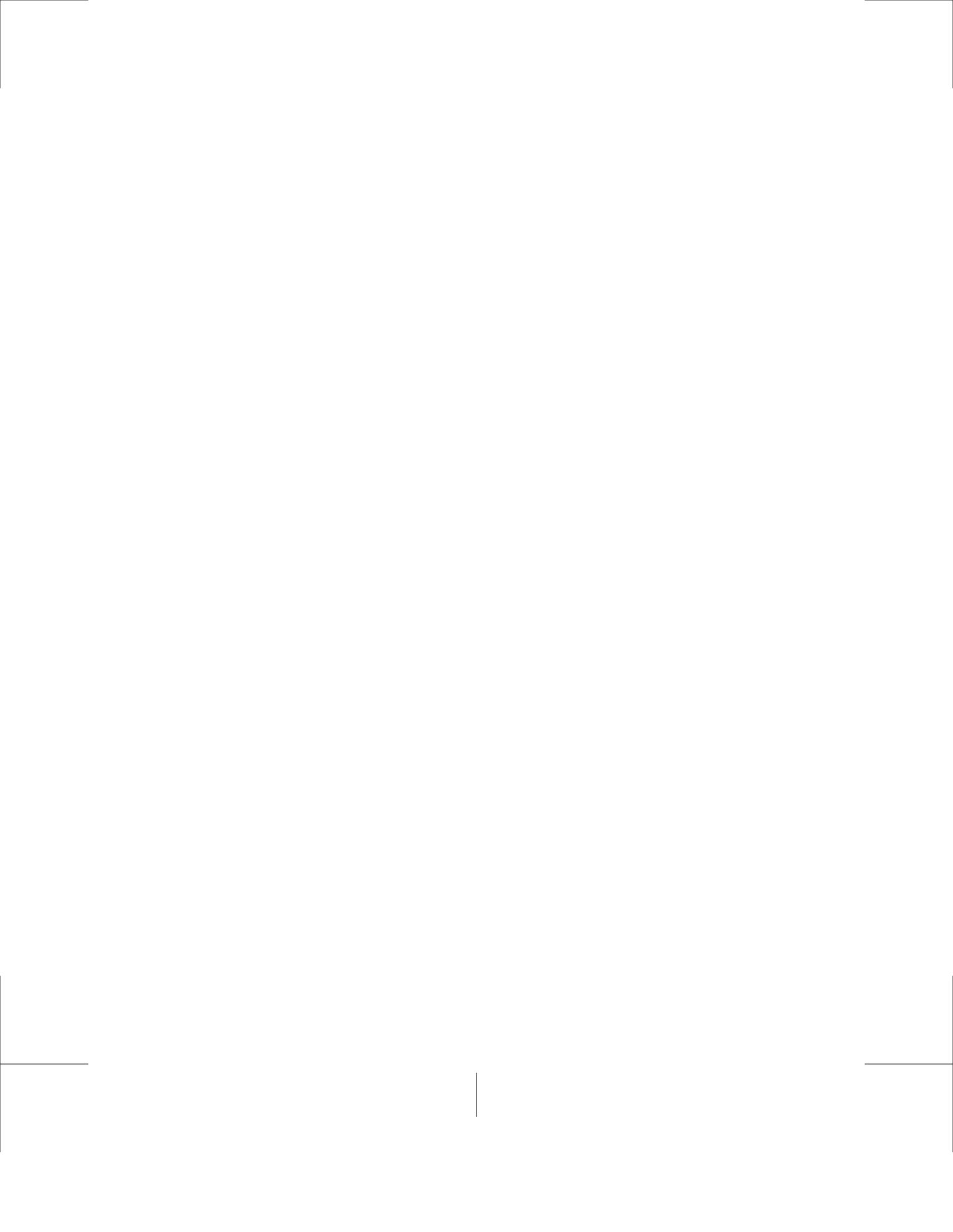
This is the second edition of our handbook. In future editions we hope to expand and clarify our teaching style's emphasis of prevention-based care.

This handbook is written using the pronouns he, him, his, she, her, and hers. While we recognize that this usage excludes other genders, we chose this approach in an effort to make the handbook accessible to people whose first language is not English.

You can email us at [chicagoactionmedical@riseup.net](mailto:chicagoactionmedical@riseup.net). We look forward to hearing your suggestions, questions, and criticisms about this handbook.

Typeset by Esther Mack in  
L<sup>A</sup>T<sub>E</sub>X- Memoir

<b>1 Introduction</b>	<b>1</b>	Fainting . . . . .	43
What are street medics? . . . . .	1	Abdominal illnesses . . . . .	43
Why medic? . . . . .	4	Diabetes . . . . .	44
<b>2 Before You Hit The Streets</b>	<b>6</b>	<b>8 Environmental Health</b>	<b>46</b>
Prevention by self-care . . . . .	6	Dehydration . . . . .	46
Medic fashions and kits . . . . .	8	Heat . . . . .	46
Buddies . . . . .	8	Not enough heat . . . . .	47
Ethical dilemmas . . . . .	9	<b>9 Police</b>	<b>49</b>
<b>3 Streetside Manner</b>	<b>11</b>	Rumor control . . . . .	49
Principles . . . . .	11	Police tactics . . . . .	49
Legal aspects . . . . .	13	Shit! We're gonna get arrested! . . . . .	55
EMS and Police . . . . .	15	Handcuff injuries . . . . .	59
<b>4 Scene Survey</b>	<b>18</b>	<b>10 Herbal First Aid and Aftercare</b>	<b>65</b>
Triage . . . . .	20	Herbalism and street medicine . . . . .	65
Team Roles . . . . .	20	Preparations . . . . .	67
<b>5 Initial and Secondary Assessment</b>	<b>22</b>	<b>11 Mobilizations</b>	<b>68</b>
Initial assessment . . . . .	22	Public health . . . . .	68
Secondary assessment . . . . .	29	Plugging in . . . . .	70
Beyond assessment . . . . .	34	<b>A Cool things</b>	<b>73</b>
<b>6 Trauma</b>	<b>35</b>	Kits . . . . .	73
Wounds . . . . .	35	Code of Conduct . . . . .	76
Burns . . . . .	35	When Your Affinity Group Goes to Jail . . . . .	79
Musculoskeletal injuries . . . . .	36	<b>B Resources</b>	<b>83</b>
Head trauma . . . . .	37	Resource Lists for Activists . . . . .	83
<b>7 Illness</b>	<b>40</b>	Learn More . . . . .	85
Seizures . . . . .	40		
Asthma . . . . .	42		



# 1 Introduction

*Fight the power; do no harm*

National first aid systems in most of the world came out of the medical corps of popular and liberation movements of the 1950s and 1960s. In the United States, street medics were operating and training in Mississippi and New York City at least four years before the first statewide EMS program was established in Maryland.

## WHAT ARE STREET MEDICS?

Street medics are an international informal community of people who have provided medical support during the last half-century, at protests, direct actions, uprisings, and natural disasters that are complicated by police or military targeting of survivors. Becoming a member of the street medic community involves completing a 20-28 hour training (or a bridge training for medical professionals), working at an action as the buddy of an experienced street medic, and maintaining relationships in the street medic community. Street medics:

- Establish safety with preparedness and prevention.
- Maintain safety with ethical, dependable

care.

- Establish safety for the sick or injured person.
- Provide first aid and education to injured people until they recover or reach further care.
- Rehumanize situations after brutality and burnout so that communities feel safe again.

Street medics have varying levels of training. They are expected to keep their skills current by pursuing continuing education and maintaining involvement in action medical response. Many street medics identify as anarchists or radicals, and these values influence the street medic approach.

## A BRIEF HISTORY OF STREET MEDICS AND ACTION MEDICAL

In 1963, the Medical Committee for Civil Rights formed an integrated affinity group of medical professionals and joined the March On Washington to demand civil rights for black Americans. As the March wound down, MCCR transitioned into a standing group that offered health support to Civil Rights workers at Mississippi Freedom Sum-

mer in 1964. Their name changed to the Medical Committee for Human Rights as their ideology shifted. Early in the summer of 1964, the need for first aid led to a nurse training civil rights workers to administer first aid at protests.

Street medics developed protocols and ethics and a particular approach to training health workers. By the late 1960s licensed health professionals were attending street medic trainings in order to be cross-trained to work in the different protest environments that had emerged. Trainings were often offered by medics who had no medical licenses or certifications.

### **Community public health**

Street medics considered medical knowledge a form of self-defense, and provided health education and medical support during the movement to end the war in Vietnam, the New Left, and movements for the equity and independence of women, queers, veterans, Native Americans, prisoners, and mental patients. In the course of supporting long-term struggles, street medics shifted from a focus on prehospital care to a focus on community health and mental health. In the 1970s, street medics worked in Black Panther community programs and People's Clinics, the American Indian Movement battle at Wounded Knee, and other revolutionary projects.

Street medics and health professionals, part-

nered with national liberation organizations, pioneered in the field of public health. Together with organized communities, they helped develop rat abatement programs, lead testing programs, children's free breakfast programs, and community drug prevention and treatment programs. They helped force more equitable inner-city garbage collection, fire safety and firefighting, and they supported long struggles to reform the VA hospital, recognize Agent Orange sufferers, define and acknowledge post-traumatic stress, close the mental asylum system, and end the diagnosis of homosexuality as a mental disorder.

As the remaining first wave of street medics maintained their focus on long-term community support, new traditions of protest health care emerged in the 1980s and 1990s. ACT-UP, nuclear disarmament and native sovereignty long marches, and extended backwoods direct-action campaigns all had medical wings. The Peoples' Medics did urban healthcare and protest healthcare in the Bay Area in the 1980s, and American Indian Movement street medics worked together with other medical professionals in the Guatemala Acupuncture and Medical Aid Project (GUAMAP) to train displaced Mayan survivors of the Guatemalan civil war to provide comprehensive health care in their new and isolated communities.

## **Convergences against militarized austerity**

The values and lessons of thirty-five years of protest medicine reached a new generation in the months before and after the 1999 World Trade Organization (WTO) protests in Seattle, Washington. Many communities of health workers converged in the medical response to Seattle, with backgrounds in Earth First!, ACT-UP, community herbalism, and radical feminist health collectives. The street medic model broadened through field testing and new forms of horizontal organizing.

Almost every month for several years, mass mobilizations converged throughout the world and engaged in direct action. Anti-globalization, forest defense, and environmental justice convergences faced a growing militarization of police and a growing national security apparatus.

Medics trained tens of thousands of protesters in short courses focused on health and safety, eyeflushes, critical incident stress management, herbal aftercare, and day-long Affinity Group Medic trainings. Street medics functioned as a second tier of care to an informed public. Dozens of medical professionals attended bridge trainings and joined the street medic community. Dozens of medics pursued advanced medical training after finding a life purpose in medical work. Some entered war zones during mass deportations in Europe and during the Second Intifada in Palestine, where they provided support and care with

voluntary ambulance services and on foot.

## **Disaster mutual aid**

As mass convergences became fewer and farther between, street medics entered new fields. A team of Native American medics and traditional clowns responded to the impact of the 2004 Asian tsunami on indigenous fishing villages in coastal Thailand, where they provided mental health and medical aid and helped bury bodies. Street medics developed the first medical clinic in New Orleans to provide care after Hurricane Katrina and transitioned control of the clinic to the local community. The clinic was the highest-volume free clinic in the U.S. for much of its first year and won awards for the quality of care and health education provided.

Street medics rendered medical care and medical education to relief workers, undocumented immigrants, and poor blacks and Vietnamese people in urban and rural parts of Louisiana. They provided medical support and training to poor Appalachian families and their supporters over half a decade in the ongoing pitched battle against mountaintop removal coal mining. Street medics formed community health collectives in their home communities. Four affinity groups of street medics from the United States and Australia responded during the early aftermath of the 2010 Haiti earthquake, and a group

of street medics visited thousands of elderly residents of NYC Housing Authority developments who were trapped in their buildings after Hurricane Sandy.

Street medics now find themselves almost fifty years in. We are being re-formed again through dialogue with a new generation of protesters and health workers and through new challenges.

## WHY MEDIC?

Corporate medicine is a broken system that greatly undermines emotional, mental, spiritual, and physical well-being, and doesn't consider the impact of these issues on a person's ability to heal. This is a system that separates the roles of doctor and patient, and is invested in people not knowing how their bodies work and using their own intuition about how to heal.

Corporate medicine focuses on disease and symptoms; if you can't prove a symptom or disease exists, there is no problem. Corporate medicine turns patients into consumers, instead of people in need of care. That said, some aspects of western medicine are very useful for caring for some types of medical emergencies and conditions. Street medics aim to subvert the systems of oppression that maintain a broken and oppressive medical system, while at the same time utilizing some of these tools for the best possible outcomes. Taking care into our own hands

empowers us.

While we sometimes choose to or must work with the corporate medical system, the healthcare we seek to provide should be so much more. We believe:

- Patients are people first.
- We maintain healthy communities of resistance by supporting activists and people bearing the brunt of oppression.
- Every person has the right to receive care from a medical provider they feel comfortable with.
- We should provide decentralized methods of healthcare outside of the dominant framework of oppressive healthcare.
- We share the resources and skills that we have, and create networks to enable people to access resources of their choosing.

## THINGS TO CONSIDER

Medicking is hard work. Many of us carry heavy packs around on long marches and encounter situations ranging from incredibly dull shifts at clinics to facing down a line of police.

Many of us come to this work for one or many of the wrong reasons: we like the attention, we want to feel like heroes, we work too hard, or we always want to be where the action and excitement is. It is important to recognize those feelings and remember that if we ignore them they

will eventually lead to burn-out, feelings of frustration, and sometimes even put our patient's and our own well-being at risk. Acknowledging our

motivations lets us honor our feelings and also allows us to be long-term members of the medic community.

## 2 Before You Hit The Streets

### PREVENTION BY SELF-CARE

Our health and well-being have a huge impact on how effective we are as activists. By caring for ourselves, our friends, and fellow activists, we sustain ourselves and our movements. There are simple things we can all do to avoid injuries on the streets, and to reduce the severity of illness that results from stress, dehydration, exhaustion, and exposure to chemicals.

Here are some things you can do for yourself before an action.

#### Water

Water flushes waste from your body and keeps things moving. Drinking water helps prevent and ease stress, asthma, fever, pain, and more.

At protests it is common for people to avoid drinking water because they are worried about finding a place to pee later. Do not buy it: bathrooms are available at places like Starbucks, McDonalds, and public libraries, and dehydration is dangerous.

#### Nutrition

You are what you eat. Before an action, it is a good idea to:

- Eat colorful fruit and vegetables.
- Avoid processed, fatty, and fried foods.
- Add more fresh herbs, garlic, and ginger to your food.
- Eat fermented foods like yogurt, kimchi, and miso.
- Avoid nicotine, alcohol, caffeine, and other chemicals that put a strain on the body.
- Increase your mineral intake by eating seaweed or drinking a high-mineral tea (like oatstraw, nettles, or lemon balm).

#### Plant medicines

There are lots of plants that can strengthen your health. Many of them are considered weeds and can be found in your neighborhood. If you decide to harvest plants yourself, get them from areas where pesticides are not used. You can learn more about using herbs in chapter 9, *Police*, and 10, *Herbal First Aid and Aftercare*.

#### HALTS

Groups of survivors of psychiatric abuse, such as the Freedom Center in Northampton, Massachus-

setts, have discovered that most psychosis is caused by prolonged lack of sleep. 12-Step recovery groups have discovered that most relapses are the result of being too hungry, angry, lonely, tired, or taking yourself too seriously (HALTS). Check in during hard times with your own body or with your friend. What can you do to make sleep more possible? Can you get a bunch of water and some food that helps you or your friend feel better? Would it be cool to just hang out in the room for a while with him? Do you just want to talk about why you are pissed and get it off your chest?

## **Grounding**

Grounding is a way to deal with emotional pain. You can also think of it as centering, finding a safe place, or looking outward. The point is to free yourself from feeling too much (overwhelming emotions or memories) or too little (numbing and dissociation). Grounding helps you attain balance between the two, becoming conscious of your body and the world around you and able to tolerate it. Here are some ways people ground:

- Blink hard. Blink again. Do it once more as hard as you can.
- Make tea. Drink it.
- Call a friend.
- Eat a snack.
- Jump up and down, waving your arms.

- Lie down on the floor. Feel your body connecting with it. Keep your eyes open. How does it feel? Describe it out loud to yourself.
- Make eye contact with your pet and hold it.
- Clap your hands.
- Breathe deeply. Keep breathing. Pay attention to your every breath.
- Hold a stuffed animal, pillow, or your favorite blanket.
- Alternately tense and relax some muscles.
- Blink with your whole body, not just your eyelids.
- Move your eyes from object to object, stopping to focus on each one.
- Wash your face.
- Go outside for sunshine or fresh air.

(This list was borrowed from the *Support* zine edited by Cindy Crabb.)

## **Asking for support**

Everyone needs supportive community. Street medics often give deeply to others and yet find themselves without as many supportive relationships as they would like. Learning to ask for support can feel very awkward, especially at first, and especially for caregivers. Learning how to ask for support makes you stronger and better able to support other people in the long term. Often people put off reaching out for support until things are really bad, and then reach out impulsively. At that

point they may just want bad feelings to stop immediately, but the people they reach out to may not be prepared to respond appropriately.

You can ask for support at any time – before, during, or after a hard time. Here are some suggestions to help with asking for support:

- Start small: practice on safe people, with simple requests.
- Know what you will do if the person or community resource refuses your request for support.
- You do not have to tell the whole story.
- Be gentle: do not demand, threaten, or insult.
- Carry a written list of phone numbers you can call, even if you have a cell phone.

## MEDIC FASHIONS AND KITS

**Dress to protect yourself.** Here are some tips:

- Wear long sleeves and pants so your skin is less exposed to sun, chemicals, and scrapes.
- Wear layers.
- Wear good shoes that you can walk in for a long time.
- Wear water-based sunscreen (oil-based sunscreen may trap chemicals such as pepper spray).
- Dress appropriately for the time of day, weather, length of event, etc.

- Do not wear contacts. Carry an extra pair of prescription glasses if you need them.
- Do not wear tampons if you are menstruating; it may be a long time between bathroom breaks, especially if you are arrested.

### **Pack a kit**

Along with what to wear comes what to carry. A list of possible items for a medic kit is included in the appendix; remember that carrying gear we do not know how to use just wastes space and energy. When packing our kits and geeking out over tools, it is important to remember the basics of what really lets us help people:

- Our knowledge and skill (and knowing our limits).
- Cell phones for getting additional resources.
- Gloves for touching patients.
- The absolute best medic tool ever invented: the medic buddy.

## BUDDIES

As street medics we work in pairs, or sometimes in groups of three. Multiple buddy pairs can also work as a team. **A medic without a buddy is off duty.**

### **Buddies**

- Keep each other safer.

- Are witnesses for the medical and non-medical actions each person takes.
- Increase confidence.
- Have a second opinion.
- Have two sets of skills, experience, and perceptions.
- Provide each other with emotional support.
- Increase the likelihood a patient will feel comfortable with one of the medics.
- Often several roles need to be carried out – care for the patient, watch the scene, etc.
- It is more fun!

The importance of a buddy who you trust and work well with cannot be overstated. Take time to get to know your buddy and practice together before an action if you can. Your buddy is your single most important piece of medical equipment!

**Talk to your buddy about RIVAL:**

**R** for **Roles:** Would you rather focus on patient care or scene control and comms? Do you want to be in the thick of the action or hanging near the back? Would you rather be on the street, in the first aid station, or on street medic dispatch?

**I** for **ID:** What name are you using? Who trained you as a street medic, when, and where? Have you medicked any major actions? Who can vouch for you? If you have other relevant training or experience, where and when did you train, appren-

tice, do your residency, etc? Is your credential current? Where is it valid?

**V** for **Vulnerability:** Do you have any relevant disabilities and impairments, reasons you might be targeted, medical issues, medication schedule, or situations you must avoid? Do you feel safe with your buddy?

**A** for **Arrestability:** What is your willingness to go to jail versus your desire to stay out?

**L** for **Loose Ends:** Languages spoken, experience and training level, gender, special skills, etc.

**ETHICAL DILEMMAS**

As medics, we have a responsibility to know ourselves before we go out to provide care to others. If we know we are medicking for the wrong reasons, we should at least be able to admit that to ourselves, and be working on finding some of the right reasons.

Some dilemmas each of us should think about or discuss with other medics before an action:

- How much does your presence support the cause of the action? How well should you understand the topic and purpose of the action before you go to it? Will you leave if the topic of the march changes significantly or if you were misinformed?

- Would you care for someone you strongly disagreed with (e.g. a cop, a Nazi, a counter-protester)? Is it possible to maintain a safe scene while providing care for someone who may be hostile to you?

- Would you care for someone who was injured doing something you do not approve of? How would you deal with a patient you are caring for who is being rude in front of you, or possibly to you or your buddy?

# 3 Streetside Manner

*Like bedside manner, but with less beds.*

## GUIDING STREET MEDIC PRINCIPLES

### Do no harm

This is the first principle of all types of medical work. Do No Harm means that we must consider the possible outcomes of anything we do before we do it. Do the benefits outweigh the possible harm caused? What are the benefits and harms of not taking an action?

Do No Harm also means following the principles laid out below.

### Spread calm

Difficult situations such as confrontations with police are both frightening and exciting, but it is important to spread calm: panic not only weakens us, but does half of the police's job for them. In crisis situations people tend to mirror the emotions of those around them. Encourage crowds towards a safer position by saying, "Let's walk over there," rather than saying something alarming like, "Run! The police are coming!"

### Do not create a second patient

If you become injured, you will not only be unable to help others but you will need to be attended to as well. When a medic is hurt his buddy cannot help others until that medic is better. By getting into a situation that gets you injured you are taking two medics out of the picture.

### Work within your scope

Scope means how much medical knowledge someone has and what skills she is trained to use. Knowing each other's scope allows us to understand who needs to be in charge of the care for a patient. Generally this is the person with the most training. More training and higher levels of certification increase scope and allow a street medic to ethically and legally perform more medical services.

When considering scope it is important to remember that different medical fields have different certification practices. Often the only way to really understand another person's scope is to work and talk with them; accurately representing your own scope is extremely important.

## **Know what to do when you do not know what to do**

We often see patients who confuse us. Maybe the patient looks so bad when we first lay eyes on her that we panic, feel inadequate and reconsider why we thought becoming a medic was a good idea in the first place. Know what to do when these feelings strike. No matter what is going on with a patient, the triangle system (see chapter 5) is a good tool to use.

## **Slow is smooth, smooth is fast**

Our response to high intensity situations is often to speed up, to panic, to fight or to run. Sometimes those instincts are necessary to our survival, but being a good medic means knowing when to slow down. Take the time to be methodical, learn the assessment system and go through it slowly and thoroughly, and you will make less mistakes. Mistakes cost time and sometimes lives.

## **It is not our emergency**

It is not our emergency: we are not the one hurt, sick, or in pain. It can feel like our emergency because we care about our patients, and it is hard not to empathize while we are medicking them. It is okay to know that the patient is in pain and to want to help the patient get better as soon as possible. We should avoid letting our desire to help

push us into a state of panic or of taking on our patient's pain, which will get in the way of allowing us to help the patient.

## **YOUR PRIVILEGE: KNOW IT, CHECK IT, DE-NATURALIZE IT**

Think about: How might my privilege (as a man, a white person, a cisgender person, a person with class privilege, an able-bodied person, a thin person, a citizen, etc.) affect my medic work? Oppression is the act of using power to empower and privilege one group at the expense of disempowering, marginalizing, silencing, and subordinating another group. It is essential for anyone interested in providing healthcare to work to understand privilege and oppression.

If someone calls you out on your privilege:

- Be accountable for your mistakes. Take complaints about your behavior or the care you provide seriously.
- Say that you are sorry.
- Ask if there is anything that you can do.
- Know that it is not another person's job to explain or educate; it is your job to educate yourself and seek out information.
- Be willing to enter mediation.
- Ask another medic for guidance and support.

## LEGAL ASPECTS OF BEING A STREET MEDIC

Good Samaritan Laws in the U.S. provide protection for those giving emergency medical assistance. They offer protection only for people who have no “duty to act” (i.e., it is not part of their paid job description to provide care) and who do not expect to receive pay for their services.

Here are a few important things to keep in mind when providing care:

### **Only work to the level of your skill**

You are protected as long as the care you provide is free, and as long as you do what other people with your training would usually do. If you are not trained for CPR, do not do CPR. If you are trained as a Wilderness First Responder (WFR), you can provide the level of care a WFR would normally provide, and you will be held to a standard of care that a WFR is trained to.

Good Samaritan Laws do not cover people who:

- Give someone an over-the-counter drug (like aspirin or Advil) or a prescription drug.
- Commit gross negligence, willful harm, or abandonment.

### **Never abandon a patient**

Once care is started you must wait until someone with your level of training or higher is ready to take over care. Leaving your patient after you have started care is abandonment and is morally and legally problematic.

You are not legally required to give aid in Illinois (no “duty to act”). However, if you do have training or certification recognized by the state, you may want to be familiar with the legal aspects of negligence associated with your training.

### **Patients can refuse care at any time.**

## INTRODUCE YOURSELF

Approach a potential patient slowly and with confidence. Have gloves ready to protect yourself from body fluids. Be aware of your tone of voice, body language, and eye contact. Make sure you approach a patient on his level and from the front; do not make him turn his head to see you. If a person is lying down, approach from his feet. Say, “Hi, my name is Martha Jones and I am a street medic/WFR/herbalist/whatever. Can I help you?”

## CONSENT

There are two major kinds of consent relevant to a street medic: informed and expressed consent, and implied consent.

**Informed and expressed consent** is present when you say what you want to do, why, and what the risks might be, and a reliable patient verbally expresses consent to receive care.

Street medics get informed consent for everything we do – touching someone, asking medical questions, and providing first aid. Introduce yourself and get consent before you start patient assessment. Maintain consent throughout the assessment and care process to ensure you are following your patient's wishes. The patient has final say over what happens with his body.

Injuries and illnesses in protests often involve feeling a loss of control or autonomy:

- Lost control to police.
- Lost control of bodily integrity or function by being injured or ill.
- Lost control of what will happen next .

A key way that street medics support protesters in recovering their autonomy is by getting consent for everything we do.

**Implied consent** is a legal assumption that an unresponsive or unreliable patient would want help during an emergency.

An unreliable patient is considered to be any patient who is not fully alert and oriented. Examples include patients who are unresponsive, on drugs or alcohol, have a head injury, screaming 6 year-olds, or patients who are not acting as they usually do. Everyone has a different normal, so

talk to the patient's friends if possible to find out if this person is acting "abnormally."

### **Consent culture**

Besides dealing with the legalities of consent, we care about the ethics of a consent culture as well.

- Consent for responsive patients is crucial!
- Do not touch someone without permission.
- Continue to get consent for every new thing you want to do.
- Make sure you check in continuously so that you are following the patient's wishes.
- Someone who is alert and oriented but irrational has the right to refuse care.
- It is okay for someone to not give consent!
- If individuals do not consent, encourage them to define the problem. See if the concern is something that can be worked with.
- If the patient does not consent, alert her friends of problems that may arise and what they can do to help. If a combative patient refuses consent, do not fight.
- Call 911 and let paramedics use their expertise and (non-physical) coercive authority to invoke implied consent and take patient to the ER.

### **MEDIC/PATIENT INTERACTIONS**

- Do not make promises you cannot keep. Instead of saying, "Everything will be okay,"

say, “We are doing everything we can to help you,” or, “The ambulance will be here soon.”

- Encourage patients who ask questions. If a patient is asking you questions you do not know how to answer, do not lie. Say, “I do not know,” or, “It is how I was trained.”
- Never talk about a patient’s condition or injury in a pessimistic, hurtful, or scary way, even if she is unresponsive (e.g., “She is not gonna make it/that is gross/oh my god.”). Just because someone is unresponsive does not mean she cannot hear you.
- Help the person; do not take over for her.
- While you are caring for someone, interact with her as much as you can.
- Explain everything you are doing and why. People hate surprises.

## CONFIDENTIALITY

Medical information is sensitive, and so is other information that you may learn when you get a patient’s history or while talking with patients in emotional distress. Unless the patient gives consent, this information should not be shared with anyone except other immediate care providers: EMS and other assisting medics on scene, but not over celly or radio. A patient who says, “Tell my friend I hurt my ankle!” is giving consent to have only that much information shared with that specific friend.

If a patient does not give explicit consent to have information shared, it should be kept private. This includes information about what kind of care you provided to the patient.

No information that can clearly identify a patient should be transmitted over phones or radios, and certainly not by twitter, facebook, or email. Do not ever transmit a patient’s name, date of birth, any ID number, or detailed description to anyone electronically.

Do not share exact cross-streets or details of someone with an injury in any more detail than is needed to send appropriate back-up.

## ACTIVATING EMERGENCY MEDICAL SERVICES (EMS)

Throughout this training we will refer to “call 911” as an option when things are beyond your scope. When you encounter a **red flag** and need to activate EMS:

- Know who will make the call and who will provide patient care.
- Know where you are before you call. Do not get overly excited and call 911 to tell them all about your patient’s red flags – they cannot help us if they cannot get to us! Walk to a corner to read a street sign or ask someone in the crowd where you are.
- Be aware that the patient may require the

attention of both you and your buddy. In that case, designate a specific person to call for you. “You in the blue shirt, please call 9-1-1 and tell them someone is bleeding uncontrollably, then come back and let me know what they said.”

- Even if he is unresponsive, the patient may be able to hear you. Others in the crowd can also probably hear you. Spread calm. When you call 911 move out of the earshot of others and be clear and concise.
- Use the other medics around you. It is possible that EMS will not come to your patient until the police declare the scene safe by their standards, and you may need help before that time. Call the other medics at the action or call medic dispatch to get in touch with differently trained medics.

Throughout the handbook red flags will appear in boxes like this one. Red flags always go to higher care.

## TALKING WITH POLICE

Talking with police is not the most fun thing we do as street medics, but it is sometimes necessary for the wellbeing of our patients.

### GOOD POLICE NEGOTIATORS:

- Do not think they “can handle it” or outsmart the police. They recognize the inherent unfairness and injustices in the situation and are willing to set those aside for the needs of the patient.
- Are calm, straightforward, and willing to repeat themselves ad nauseam.
- May have a state certification (remember, we are playing by Their rules now, and They support most hierarchies).

Remember that police can lie to you, but supervisors try to avoid bad publicity and lawsuits.

**Know what you need** before you begin to negotiate.

- If the police are holding you somewhere and you need a patient taken to the hospital, you are negotiating to get an ambulance in (or get the patient out to a waiting ambulance).
- If you are being held and the patient needs to get out (panic attacks, weather problems, etc), ask police if the patient, one friend, and a buddy team of medics can leave.
- If you need a patient to be stationary while waiting for an ambulance and the police are trying to clear an area of protesters, ask if the patient, one of the patient’s friends, and a buddy team of medics can stay until the ambulance arrives. Specify what will hap-

pen after the patient is loaded into the ambulance – will the medics be allowed safely out of the area? Will they need a police escort to leave?

**Approaching a line of police** who are holding an area (or possibly holding you inside an area):

- Approach slowly, holding up some form of ID (a certification card, a badge, or something with a cross symbol).
- If the cops signal you to stop or back up, believe them. Do not keep approaching if it may get you hurt. Do not create a second patient!
- Speak loudly and clearly and say, “I am a (street medic, Wilderness First Responder, EMT, etc). I need to speak to someone about a patient. Who can speak to me?” Cops are sometimes under direct orders to not respond to any requests from the crowd. Most cops lack the authority to negotiate with you anyway. Keep moving down the line.

**If the cops will not** let you close enough to speak to them, or if they will not get someone who will talk to you, there are other options:

- Find a legal observer from the National Lawyers Guild (they wear bright green hats)

and take her with you, preferably with a video camera rolling.

- Use Media™. Corporate media will like the story.
- Call 911 and tell the dispatcher where you are and what you need.

**When you find an officer who will talk to you:**

- Introduce yourself and restate your qualifications.
- Calmly explain that you have a patient with X problem who needs Y. When the cop tells you what she can (or cannot) do, ask for a badge number and name or a business card. Repeat what the officer said she would do: “So I will bring my patient back here and you will let her and her friend leave, right?”
- Keep your patient out of sight of the cops unless they ask to see her. You do not have to let cops “examine” your patient for any reason.
- Be aware that if police let someone out of an area where others are being detained or arrested, they are likely to search the person to ensure nothing “illegal” is being sent out with her. Tell your patient this and consider giving her a safer, private place to dump anything she does not want found in a search.

# 4 Scene Survey

All medical interactions start with a scene survey. You cannot medic unless you are safe and you know what is going on around you. There are five steps to the scene survey, and luckily, there is a rhyme to help you remember them.



1. “Number one: look out for number one.”
2. “Number two: what happened to you?”
3. “Number three: don’t get any on me!”
4. “Number four: are there more?”
5. “Number five: now we arrive.”

## 1. Look out for number one.

Your safety comes first when someone is injured. Never create a second patient.

## 2. What happened to you?

What happened to the patient is referred to as the Method of Injury (MOI) or Nature of Illness (NOI). This is also part of keeping yourself safe: if some-

thing fell on the patient, is it going to fall on you, too? Is the cop who hit the patient still standing next to her?

Beyond your own safety, understanding what happened to the patient helps you focus on possible injuries and relevant care. Since we **cannot diagnose** without expensive equipment and training, the best we can do is make good guesses based on what we see and know and act accordingly.

Early detection of some injuries (for example, to the spine or neck) is so important that we encourage a policy of “better safe than sorry.” For example, we hold c-spine for a patient we find on his back behind a ladder: we do not know how far he fell (if at all), but moving him could be very dangerous, so we act as though his spinal column is in jeopardy and have him remain still.

Remember, this is just a quick general impression. We will continue with a more detailed assessment after our scene survey.

## 3. Don’t get any on me!

Whatever is on the patient (blood, snot, pepper spray), you do not want any on yourself. This is called **Body Substance Isolation**, or **BSI**.

We use gloves as barriers between ourselves

and the patient to prevent mucus membranes or broken skin from coming into contact with pathogens and bacteria that can cause infections. Mucous membranes are any part of the body that has moist tissue, including eyes, mouth, inside of nose, and cuts.

**BSI:**

- Protects the patient from us.
- Protects us from the patient.
- Protects patients from other patients we care for.

Many people are allergic to latex, so street medics use only non-latex supplies. Non-latex gloves, band-aids and ace bandages are easily available.

Wear non-latex gloves any time you might have contact with any body fluid. Most medics wear gloves any time they are caring for somebody because you never know when someone might vomit or you might find hidden bleeding. Put gloves on before approaching a patient, but do not walk around with gloves on – then they get dirty and contaminated and do not help to protect the person being cared for. Additionally, wearing gloves when you are not caring for someone may cause people around you to panic, and that is definitely not do-no-harm.

Change gloves after every patient. Do not expose multiple patients to chemical weapons or bodily fluids; remember that gloves are dispos-

able and our health is not. Take your gloves off when you go through your kit, write something down, or touch anything that can transmit body substances or chemical weapons to another object or a person. If you need to get something while caring for a patient, have your medic buddy get it.

Store gloves by pairs in small ziploc bags or film canisters. Ziploc bags make our kits more organized and protect supplies from chemical weapons.

Toss used gloves into the street. Clean-up crews know to treat gloves appropriately.

**4. Are there any more?**

Figure out how many patients there are. If there are more patients than medics, call for more medics before initiating care. Look around for hidden patients – there may be people screaming from pepper spray, but the silent patient passed out on the ground is probably a higher priority.

**5. Now we arrive.**

Now you can focus on your the person you are caring for. Your observations are the first indications of what we may need to do for the patient, or what they are experiencing.

Assess Level of Responsiveness (LOR). AVPU is the acronym to help you remember the levels:

<b>A</b>	Alert: Awake and able to talk to you (alert will get broken down into steps later).
<b>V</b>	Verbal: Not alert, but can hear and respond in some way.
<b>P</b>	Pain (as in responsive to pain): Doesn't respond to verbal stimulation, but responds if pinched
<b>U</b>	Unresponsive: Doesn't respond to verbal or pain stimulation.

## TRIAGE

During scene assessment you and your buddy have to pause and sort things out. If you begin to take care of someone and then notice another person who is in a more serious condition than your patient, there is nothing you can do: you already have a patient and cannot help the other person.

Before engaging care, determine:

- How many people need help.
- Who can wait and who cannot.
- How to get more help when needed.

Once your team initiates care, transfer care only if:

- You are in immediate danger.
- The person you are helping refuses care.
- A person with equal or greater training takes over.
- Care is completed.

## MASS CASUALTY INCIDENTS

The first buddy team on the scene assesses the whole incident and decides what is most important when more teams arrive. They stay in the triage assessment role until relieved by a buddy team competent to do the job, preferably the most highly-trained or most experienced medics on scene. Triage teams give a full report to their replacement when they are relieved.

You can enlist the help of bystanders

- For their skills.
- To blockade a crowd from a patient.
- To bring people in need of aid to your triage/first aid station (outside the highest intensity area).
- To sit with someone until back-up arrives.

## TEAM ROLES

### TRIAGE ASSESSMENT

If you have a team structure of multiple buddy teams who arrive at the incident together, the buddy team with the highest medical training/experience does continuous triage assessment and sends other buddy teams to people most needing care. This buddy team does not provide care.

## SCENE ASSESSMENT

Buddy teams dedicated to scene assessment do not need to be medically trained. They look for dangers and changes in the scene and report to the triage assessment team.

## PROVIDING CARE

Buddy teams check in with the triage assessment buddy team before making scenes safer or initiating first aid with patients.

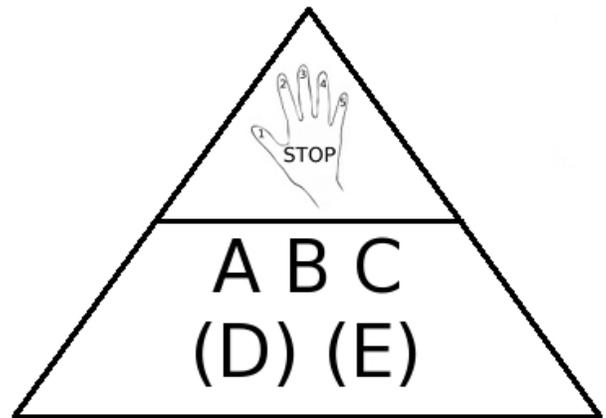
# 5 Initial and Secondary Assessment

## INITIAL ASSESSMENT

Initial Assessment is a series of steps that we go through at least once with every patient. Depending on the patient, we may repeat these steps as often as every 5 minutes. We will return to them at any point necessary while caring for our patient.

The steps are:

- A** for Airway
- B** for Breathing
- C** for Circulation
- (D)** for Disability
- E** for Environment)



Our primary considerations as we move through ABC(DE) are life-threatening problems. D and E are problems that may not be immediately life-threatening, but could become so without proper recognition and care.

The ABC(DE)s are called stop-and-fix steps. At each step we fix whatever problems we find before moving on to the next.

Any ABC problem is a **red flag**, and you should activate EMS and use the highest-trained medics at the action. If it's not a life-threatening problem, it is not an ABC problem, and we can and should delay care until we have completed assessing ABC(DE).

### A IS FOR AIRWAY

An open airway is essential to being alive. If your patient is talking, she has an airway.

The most common cause of airway blockages

in a person who is not alert (i.e. V, P, U) is the tongue. A head-tilt-chin-lift is used to move the tongue out of the way in a patient who can't do it herself.

- Put one hand on the patient's forehead and two fingers under her chin. Be sure your fingers are not pressing into her trachea! Tip the patient's head back. Most people do not tip the head far enough on adults; the patient's shoulders should be affected by the position of the head. Once the airway is open, move on to Breathing.
- If for any reason you need to leave a compromised patient (even for a moment), you will have to put them in the rescue position to keep their airway clear of their tongue and possible vomit. They should be stable, with their head angled downward and to the side. This should not be used for patients with potential spinal damage.

All you have to do for a talking patient is make sure she doesn't lose that airway. Ask, "Is there anything in your mouth?" and look in her mouth. Anything (chewing gum, chewing tobacco, dental braces, broken teeth) can become an airway obstruction. Liquids (including vomit or increased saliva from pepper spray) can also cause a patient to choke.

If there is a potential obstruction, encourage the patient to lean forward and spit until her air-

way is clear. When she confirms her mouth is empty, or when you can see that it is, move on to Breathing.

### **Abdominal thrusts**

Abdominal thrusts are a potentially dangerous but lifesaving technique for assisting a choking patient who has a fully blocked airway (i.e., totally blocked by a foreign body; no cough, no speech, no breathing).

This action should be attempted ONLY once the patient loses the ability to inhale and make noise (not the patient who coughs loudly or yells, "I'm choking, who knows the Heimlich?"). If the patient can still cough, he should be encouraged to do so to try to dislodge the foreign body.

Once you have introduced yourself and obtained consent, step behind the patient. Ask her to point to her belly button. Curl one hand into a fist and cup it in the other hand directly above where she points. Thrust your balled fist in and up into her abdomen, asking the patient to try coughing. Firm, rapid "J" movements work best for this (imagine you are trying to touch her belly button to her ribcage).

Make sure of your footing. Not only can abdominal thrusts be taxing, but frequently patients will pass out in the middle of the process and good footing will enable you to help him to the ground easily. Place one foot between his legs

and your other behind you. If the patient goes limp, ease him down to the floor by stepping backwards. Be careful with the patient's head and neck.

## B IS FOR BREATHING

For a patient who is A on the AVPU scale, the next step after ensuring an open airway is to check ease and effectiveness of breathing.

**Look at** and **listen to** the patient. Patients experiencing breathing emergencies may show signs of unusually fast, slow, shallow, deep, noisy, or difficult breathing. They may not be able to speak in full sentences. Disorientation and changes in skin color and temperature may also occur.

Some people may be wearing garments that constrict their breathing: back braces, chest binders, corsets, etc. Be respectful and remember to get consent if you think someone should remove a constricting piece of clothing.

Ask for consent to place your hands high on the sides of the patient's ribcage and apply gentle pressure. Ask the patient to take a deep breath and let it out. Move your hands down to the lower portion of the rib cage and have the patient take another deep breath and let it out. If a patient reports pain or you feel something not normal for the patient, ask if you can expose the injury to determine the extent.

Difficulty breathing is a challenging problem to fix with limited scope and medical supplies. Have the patient stay in a comfortable position. Many people will naturally anatomically splint to help ease chest pain. Your patient may hold her arm firmly against her chest, lay on one side, or brace her hands on her knees (tripod position). Encourage a position that eases breathing and do not force a patient to move. Keep the patient calm and give encouragement.

A patient who is V or P on the AVPU scale is breathing and has a pulse. Monitor her in case that changes and CPR is needed. Having a patient at V or P is a red flag – call 911 and utilize higher trained/CPR-certified street medics.

A patient who is U on the AVPU scale may or may not be breathing or have a pulse. If neither is present, the patient is considered dead and CPR may be started.

A patient who is U but breathing or has only a pulse is also a red flag – call 911 and utilize the highest-trained street medics.

While there is no substitute for the muscle memory and feedback of hands-on training, hands-only CPR instruction is now available online through the Red Cross and American Heart Association.

**RED FLAGS:**

- Signs of pain (watch the patient's face).
- Uneven expansion or deflation of chest (one side larger or takes longer than the other).
- Soft spots on the ribcage.
- Crepitus (the sound of bone grating on bone).

**C IS FOR CIRCULATION**

Circulation assessments has two main components: **pulse** and **bleeding**.

**Pulse** A patient who is anything above U on the AVPU scale has a pulse – done! A patient who is U on the AVPU scale may or may not have a pulse. If this patient does not have a pulse, she is dead and needs CPR. If this patient does have a pulse, this is still a red flag – call 911 and utilize the highest-trained street medics available. After calling for help, go on with the blood sweep described below.

**Bleeding** Only certain types of bleeding are a concern at this point in the assessment. Remember, ABC(DE) deals only with life-threatening problems. If we find non-life-threatening bleeding,

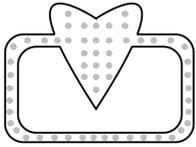
we will come back to it after our assessment is over.

Life-threatening bleeding is:

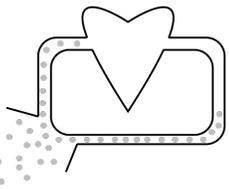
- Blood spurting (shooting out in pulses, in rhythm with the pumping of the heart). This signals an arterial bleed. The blood from an artery is bright red because it has just come from the lungs and is highly oxygenated. To stop this type of bleeding, apply direct pressure over the spurt with gauze, and raise the area above the level of the heart. Do not remove that first layer of gauze, but add additional layers if needed.
- Bleeding from the core of the body. To identify this, perform a blood sweep: Ask the patient for consent, then run your gloved hands as close to skin level (under jackets, thick sweatshirts, etc.) as possible. Examine your gloved hands for blood after checking each area of the body. Check the head, neck, trunk and thighs. If bleeding is found, stop it with direct pressure and, if possible, elevation above the level of the heart.
- Bleeding may be internal as well as external. We cannot always see internal bleeding, but we can see signs that it is present at a dangerous level. See shock, below.

**Shock** occurs when the vital organs do not receive enough blood. It is different from the emotional state that can occur following a traumatic experience.

**There are three ways shock can happen:**



**This is your circulation system** in diagram form. It sends oxygen to all your important parts. Here is a few simplified ways it can all go terribly wrong.



**A "volume problem"**- There is not enough blood to provide organs what they need. This may be because the blood is spilling out onto the ground (or into the body's cavities), or it could be the body cannot produce more blood because of dehydration.



**A "pump problem"**- The heart, the body's pump, may cease to function, causing the blood to cease circulating to vital organs.



**A "container problem"**- Veins carrying blood to the vital organs may swell (dilate). Because the amount of blood no longer fills the veins, they lose pressure and the blood in the veins may pool instead of circulating. This can happen during a severe allergic reaction.

**D IS FOR DISABILITY**

For the purpose of initial assessment, disability means "a person is less able to perceive or move away from life-threatening danger than she normally is." If she lost mobility aids (walker, crutches) or perception aids (glasses, hearing aid), has lost her ability to be as oriented or alert as she normally is, or has sustained a musculoskeletal injury, she's gonna need the scene

made safe around her or assistance exiting it. With her consent, it is your job to help her get to safety and any necessary further care.

At this point in initial assessment we are most worried about potential spine injuries.

**Mechanisms of Injury (MOI) for spinal injury:**

- Falls of more than twice the patient's height.
- Landing on head or neck from any height.
- Twisting or whiplash injuries.
- Any patient who is V, P or U on the AVPU scale, unless you saw him fall gently from a standing or sitting position.

**Responding to MOI for C-spine:**

Approach the patient from the front so that you are in her line of sight. Before asking for consent, tell the patient to keep her head still. "Please don't move your head, I'm worried you might have hurt your (neck/back/head). Can I put my hands on your head?" (Some medics start holding C-spine while introducing themselves and asking for consent.)

Take hold of the patient's head as a reminder to keep still. It is best if the patient is laying flat on her back, but environmental concerns or other injuries may preclude this position. You can still hold C-spine on a standing or sitting patient!

Every question to the patient should be prefaced with, "Don't move your head." Remind the patient to not move her head as often as neces-

sary.

When we need to move a patient who is already in C-spine we use specific rolls and other careful, calculated movements to protect the spinal cord. With two or more people, the person holding the patient's head is in charge of the roll and gives a countdown. "We'll roll her toward Mary on the count of three, after "three", not on "three". Is anyone not ready? Okay, one, two, three."

Once you have determined that there is a MOI for a spinal injury and have initiated spinal precautions on a patient, you may not let go except under certain circumstances:

- The scene becomes unsafe for you to stay.
- A person with higher training takes over.
- It is medically necessary – remember that D comes after A, B and C. If you must let go of a patient's head in order to clear her airway, do it! If you must let go of a patient's head to stop bleeding, do it! Do not let go of a patient's head in order to complete a head-to-toe exam (step F, which comes later).

An MOI for a spinal injury is a **red flag**. The patient must be transported via ambulance (to ensure continued immobilization of the spine) to a hospital. Utilize the highest-trained medics available to you on the street. Certified WFRs and others can do a spinal exam and may be able to release the patient from C-spine.

### What if the scene becomes unsafe?

There may be a time when you are holding C-spine on a patient who is lying down and the police attempt to clear the area with threats of arresting anyone who stays. This is when your medic police negotiator comes in. This person needs to explain to the commanding police officer (out of earshot of the patient) that you have a potentially seriously injured person who needs to be transported to the hospital via ambulance. Ask for the patient, the patient's friend, and two medics to be allowed to stay where they are until EMS can take over the patient, and specify that the medics will then rejoin the crowd.

Remember that every situation is different and no amount of writing or teaching can give the One Correct Answer for every possibility. If we have decided that our patient has an MOI for a possible spinal injury and we begin to hold C-spine, that decision cannot be reversed based on the changing scene. If the patient needed to be in C-spine before the police showed up, she needs to be in C-spine after the police show up!

### E IS FOR ENVIRONMENT

Things to ask yourself:

- Is the scene still safe?
- What's the vibe of the crowd? Who do you know? Are people calm?
- What's happening next?

- Where are the other medics?
- Where are the cops? What are they doing? Can you send a scout to confirm rumors?
- With whom did your patient arrive? Are they nearby?
- What is the weather doing to your patient? Being too hot, too cold, or not having enough water or food can all have drastic effects on the patient.

When we consider environment, ask, “Is the situation surrounding my patient right now going to do harm to myself, my patient, or other people?”

If the answer is **yes**, move yourself and/or the patient immediately.

If the answer is **maybe**, consider the factors leading to that decision and what is already going on with the patient. Does the patient have a life threat? Have you activated EMS and do they expect to arrive within a few minutes? If the patient does not have any red flags and you are going to continue providing care, consider how long it might be before the conditions in the area begin to affect your patient, and move her before they do.

If you had to remove a patient’s clothing for any reason in steps A through D, consider the Environment: it can be very important that they get covered up again. Especially in colder weather, having a jacket off for even a few minutes can chill a person significantly.

This is also the point where we should make sure the patient is off the ground. There will rarely be a time when the ground is the ideal place for the patient. After checking for ABCD injuries and considering the entire scene again, get something between the patient and the ground. If there is a D-step problem, use a log roll to put the patient on her side, put insulation (cardboard is wonderful) on the ground, and roll the patient onto it. If your patient is mobile, have her sit or lie down on some kind of insulation.

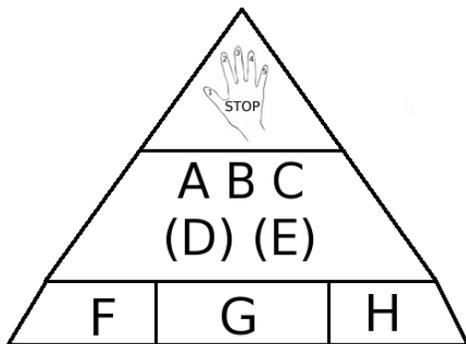
## SECONDARY ASSESSMENT

The following steps are used to find and provide care for problems and injuries that are not immediately life threatening. If you find an ABC(DE) problem while doing secondary assessment, take care of it immediately. Otherwise, problems found now are addressed once you have completed the following:

F for Full Exam (also called Head to Toe).

G for Get Vitals.

H for History.



Because we will finish these steps before providing care, we may change the order of the steps as long as all are completed. When dealing with trauma the steps should be done as Full Exam, Get Vitals, and then History. When dealing with an illness, the steps should be done as History, Get Vitals, and Full Exam. We will talk more

about this when we talk about care for specific injuries/illnesses.

### F IS FOR FULL EXAM

A full exam, more commonly called a "head to toe," is a way to physically identify injuries on a patient. Each time you do a full exam, say each part out loud; this will help you remember your system and is helpful to your patient so she knows what is coming next. Be sure you have consent and that your patient is comfortable with the exam.

Following the same system each time you do the exam is important for building muscle memory and ensuring no parts are left out. However, if a patient has a distracting injury, take a look at that first to determine the extent, then start the exam at the head.

Look, listen, and feel using firm pressure for anything that is out of the ordinary or that wasn't there before the injury: bruising, bleeding, swelling, pain, tenderness, deformities, crepitus, or unusual hardness or softness. Injuries should be exposed so they can be examined, but not addressed until the end of the FGH steps. Be sure to have consent to remove the patient's clothing.

### Head, face, and neck:

Carefully remove hats, helmets, sunglasses, etc. Keep track of the patient's things by putting them in a bag or giving them to a friend to hold. Run

your fingers through the patient's hair, palpating the skull. Examine the face, pressing on bones. Check eyes, nose and mouth. Check in, behind, and below the ears. Feel along the muscles and bones of the neck. Check for tracheal alignment. Check for a medical ID tag necklace.

### **Shoulders:**

Check one shoulder at a time, check the collarbone, then compare shoulders.

### **Chest:**

Spread hands over sides of chest wall. Check for instability and/or asymmetry on inhalation – once high on the chest, once low on the chest. Ask the patient to take a deep breath on both checks. Press hand on center of sternum.

### **Abdomen:**

Imagine an X and Y axis overlaying the abdomen, where (0,0) is the belly button. Press with the palm of your hand on each of the quadrants of the abdomen. If patient is responsive, look at her face while you are doing this to assess for tenderness, pain, or guarding.

### **Pelvis:**

With hands cupped on the hipbones, press inward, then downward toward the patient's back.

If there is any pain or movement when you press inward, do not press down.

### **Genitals:**

Ask, "Is there any reason to check your genitals?" Unless the patient says yes, move on.

### **Lower extremities:**

Check one leg at a time with hands encircling the extremity. Check from hip to toes. Check toes on both legs at the same time for **Circulation, Sensation, Movement** (CSM). Feel for warmth; ask, "which toe am I touching?"; have patient push down and pull up against your hand. Compare the two legs. Check for medical ID tag anklet.

### **Upper extremities:**

Check one arm at a time with hands encircling the extremity. Check from shoulder to fingers. Feel fingers for warmth; ask "which finger am I touching?"; have patient squeeze your fingers. Check for medical ID tag bracelet.

### **Spine and back:**

If the patient is being held in C-spine, do a two-person roll to check the back. If there was no MOI for C-spine, have the patient sit up. Palpate the entire length of the spine from the base of the skull to the beltline. Press on each side of the

spine at the shoulder, lower rib cage, and flank with the flat of your hand.

**Take note:**

Record the findings of the head to toe. Be very specific about the location of any injuries found (which side of the patient, which side of the limb), how large, what shape, and anything else of note. Remember that this is not a stop and fix exam. Find the injuries, note them, and move on, re-assuring the patient that you will come back and take care of these things in a moment.

**G IS FOR GET VITALS**

Vitals tell us what is going on in a patient's body. Monitoring changes in vital signs over time gives us a lot of information about a patient.

**Tools needed:**

- Watch with second hand/second counter
- Paper and writing utensil

Every set of vitals should be recorded along with a time stamp.

**Level of Responsiveness (LOR):**

This is the most important vital sign. We made a first observation during the Scene Survey and continue to monitor it as we provide care.

At this point, we have time to be more specific about where the patient is on the AVPU scale.

Now A stands for **Alert and Oriented:**

to Person, Place, Time, and Events – A&O X 4  
to Person, Place, and Time – A&O X 3  
to Person and Place – A&O X 2  
to Person only – A&O X 1

Responds to Verbal stimulus – V  
Responds to Painful stimulus – P  
Unresponsive – U

Keep in mind:

- Order matters: patients will generally forget what happened and when before they forget where and who they are.
- To be AO X 3 after an injury is fairly common and a way the body defends itself – who wants to remember getting hit by a cop?
- People may not want to share their legal name or what they were up to when they were injured. What is important is that they know.
- Every person has a different normal. Some people may be normal but unable to respond appropriately to a simple request.

Make sure that you constantly monitor and re-assess LOR. Some conditions may cause noticeable drops in LOR in a few minutes.

## RED FLAGS

- The patient is currently lower than AO x 3.
- The patient was, at any point, V, P or U – even if “fully recovered”.
- The patient’s AVPU level drops at all, even from AO X 4 to AO X 3.

**Heart rate (HR):** Feel radial (wrist) pulse for 15 seconds and multiply by 4 to get beats per minute.

Note rhythm – regular or irregular.

Note quality – strong (‘normal’), bounding (too strong), weak.

Practice checking your own and your friends’ pulses so you get a sense of what regular and strong are.

**Respiratory Rate (RR):** Count breaths for 15 seconds and multiply by 4 to get breaths per minute.

Note rhythm: regular or irregular.

Note quality: unlabored (‘normal’), shallow, deep, labored, wheezy.

## Skin (SCTM):

Skin –

Color: pink, pale, ashen, red, blue. Use non-pigmented areas like inner lips, palms, or nail beds.

Temperature: cool, warm, hot. With consent, feel under the shirt on the shoulder.

Moisture: dry/moist/wet (on unbroken skin, not mucus membranes)

**Pupils:** Should be Equal, Round, and Reactive to Light (PERRL). You do not need a flashlight to check your patient’s pupils: In daylight, ask your patient to close her eyes and use your hand to create a shadow over her eyelids; wait at least 10 seconds, then remove your hand and have the patient open her eyes and look at you.

## H IS FOR (SAMPLE) HISTORY

<b>S</b>	<b>igns and Symptoms (S/Sx)</b> "Signs" are what we as medics observe; "Symptoms", what the patient feels. Suspected MOI for trauma: signs should surface primarily in the Head-Toe and Vitals; remember to ask about all symptoms in addition to chief complaint NOI (the patient seems to suffer from something illness-related): we refer to OPQRST [5.8b] to characterize symptoms	
<b>A</b>	<b>llergies</b> What you are allergic to? What happens when you are exposed? Is it possible you were exposed today? How long ago you were last exposed?	
<b>M</b>	<b>edications</b> Prescriptions Over-The-Counters, Herbs and supplements Recreational substances (+ alcohol)	Also ask: When did you last take them How much/often? What you are taking them for If they carry them with them, where?
<b>P</b>	<b>ast Pertinant History</b> Seeing a doctor for anything (conditions)? Who? Contacts? Had any relevant surgeries/injuries/illnesses previously? Being treated for? (currently or recently) Pregnant?	
<b>L</b>	<b>ast In/ Last Out</b> When and what did they last eat/drink? Are they peeing?; Qualities (eg. color, pain), frequency, unusual characteristics Same with Pooping, Vomiting	
<b>E</b>	<b>vents Leading Up To The Incident</b> What happened before the patient fell? (Did she feel dizzy? Was she running from bees, to which she is allergic?) How has the patient felt today? Try to get full picture of what is going on.	

<b>O</b>	<b>nset</b> When/how fast it began What were they doing when it started?	
<b>P</b>	<b>rovokes/Palliates</b> What makes it feel better? Worse? Anything they think might have triggered it	
<b>Q</b>	<b>uality of the Pain</b> Burning, stinging, sharp, dull, aching, Get the words from them without prompting (open-ended is best)	
<b>R</b>	<b>egion/Refers/Radiates</b> Where/how large is the region experiencing pain Does it radiate (grow), refer ("jump") to other/larger area?	Palpation & S/Sx may provide clues to source or epicenter Some common referrals may suggest specific conditions (eg. angina/heart attack refer to shoulders, back, neck, arms)
<b>S</b>	<b>everity</b> On a 0-10 scale with 0 being no pain and 10 being the worst pain the patient has ever experienced. (Find out what 10 is: If a hangnail is the worst pain they can imagine; 8 may not be so bad. Nerve pain from a torn disk = serious) If they won't play your game get the words they use ("really bad," "sorta bad," "not too bad" etc.)	
<b>T</b>	<b>ime</b> Constant or Intermittent Use to track changes in vitals and SAMPLE / OPQRST	

SAMPLE and OPQRST are handy mnemonics that will help you remember the steps for secondary assessment. SAMPLE is more useful for assessments that are focused on determining the NOI (Nature of Illness), whereas OPQRST is more useful for assessing MOI and pain.

A SAMPLE history involves asking all of these questions in an effort to learn as much as possible about what is going on with your patient. Your patient's chief complaint may be a distracting traumatic injury, but asking the questions in the table to the left will help you catch their history of un-

managed diabetes or the fact that they have eaten nothing for three days.

OPQRST is a way that you map and understand your patient's experience of pain and discomfort. You want to know as much as possible about it.

For example, your patient is experiencing a very bad headache. An example set OPQRST answers for this patient might look like this:

**O:** Very sudden, yesterday; **P:** Not moving/sleeping makes it better; **Q:** Dull, aching, throbbing; **R:** Pain is nauseating; **S:** 9, like a past

serious concussion; **T**: Constant as of 12/13/2012

## BEYOND ASSESSMENT

That's Initial and Secondary Assessment. This is the foundation of everything we do as medics. Remember that ABC(DE) are stop-and-fix steps and should be continually monitored throughout the entire interaction with our patient. FGH should all be completed before beginning any interventions ("I").

### I IS FOR INTERVENTIONS

This is action we take to care for the patient. This will oftentimes be transfer of care to a person with

more (specialized) training. Before we go on to any Interventions, don't forget to document everything you have learned or done.

### J IS FOR JOT IT DOWN

While one medic is taking vitals and interacting with the patient, the other can be writing down information. Some people carry notebooks, while others use SOAP notes.

SOAP stands for Subjective, Objective, Assessment, and Plan – what the patient reports, what you observe, assessment including vitals, and what care was given. Here is a sample SOAP note:

**Subjective:** age, sex, MOI/NOI, C/C  
**Age/Sex:** \_\_\_\_\_  
**MOI:** \_\_\_\_\_  
**C/C: Chief Complaint in patient's own words:**  
 " \_\_\_\_\_"  
 \_\_\_\_\_"  
**Objective:** vitals, focused exam, sample history  
**Time:** \_\_\_\_\_  
**LOR:** \_\_\_\_\_  
**SKIN:** \_\_\_\_\_  
**HR:** \_\_\_\_\_  
**RR:** \_\_\_\_\_  
**PUPILS:** \_\_\_\_\_  
**BP:** \_\_\_\_\_  
**Full Exam:** locations of pain, tenderness & injuries:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SAMPLE HISTORY**  
**S** igns/Symptoms \_\_\_\_\_  
**A** llergies \_\_\_\_\_  
**M** edications \_\_\_\_\_  
**P** ast pertinent medical history \_\_\_\_\_  
 \_\_\_\_\_  
**L** ast in/out \_\_\_\_\_  
**E** vents \_\_\_\_\_  
**A** ssessment: (problem list)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
**P** lan: (for each problem)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

MONITOR PATIENT

# 6 Trauma

## WOUNDS

Broken skin of any sort: abrasions, cuts, avulsions (skin flap).

### RED FLAGS

- Anything gaping more than 1/2 inch – consider the necessity of going to the ER for stitches.
- All amputations (something cut off completely) or circumferential injuries (an injury that goes all the way around a body part, such as finger or limb) should go to the ER.

Note that these situations may not require ambulance transport – it may be fast enough to take the patient in a car.

For puncture wounds be aware of the higher risk of infection and seek further attention.

### Care for minor wounds

1. Stop the bleeding.
2. Clean by forcefully flushing with clean water or saline.

3. Cover with clean gauze and tape or other form of bandage.
4. Discuss aftercare instructions with the patient including how to keep the wound clean and how to reapply bandages.

## BURNS

### RED FLAGS

An easy way to remember when a burn should be seen in an ER is the “oh my gosh!” rule. If we look at a burn and think, “oh my gosh!” it should probably go to an ER.

This includes burns that are:

- Black or white in the middle.
- On faces, hands, feet or genitals.
- Larger than 5 times the palm of the patient’s hand.
- Circumferential (go all the way around a limb or digit).
- On the very young, the very old, or those very susceptible to infection.

Burns occur when the skin receives more energy than it can handle. This energy comes in many forms – sunrays, heat, steam, chemicals (including pepper spray), and others.

### Care for superficial burns

1. Stop the burn. This may mean using cold or cool water (not ice), getting the patient out of the sun, or removing the chemicals causing the burn.
2. Evaluate the size of the burn. If it has a red flag, send on for further care.
3. Remove anything constricting, such as jewelry and watches, from the area of the burn. These can interfere with circulation when the area swells.
4. Once the skin has cooled down, consider using soothing agents such as ching wan hung or raw honey.
5. Give patient aftercare instructions, including attention to hydration and keeping the area clean. Pain medication may also be necessary but street medics can not prescribe medication.

## MUSCULOSKELETAL INJURIES

Musculoskeletal injuries are very common. We do not have X-ray vision, and it can be very difficult to tell the difference between a fracture and

a strain. For the sake of this training we differentiate between injuries that affect the patient's mobility and injuries that do not.

### MOBILE INJURIES (SPRAINS AND STRAINS)

#### Common symptoms

- Swelling.
- Pain.
- Reduced range of motion.
- Reduced CSM.

#### Care for mobile injuries

RICE for 24-48 hours.

- **R**est: Reduce or prevent movement
- **I**ce: 20-40 minutes with a well insulated ice pack (never directly apply frozen things to the skin!) followed by 15-20 minutes without an ice pack. Reduce time with ice as swelling lessens.
- **C**ompression: Wrap injured site with an ace bandage (check CSM before and after). Apply splint if appropriate.
- **E**levation: Elevate to resting position above the heart to reduce swelling.

Continue RICE and monitor for improvement.

Expect the condition to worsen over the first 24 to 72 hours. Seek further care if it continues to worsen beyond that time frame; if at any point the injury becomes unusable; or if CSMs are diminished.

## IMMOBILIZING INJURIES

### **RED FLAGS:**

Any immobilizing injury other than to a finger or toe. Even an unusable digit can be a red flag if your patient is concerned about it.

### **Common symptoms**

- Pain.
- Bleeding.
- Swelling.
- Deformity or dislocation.
- Diminished CSM.
- Patient will often report hearing or feeling a “break” and report “I think it’s broken.”

### **Symptoms of associated nerve damage:**

- Numbness.
- Paralysis.

### **Care for immobilizing injuries**

- Seek higher trained medic if possible. Act within your scope!
- If site of injury is obviously deformed and injured, activate EMS.
- Monitor CSM.
- Monitor for shock.
- If appropriate, splint or immobilize and seek further care immediately.

- Consider C-Spine precautions. If MOI is strong enough to break bone, patient could be at risk for spinal injury.

## HEAD TRAUMA

**Head trauma occurs** whenever someone has a blow to the head:

- From a fall – From how high? How did they land? On what (kind of surface) did they land?
- From a blow – From what kind of object? Angle? Blunt or sharp? Soft or hard?
- From a sudden acceleration/deceleration (i.e., whiplash). How fast did it happen?

### **Types of head trauma**

- Open – Visible damage to skin, skull, brain, and/or casing. May be minor or very serious.
- Scalp – external laceration; may look really bloody because there are a lot of capillaries in the scalp; treat like other lacerations, but care should be given to protect vital centers (brain, spine, etc).
- Closed – Little or no visible bleeding, but this can be very dangerous as brain swelling and/or bleeding can damage parts of the brain that control vital life functions. Evaluating and controlling the damage requires

special equipment.

#### **RED FLAGS:**

- Decreasing LOR.
- Currently lower than AO X 2.
- Loss of responsiveness at any time.
- D.I.C.C. head – Disoriented, Irritable, Combative, Coma.
- Vomiting.
- Seizure.
- HR decreasing and bounding.
- RR erratic and shallow.

#### **Common symptoms**

If a patient exhibits signs or symptoms of a head injury, get help immediately!

- Loss of responsiveness (even briefly).
- Obvious deep cuts or tears in scalp, protrusion of bone or brain matter.
- Reduced or decreasing LOR (Level of Responsiveness–AVPU) DICC-head (review Mental Status).
- Headache, Amnesia, Seizure.
- Vomiting: especially if periodic, projectile or for an extended time.
- Dizziness: Visual changes – seeing stars, blurred vision.
- Bleeding: especially from ears and/or nose. May be mixed with cerebro-spinal fluid.

- Bruising: bumps, deformity.
- Battle's sign: (bruising behind ears), raccoon-eyes (bruises under eyes).
- HR (Heart Rate): decreases and bounds. This is a late sign. This person needs critical care immediately!
- RR (Respiration Rate): Hyperventilation and erratic – This is a late sign. This person needs help immediately!
- Skin: Warm and flushed.

#### **Care for head injuries**

Anyone with head trauma has a high possibility of C-spine injury, so always immobilize head and spine. Elevate upper body at approximately 30 degrees, or several inches, to discourage brain swelling.

1. Do NOT put direct pressure on injury site (including ground); use donut bandage.
2. Recommend that your patient be examined by a health care professional.
3. Most symptoms develop within 1-6 hours, but monitor for 12-24 hours. Don't let her sleep through that time, wake up every 2 hours and check for LOR. If LOR decreases or if signs and symptoms get worse, go to emergency room immediately.
4. Lots of possible concussion patients don't want to go to the hospital, so aftercare instructions to friends who will be around are

essential.

5. Avoid pain medication for 24 hours if not go-

ing to a healthcare professional because it may mask symptoms or increase intracranial (inside the head) bleeding.

# 7 Illness

## SEIZURES

A seizure is a temporary alteration in behavior or responsiveness. Generalized seizures are typically characterized by unresponsiveness and a generalized severe twitching of all the body's muscles that can last several minutes. Another type of seizure is called an absence seizure, which is characterized by a brief lapse of responsiveness in which the patient seems to stare and not respond to anyone, possibly performing a repetitive action (lip smacking, brushing hair, etc.) that the patient was doing before the seizure began. Other presentations are also possible.

### Causes

- Epilepsy – Epilepsy is congenital, which means the patient was born with the condition.
- High fever – Usually seen in small children, these are called febrile seizures.
- Structural – The physical structure of the brain is affected. This can be from a tumor, infection, scar tissue from an old injury, head trauma, or a stroke.
- Metabolic – The physiology of the brain is affected. This can be from hypoxia (lack of oxygen), hypoglycemia (lack of sugar in the

blood), poisoning, drug overdose, or withdrawal from a chemical such as alcohol or medication.

### RED FLAGS:

- A first-time seizure, no matter the suspected cause (head injury, fever, etc).
- A seizure following a head injury (even if it is not a first-time seizure).
- A seizure accompanied by a high fever (even if it is not a first-time seizure).
- Repeated seizures. Some patients normally have two seizures in a row or within a brief time and do not need advanced care for that. However, any patient who has three seizures in a short period of time should be transported to an ER.
- A seizure that lasts longer than 30 minutes.

### Symptoms:

A patient will often experience a warning prior to the seizure, which is called an "aura." The patient may notice a funny smell, or feel dizzy or weak. Patients who have a history of seizures may have time to warn people around them that they are go-

ing to seize and may lay themselves down in a safe place.

The **tonic phase** of the seizure may have the following characteristics:

- Sudden loss of responsiveness.
- Chaotic muscle movement and tone.
- Apnea (lack of breathing).
- Bladder or bowel incontinence.

The **tonic-clonic** phase may have the following characteristics:

- Muscle spasms lasting 1 to 3 minutes.
- Raised heart rate.
- Hyperventilation.
- Intense salivation.

The seizure will be followed by a **postictal** state with the following characteristics:

- May last 5 to 30 minutes, sometimes longer.
- Patient is Unresponsive at first and gradually moves up through the AVPU scale, including becoming awake but disoriented and dazed.
- Fatigue.

#### **Care for seizures:**

- Do not attempt to hold her still.
- Do not attempt to put anything in her mouth.
- Protect her head – put a blanket, coat, your arms under her head without trying to stop it from moving.
- Keep the area around her clear, moving objects if necessary.

- Form a privacy circle around her and wait for the seizure to stop.
- Ask her friends if they know of a history of seizures. Did she suffer head trauma today? If you hit a red flag at this point, activate EMS immediately.

#### **Aftercare**

Recognize that the patient will have a postictal phase, which will start with Unresponsiveness. Monitor ABC and consider DE. Note that a seizure alone is not a MOI for a spinal injury so you do not have to hold C-Spine, although it will not do harm to the patient after the seizure has ended.

If the patient has lost control of bladder or bowel function try to maintain privacy and possibly get her some clean clothes.

The patient may never be AO X 4 – she may not have any memory of the beginning of the seizure. Even a patient who has a history of seizures may forget that she has had one, and this may cause her concern as to why strangers are taking such an interest in her. Be calm and understanding, and without inducing panic, explain that she has had a seizure and you are here to help. You can take a SAMPLE history at this point.

A patient with a history of seizures will be able to tell you what she normally does after a seizure, which probably includes a lot of rest. She will probably be unable to transport herself home; arrange

transportation for her and make sure she has a trusted friend to check in on her.

## ASTHMA

Asthma is a spasm of the air passages causing difficulty breathing. The air passages usually open easily during inhalation but tighten during exhalation, producing a characteristic wheezing sound as the patient struggles to exhale.

Asthma attacks can be triggered by many things:

- An allergic reaction to an inhaled or ingested substance (allergic reaction itself is a separate phenomenon).
- Exercise.
- Emotional distress.
- Respiratory infections.
- Cold weather.

### Symptoms:

- Shortness of breath; coughing.
- Wheezing sound on exhalation.
- Chest tightness.
- Increased HR and RR.
- Anxiety.
- Tripod position.

### Care for asthma attacks:

- Keep the patient calm.

- Move away from triggering elements (pollen, cold air, pollen that are causing the emotional response).
- Encourage the patient to stay in a position of comfort to ease breathing.
- Have the patient make purse her lips and push air out. This may help open the air passages.
- If the patient has an inhaler, she may use it. If she cannot use it herself, activate EMS and utilize the highest trained medics available; street medics cannot administer medicine.
- Do not give the patient anyone else's inhaler. Inhalers have different medications in them at different doses.

### RED FLAGS

- An asthma attack that continues for longer than 30 minutes, with or without medication.
- A first-time asthma attack causing serious breathing difficulty.
- Cyanosis (bluing from lack of oxygen).
- Loss of responsiveness from an asthma attack.

## Aftercare

Most people familiar with their own history of asthma will be fine after an attack has ended. They may want to go somewhere and rest, but they may also decide they are fine to return to the previous activity. Listen to your patient.

## FAINTING

While loss of consciousness is usually a red flag, fainting is the exception. Fainting is when a patient loses consciousness for a very short time.

- If possible, help the person who has fainted to the ground to minimize injury.
- Stimulate the person vigorously (yelling, briskly tapping). Call 911 if the person does not respond within a few seconds.
- Go through initial assessment.
- After the person recovers, encourage her to lie down until medical help arrives. Even if you believe the cause of the fainting is harmless, have the person lie down for 15-20 minutes before attempting to get up again.
- Ask about any persistent symptoms such as headache, back pain, chest pain, shortness of breath, abdominal pain, weakness, or loss of function, because these may indicate a life-threatening cause of the fainting. Go through the SAMPLE history.
- Causes for fainting can include circulatory,

neurological, psychological respiratory, medication/chemical or blood sugar problems as well as dehydration.

## ABDOMINAL ILLNESSES

The abdomen is one of the most busy parts of the body and contains most of our organs. Many symptoms associated with other illnesses and conditions may manifest in this region (e. g. anxiety, nausea from head trauma, etc. ). Although most symptoms we encounter in this area are relatively non-threatening, there are red flags that may signal very serious situations. Our assessments and care address symptoms and not causes.

Street medics are not qualified to diagnose or provide care for abdominal problems.

## RED FLAGS

- Symptoms of Shock.
- Blood in vomit, feces, or urine.
- Persistent pain (longer than 12-24 hrs, especially constant). Localized, especially with tenderness, distention (ballooning), or rigidity.
- Pain accompanying movement such as jarring or footsteps.
- Persistent loss of appetite, vomiting, or diarrhea (> 24 hrs).
- Fever above 102° F (39° C).

### Common symptoms:

- Pain.
- Nausea, vomiting.
- Diarrhea.
- Bloating, gassiness, constipation.

### Care:

- Hydrate.
- Consider possible dietary factors.
- Consult with healthcare providers.

### Trauma

Any abdominal trauma, even seemingly minor trauma, should be noted during SAMPLE and

OPQRST when taking a history and monitored for at least 24 hours. Any display of the above red flags should seek rapid medical evaluation.

## DIABETES

Diabetes refers to a condition wherein the body's ability to metabolize simple carbohydrates (glucose, which is sugar) is impaired. The main problem in diabetes is the lack or ineffective action of insulin, which is a hormone produced by the body to aid in the metabolism of glucose. Diabetic emergencies are caused by either too much or too little insulin in the body.

There are two types of insulin reaction: **Hypoglycemia** and **hyperglycemia**. Hypoglycemia, or low blood sugar, occurs when there is too much insulin in the blood. Hyperglycemia, or high blood sugar, occurs when there is too little insulin in the blood. The symptoms for both are similar, but hypoglycemia has a fast onset (minutes or hours) while hyperglycemia has a slow onset (days).

The symptoms of both are similar:

- Change in LoC.
- Fast heartbeat.
- Shaking, trembling, convulsions.
- Loss of feeling or function of muscles; tingling or numbness of skin.
- Confusion or unclear thinking.

If blood sugar gets extremely high or extremely low, the person may faint or go into a coma.

### Care for a diabetic emergency

A responsive patient can be given sugar in many forms, including a soft drink, candy, fruit juice or whatever is available quickly. If the patient is unresponsive, rub glucose gel or honey on the inside of his lip or gums.

#### RED FLAGS

- An unresponsive patient (no matter the suspected cause).
- A diabetic patient lower than AO X 2 on the AVPU scale who does not improve within minutes of being given sugar.

### Prevention of diabetic emergencies

A patient eating and taking her medication as prescribed can usually prevent diabetic emergencies. However, just because a patient can usually pre-

vent a diabetic emergency doesn't mean that we should judge or criticize her for not doing so. People have many reasons for doing or not doing things to keep them healthy, and our job is not to police those actions but to care for the problems that arise.

### Aftercare

The patient should return to her usual schedule and amount of eating and medication as soon as possible. There is a chance that she was on that schedule but another factor (infection, stress) changed the way her body reacted to the medication and food. Removal from those situations or careful monitoring of her status in those situations in the future may help prevent a repeat occurrence.

If absolutely no reason can be found for the emergency, a patient may need to see her doctor for tests and to possibly adjust the medication taken.

# 8 Environmental Health

Staying warm and dry in a happy home is easy enough, but in this era of cut-off heat, foreclosures, evictions, park living, and midnight direct actions and marches, things get more difficult. Thankfully, there are simple and free things that anyone can do to improve their ability to stay warm and dry during prolonged exposure to the elements.

## DEHYDRATION

Dehydration is one of the most common illnesses we see. You are probably dehydrated right now. Dehydration can occur in any weather.

### Symptoms:

- Dry skin, especially noticeable on lips.
- Thirst.
- Loss of appetite.
- Flushed skin.
- Dark urine.
- Fatigue.
- Lightheadedness.

### Care:

- Prevention is best: Drink and encourage others to drink lots of water.
- Rest – stop losing water!

- Begin rehydration with water and/or rehydration drink (water mixed 50/50 with fruit juice, honey, or sugar with a pinch of salt added).
- Aggressively rehydrate for at least 2 hours (.5-1L of water per hour).
- Monitor for heat exhaustion, stroke, or any possibly related or masked symptoms/conditions.
- Keep patient cool and calm.

## HEAT EXHAUSTION

Heat exhaustion happens when it's hot and people don't get the water that they need.

### Symptoms:

- Skin can be flushed or pale, cool, and clammy.
- Fainting and/or dizziness.
- Nausea.
- Fatigue.
- Thirst and decreased urine output.
- Patient's temperature stays below 105° F.
- Heat cramps.

### Care:

- Drink water or rehydrating fluids.

- Rest in cool, shady spot with circulating air.
- Monitor for shock symptoms.
- Rest until symptoms subside.

## HEAT STROKE

Heat stroke happens when the body is no longer able to cool itself due to extreme heat, exertion, or ongoing medical issues.

### Symptoms:

- LOR changes.
- Hallucinations and seizures.
- Uncoordinated movements, falling down, stumbling.
- Skin is red, hot, and dry or moist; sometimes pale.
- Patient's temperature is above 105° F.

### Care:

- Aggressive cooling (spray with water, fan patient).
- Monitor for relapse.
- Considering severity/recovery time, possibly transport to ER.

## NOT ENOUGH HEAT: "COLD" AND HYPOTHERMIA

Feeling "cold" and "not warm" are the same thing.

If someone is not warm, they are losing heat. This will continue until:

1. They change something about their current situation, including getting out of the cold, or
2. They get sick from losing too much heat.

### Symptoms:

- The patient will first report feeling chilled or "freezing," but eventually stop feeling cold.
- Irritability.
- The Umbles: The patient mumbles, stumbles, fumbles and grumbles.
- Fatigue and apathy towards the situation.
- Patient will have blue or white skin around lips and eyes.

### Care:

- Prevention! Know the weather. Assume that it will be colder than expected and bring extra clothing. Hypothermia is most common at 40-60° F because people don't take the temperature seriously.
- Bring stuff to keep people warm: hand warmers, candied ginger, cayenne for shoes (note: cayenne can cause burns when applied to bare skin).
- Keep moving! This will generate heat in your body.
- The body needs fuel and water to keep warm. Eat high calorie foods (nuts, choco-

late, fruit, etc.), hydration, warming herbs (ginger, thyme, cayenne).

- Alcohol, cigarettes, and other drugs can increase heat loss or make people oblivious to the initial signs of serious problems, so best to avoid them if possible.
- Seek shelter; change the environment around them if possible. Changes in clothes should be considered as well.
- If the patient's LOR drops, seek emergency medical care immediately.

#### URBAN HYPOTHERMIA

Urban hypothermia occurs when the cold has been mild but prolonged. It is often seen in houseless

populations where the weather is wet and slightly above freezing for weeks at a time. When working with patients in typical wintertime weather it is important to keep in mind what sort of medium-term (days-weeks) exposure to the weather this person has had, and to be prepared to care for hypothermia even in temperatures in the low 40s.

#### **RED FLAGS FOR HEAT LOSS**

Lowered/Dropping LOR.

#### **RED FLAGS FOR ALL HEAT RELATED**

Altered LOR (even AO X 3) with symptoms of heat illness.

# 9 Police

## RUMOR CONTROL

Medics get lots of information from different sources, often conflicting, and often inaccurate. Sharing the information you have with your affinity group or buddy can sometimes be a tricky thing. Be specific about where your info is coming from and careful as to how and to whom you relate it: “I heard a rumor that the cops are coming to the intersection from all four directions,” instead of, “Oh my god, they are coming!” Use your best judgment in general, and err on the side of caution when in doubt. Keep in mind that everything we hear is a rumor unless we see it personally, and even if we have it still might not be helpful to relay the information.

When it is important to discuss information with others, a helpful tool to use is to state what you see, what you have heard or know, and what you feel. For example:

“I see police all around us. I have heard that more police are coming, but I feel like the police are not going to arrest people right now because they seem to be having a dance party.”

## POLICE TACTICS

Police use tactics to cause **fear** and **compliance** with the aim of dispersing or containing a protest. In long actions, police apply chronic, somewhat unpredictable, low-level harassment to wear protesters down; the theory is that worn out protesters will escalate (and be contained) or give up (and disperse).

As medics, we help movements resist police tactics so that they may make their own non-compliant choice to continue to demonstrate or voluntarily evacuate without fear.

## CROWDS

When people are gathered in a large crowd, police often use the crowd to hurt the people. By pushing the crowd with barricades or making the crowd run, they can cause people to be trampled, panic, or get angry and fight each other. Crowds that panic or run result in twisted ankles, exacerbation of asthma or heart conditions, and other complications. People who try to hold the police back often become injured on their hands, fingers, arms, shoulders, faces, or heads.

## **Buddy roles in a crowd**

When the police make a crowd into a dangerous environment, you and your buddy should:

- Constantly look for openings.
- Be sure not to be caught in small spaces.
- Do not get into fights with other people in the crowd.
- Spread calm: if people are running, start a chant of "Walk, walk, walk."
- While one buddy stands tall and looks for dangers, the other buddy can look low between the legs of the crowd for anyone who may have fallen.

When crowds are gathered for long periods of time, people often forget to drink water, eat food, or piss. People sometimes do not sleep enough and drink lots of coffee to stay awake, do not attend to injuries such as foot blisters or illnesses such as colds, and are often unprepared for the weather. You can help make it safer for people to come and go from the crowd, or for resources such as drinking water, water for washing hands, protection from weather, and food to enter the crowd and be available to the people.

Everyone is safer in a crowd when they go with a buddy or in an affinity group of several buddies.

## **KETTLING METHODS**

This includes bicycle lines, barricades, kettling nets, and police lines.

## **Watch out for**

- Crowd crush – form of blunt trauma, but really asphyxiation (especially when backed against immovable walls).
- Ranked domino effect – crowd falling into crowd behind.

## **Common injuries**

- Lower limb injuries from barricades or tripping while being pushed backwards.
- Hand, finger, torso, and face injuries from tug-of-war over barricades.
- Exacerbation of pre-existing conditions, especially asthma or cardiac conditions; can provoke panic attacks.

## **Higher risk factors**

- Prone or seated persons.
- Crowd crush / ranked domino effect can be very dangerous for people with respiratory compromise or psych conditions.
- One rank falling on ranks behind can cause crush asphyxiation, inability to move, very disorienting.

## **BATONS**

Batons are basic police weapons that can be wielded in different fashions. Hardwood batons are usually wielded overhead and used to hit the upper

torso and head. Blunt trauma from overhand clubbing to head and upper torso, etc.; body-checks to chest/ribs. Tonfa-based batons (with side handles) are often used to jab people in the torso.

### **Prevention**

- Spread calm: “walk, walk, walk;” look for exits.
- Stay away from the front rank of protesters. (You should do this anyway, in order to be able to effectively assess overall situation).
- Consider a bicycle helmet and a cup for your genitals.
- Consider protecting your forearms with rolled-up magazines up your sleeves.
- Do not attempt to shield another protester from a cop unless you are willing to risk legal charge.

### **Higher risk factors**

- People with chronic illness that might get exacerbated.
- Prone or seated persons.

### **CHEMICAL WEAPONS**

Chemical weapons include pepper spray and tear gas. They are short-range weapons used to control small crowds, often used when the police panic: fence coming down, police line broken, or they feel like they have lost control.

Most often chemical weapons are sprayed from a can or large container like a fire extinguisher. We are not going to differentiate between tear gas and pepper spray for the purposes of street medicine.

### **Prevention**

The street medic community has tested remedies and has not found anything that can prevent the effects of chemical weapons. Please do not cover your body in toothpaste, baking soda paste, raw egg, milk, Tecnu, onion, lemon, vinegar, or anything else as prevention.

Know the scene, watch the cops, and stay upwind. Turn your back to any chemical weapon assault.

Do not wear contact lenses to protests, as they trap chemical weapons in the eyes. Cover your skin and hair (rain gear, ball cap); wear goggles; cover your nose and mouth with a bandana or respirator.

### **Effects**

The chemicals in riot control munitions are designed to irritate the eyes, skin, and mucous membranes. Symptoms may vary from patient to patient, but most patients will experience some of the following:

- Eye pain.
- Difficulty seeing or breathing.
- Coughing.

- Intense pain on skin – it can cause a first degree burn, like sunburn.
- Panic (can not breathe or see).
- Intense and unfocused rage.
- Flailing, screaming, spitting.

Your patient may be flailing, screaming, spitting and spluttering (remember BSI – their body fluids will cause you pain!) Occasionally you may see convulsions, shivering, and other strange things. As always, if you do not know what is going on, say that you do not know, and get help.

### Higher risk factors

- Asthma.
- Contact lenses.
- Conditions (and recovery) affecting the immune system, like HIV or medication; skin, like psoriasis or eczema; eyes, like corneal damage or infection; or respiratory tract, like bronchitis or emphysema.
- Children (especially those under the age of 6): tiny airways.
- Elderly people.
- Pregnancy, nursing, or trying to get pregnant.
- Long-term steroid use (e.g. prednisone) for Crohn's disease, rheumatoid arthritis, or other reasons.

### First aid:

When approaching people who have been exposed to chemical weapons, take a moment to call out "Who here has been sprayed?" People who are clearly making eye contact or who respond, "ooh, ooh me!" may not be your first priority. Remember it is often the people who are unable to seek care that need it most.

Once you've approached someone who has been pepper sprayed:

1. Introduce yourself and get consent. Remember the patient may be blinded and enraged.
2. Immediately ask if the patient has asthma or is wearing contacts.
3. Encourage calm and steady deep breathing. This will lessen panic.
4. Move patient to an uncontaminated area if there is gas in the air. Ask for consent, then put hands on patient and guide them.
5. Encourage coughing and spitting so he doesn't swallow the chemicals.
6. **Calm, comfort, reassure, and educate** about how the pain is temporary and we are extremely strong, and about the importance of decontamination before entering buildings. The most intense and painful symptoms are temporary and will go away within about 30 minutes with no treatment.
7. Flush eyes with water, saline, salt water, or liquid antacid with water (LAW). Our LAW

recipe is 50% Maalox brand liquid antacid and 50% water. Put it in a squirt top water bottle.

In the US we recommend Maalox because we know what the ingredients are. They may vary in other countries. Active ingredients to look for are magnesium hydroxide and sodium hydroxide. The anti-gas ingredient simethicone is not known to be dangerous or helpful. Alcohol, which some antacids contain, is bad for the eyes. Sorbitol, which is sugar alcohol, does not seem to cause harm. We recommend Maalox brand unflavored for best results, though some generics work as well.

#### **To flush eyes:**

1. Get patient lower than you – kneeling, sitting, or hunched over.
2. Tilt head forward and to the side you are going to flush.
3. Hold eyes open for patient if you need to.
4. Flush from the inside corner of the eye to the outside – be careful to not let it (and the chemicals it is moving) run across the face/into the other eye.
5. Tilt head the other way and repeat flushing the other eye.

You can also squirt LAW into patient's mouth, have them swirl it around, and then spit it out.

#### **RED FLAGS**

- Patient leaves the chemical weapons area and does not quickly breathe more easily.
- Patient does not respond to care.
- Unusual symptoms that do not quickly improve.

#### **Decontamination**

Avoid entering enclosed spaces (like your house) with contaminated clothing, and be aware of vulnerable people who you might expose.

- Take clothes off outside and put them into a plastic bag. Seal it and do not open until doing laundry.
- Avoid touching anything (pets, furniture, car, phone, etc) until you have washed up.
- Take a tepid shower – heat will irritate a new burn. Do not use soap that has peppermint in it: this will further irritate skin that has been exposed to chemicals.
- Wash clothes immediately with detergents, several times if need be.

## TASERS

### What is a Taser?

Upon contact, the Taser typically delivers a 5-second burst of 50,000 volts electricity that overrides your central nervous system with the command to curl up into a ball clenching all muscles (officers can vary the duration of the burst as well as the number of pulses per second). As long as the targeted person remains connected to one of the Taser barbs, the police officer is capable of delivering further shocks.

### First aid considerations

The purpose of the Taser is to aid in controlling and apprehending somebody – that is, incapacitating a person so that a police officer may arrest them. Considering this, it is unlikely that medics in a demonstration setting will care for large numbers of Taser injuries. However, the following methods of care have been discussed over the action-medical listserv and in trainings:

- Calm, comfort, reassure, empower the person; rehumanize the situation.
- Restore the electrolyte level of the person's body. This can be done with Emergen-C, or water with a banana.
- Assess and care for injuries resulting from falls.
- Treating barbs as impaled objects—stabilize

them and bring to further care (with consent).

- Care for burns left by the barbs.
- In the event of localized muscle spasms, ice the affected area.
- Monitor/provide care for shock, advise rest.
- This weapon takes control of a person's body away from them while simultaneously delivering a lot of pain. Remember the importance of consent when somebody has been attacked with such a frightening, dehumanizing weapon.

### RED FLAGS

- Injuries to the head, neck, or spine.
- Prolonged vomiting.
- Blood in the urine if hit in the back.

### Wound aftercare

Be aware that pain and swelling may increase, and the area of redness and bruising may expand, for up to 2-3 days.

- Apply ice as needed as long as swelling or localized muscle spasms persist.
- Keep the burn area clean and wrapped in sterile nonadherent dressing. Change dressing daily.
- Before daily dressing change, use lukewarm plain water compresses to help soak off

crusting areas.

- A tetanus booster shot is recommended for anyone who has not had one in 8-10 years.
- Follow-up with an experienced healthcare worker.

### **Supportive care/aftercare**

- Replace electrolytes by sipping nutritious fluids like water with a sports drink (e.g. Recharge, Gatorade) or Emergen-C powder with a pinch of salt and sugar added.
- Get some rest and drink lots of water.

### **BLUNT FORCE TRAUMA**

Police have a number of weapons they refer to as **impact munitions:**

- BB bags (4 X 4 in. mesh bags filled with metal BBs fired out of special guns).
- Rubber bullets (small, solid rubber).
- Dowels (usually rubber, sometimes wood).
- Pepper bullets (like paintballs but filled with pepper spray rather than paint).

Police also have horses, bikes, and a variety of motorized vehicles, which they use to cause injuries that do not always break the skin but can cause bruising, broken bones, and internal bleeding.

The police are trained to aim at the torso and arms with all of their impact munitions. Bikes, horses and vehicles tend to injure the legs and

feet. Sometimes the head and lower abdomen are targeted or hit accidentally; this is a more serious situation.

Hardness in the abdomen area along with signs of shock and compromised vitals are signs of internal bleeding. This should be considered a life-threatening emergency.

The thighs are also an area of the body where injuries can lead to internal bleeding or shock. Horses sometimes step on feet, and less often people are hit with police vehicles. These MOIs are an indicator of possible broken bones.

### **SHIT! WE'RE GONNA GET ARRESTED!**

#### **MEDICKING AT JAIL AND ARREST SITUATIONS**

Like all protesters, street medics are occasionally at risk for arrest due to mass arrest situations or because of direct action/civil disobedience. Street medics have been both targeted for their support role and released from sticky situations because they were medics; most often medics are not treated significantly different than other protesters when arrested.

When medics end up in jail we sometimes have the option to continue our role as a medic by checking in with those around us, remaining calm and spreading calm, and providing rumor control. Many medics who have spent time in jail report providing medical advocacy, reminding people to

stay hydrated and calm when possible, and helping those who have been injured strategize about their options.

We may feel scared and helpless when being arrested, but the reality is that street medics can continue to do a lot of good before, during and after arrest.

In a mass arrest situation, there is usually enough time to know what is coming. The crowd will probably be trapped in an area surrounded by cops. A dispersal order may or may not have been given, and leaving the area may or may not have been possible. The cops will likely use a loudspeaker of some kind to inform the crowd that they are under arrest.

**Spread calm. Remember that people look to medics for information.**

While waiting for your turn in a mass arrest, think about what you can do for those around you.

- Remove chemical weapons from people's skin. Advise people to change into clean clothes if they have them, or remove outer layers if they are contaminated.
- Provide food and water to people.
- Realize that there may not be a chance to use a bathroom for several hours. Make sure people around you know that, too.
- Give out the jail support phone number.
- Hugs, back rubs, smiles and sing-alongs can all help reduce tension.

- We never have to stop medicking! We can care for handcuff injuries, watch for stress related problems, and support general well-being, even after our own arrest.
- Self care is important. Get the support you need from those around you.

If you are the only person arrested out of a crowd, stay strong. The cops use fear as a weapon, and being alone and under the power of the cops is a very fear-inducing situation. Know that activists care a lot when their medics are taken and that a little preparation in advance can greatly reduce the level of fear and stress in this situation.

For more information on arrest situations and planning, see the appendix for an article titled "What To Do When Your Affinity Group Goes to Jail (In a Handbasket)." Taking a Know Your Rights training is very helpful and highly recommended.

### **Jail support medicking**

Medics do support for people released from jail. We often work with a jail support team including people from the legal collective and people from the action collective, but sometimes it is just you and your buddy. The setting can be anywhere: on a park bench, in a parking lot, in a field, in a hallway inside the courthouse, etc.

Catch people as they are released. Match their energy. Some people are fine, and some people may be withdrawn. Some people will be very

emotional – they have been holding it together for the last few days in jail, and when suddenly released fall apart for a minute. Help people put their experience into the context of their everyday life. Meet immediate needs (cigarette, food, hug from a friend, housing plans for the night, phone call, etc.).

Sometimes you sit around for hours waiting for people to get out. If you are patient, you will get lots of opportunities to help people at jail support. You may see infected wounds; taser burns; coughs, colds, and flus; exacerbated chronic illness; sore shoulders from handcuffs; and handcuff injuries.

#### GOING TO JAIL: DO THIS NOW

- If you have legal support, have the phone number written in permanent marker somewhere on your skin. Have any other numbers you might possibly need written on you, as long as you do not mind the police seeing them.
- Your bag may get taken long before you are searched, so put anything you want to have with you somewhere on your person, particularly ID, medications and money (no need for ID if you are doing jail solidarity). Other things to keep: cell phone (beware of any sensitive numbers in memory), food, extra clothes (protects against cold floors, good

pillow), pen, paper. You will probably get your stuff back, but no guarantees. If you can, consider giving your bag and keys to someone who will not get arrested.

- If you want to get anything past a search, this is the time to hide it. Pens, phones, and medication can fit nicely in the front of your underwear or bra.

#### IF YOU ARE PUT IN PLASTIC HANDCUFFS ("FLEXICUFFS" OR "ZIPTIES"):

- Plastic cuffs have caused some people long-term nerve damage. If you have pain, numbness, or tingling in your hands at any time immediately request that looser cuffs be put on. If one officer refuses, ask another and do not stop asking until they change the cuffs.
- Try not to move around too much, as this can tighten the cuffs. However, if one or both cuffs are already too tight, massage the hand whose cuff is too tight in order to promote bloodflow and limit damage.
- Consider requesting that you be cuffed in front. Ask if anyone in your group can demonstrate how to contort yourself so you can get the cuffs in front.
- If you experience pain, numbness, or other unpleasant feelings after the cuffs are removed, have these symptoms documented immediately by a medical professional.

IF YOU HAVE A MEDICAL PROBLEM BEFORE  
OR DURING DETENTION:

- If you have a medical condition that could cause problems while you are being held consider telling the police ahead of time. This may encourage them to respond more quickly if you start to have problems.
- If you or anyone in your group starts having a medical problem tell the police right away (with the person's consent), and request immediate professional medical attention. Do this early, as it may take a long, long, long time for the police to do anything. If you do not get a response initially keep asking until help arrives. Consider using chanting or other group tactics to get the police to respond.

WHILE YOU ARE DETAINED:

- Stay as calm as you can. The police may try to unnerve, dehumanize and stress you out. Try yoga, singing, meditation, sharing stories, etc.
- Remember, police lie. Your fear is their weapon against you. They will tell you things that are not true; for example, they may say that your friends have blamed you and are getting out or that you will get out in an hour.
- Think about what good can come of your arrest. Can you do a skill-share with you cell

mates? Learn new songs? Tell jokes?

- If police are abusive in any way (emotional or physical abuse or violating your rights) note the officer's name and badge number. Try to remember as many specific details as you can. If you have a pen, write it all down!

WHEN YOU GET OUT:

- Release can be paradoxically stressful: suddenly you have to deal with the outside world again.
- Try and talk about your experiences before you go to sleep, ideally with the people you were with. If possible, recount what happened and how you felt about it. If you do not feel comfortable talking, listening to others talk about what happened can help. Research shows that if people sleep before talking about traumatic experiences they have a higher incidence of long-term emotional problems related to the trauma.
- Try and be gentle with yourself. Sleep (after talking), eat healthy food, relax, get friends to give you massages, indulge, BUT avoid alcohol, tobacco and other drugs as much as possible.
- Do not go through this alone! If your regular friends are not sympathetic, find fellow activists or groups that can help. Some medics are trained in counseling, or you can call the

a good warmline or hotline

- Be creative with stress management – try herbal therapy, counseling (many people have found Eye Movement Desensitization and Retraining or Somatic Experiencing especially helpful), massage, Reiki, etc.
- Even if you do not feel terribly stressed you may have nightmares, a short temper or other reactions to your experience. This is normal, and may be a sign that you could use more formal processing of the experience.

## HANDCUFF INJURIES

Handcuff injuries are some of the most common injuries among arrestees. Plastic flexicuffs are generally used for protesters. They tend to be very tight, bringing the arms closer together. Quite often arrestees are unable to move their hands. Both of these things decrease circulation with the potential result of nerve or tissue damage.

Prevention of handcuff injuries is the best way to go. If you are not putting yourself in danger, try the following:

### **Spread calm**

Even if you or someone else has or is at risk for an acute injury from handcuffs, stay calm. Arguing and getting angry will make it less likely you will get the handcuffs removed.

If you can talk to those arrested, ask them how their hands are feeling. They might be experiencing pain around the thumb, numbness, tingling.

### **Advocate**

Advocate for removal or loosening of the handcuffs. Explain your concern calmly and clearly to the police. For example: “I am a medic and Sarah is experiencing numbness in her hands. She could have permanent nerve damage if the handcuffs are not loosened immediately.”

Ask each cop you talk to twice, and then ask someone else. Repeat as necessary. If an officer says that he is doing something about it, try to write it down, including the cop’s name, rank, and badge number.

People who have had handcuffs on too tight or for an extended period of time are more likely to have serious injuries from handcuffs.

Remind other people in the area to keep an eye out for people experiencing pain from handcuffs. If anyone complains of tingling or numbness, advocate for them!

### **Symptoms:**

Changes in sensation or pain will usually occur along the edge of the hand between the base of the thumb and the wrist.

It can also extend to the back of the hand below the first two fingers (forefinger and middle finger)

and the back of the thumb and the backs of those fingers.

In most cases, damage from handcuffs is not serious and will heal. If you have a patient who has handcuff injuries, test for any muscle weakness in the hand, thumb or fingers.

Compare hands to make sure they both have equal sensation:

- Ask the person to squeeze your fingers. Ask him if he experiences weakness. If he says yes or you feel that his grip is weaker in one hand, that could be a sign that he has nerve damage.
- Lightly touch each of his fingers and the base of his thumb, his wrist, and his forearm. Repeat on the other arm. Ask him if he feels numbness, tingling, or any other unusual sensation as you touch.
- Squeeze his fingers and thumb. Ask him if he feels numbness, tingling, or other unusual sensations.

#### **Care for handcuff injuries:**

- Examine the hands, wrists, and forearms as detailed above. Pain will subside some when the handcuffs are removed, but there is often lingering altered or decreased sensation.
- Once someone has had his handcuffs removed and you have checked CSM, try to encourage blood flow by having him stretch,

roll his shoulders, do arm circles, and clench and unclench his hands.

- Remind her that if an area was not getting enough blood flow, it can be painful to start moving again, but that this pain is a really good sign.
- If there is total numbness in any part of the hand, sensation should start returning within a few minutes. If it does not, or if it gets worse, this may indicate that a nerve has been cut and you should get that person further care.
- Numbness above the wrist could indicate damage to neck, spine, or arm. Get further care.
- Inquire about mechanism of injury (MOI) and possible injury prior to handcuffing. Like other injuries, sometimes an obvious injury may be masking a more serious problem.
- Check for tenderness in the bones of the hands and arm. If there is any, refer the person to further care.

#### **Herbal first aid and aftercare**

There are a few herbal remedies that are useful in cases of handcuff injuries. First clean any wounds, then apply salve with the herbs below to the wrist or areas experiencing pain, swelling, or loss of circulation, sensation, or motion. Massage the oil or salve on the patient's wrist (remember to use

gloves; you can also use a q-tip, cotton ball, or gauze pad) or put some in his hands and have him apply it. Be careful about using oils or salves at actions: oils can trap chemical weapons on the skin.

Here are some herbs you can use. They are all for external use only and are available in health food stores or from your local herbalist.

St. John's Wort helps reduce bruising and nerve damage.

Arnica reduces pain and inflammation and encourages healing. Do not use arnica externally if the skin is broken. You can also use homeopathic arnica tablets if you have them.

Calendula flowers promote healing and reduce inflammation.

**Note:** If someone has major nerve damage, they have about a year to heal the nerves before damage is irreversible. There are herbs that can help with this. Find an herbalist for more information.

## CHEMICAL WEAPONS AFTERCARE

Exposure to tear gas and pepper spray may damage the protective lining of the lungs, which can make us more susceptible to lung infections and diseases. Activists who have been exposed often experience lingering respiratory disorders. Additionally, the toxins from the chemical weapons can stick around in our bodies, taxing our liver and our general immune system. There are many steps

you can take to help decrease your risks from exposure to these toxins. Some of these steps need to be taken as soon as possible following exposure. Others should be done regularly over the weeks before and after exposure.

### First aid

After flushing eyes, encourage people to decontaminate themselves at home or at the wellness clinic if one is set up at a major convergence. Remind them to not bring contaminated clothing indoors unless wrapped up in a plastic bag and to wash hair and all contaminated clothing in a strong detergent.

### Aftercare

Aftercare for chemical exposure breaks down into three parts: care for burning skin, lung support, and liver support.

### Skin

Flush skin with cool water for at least 10 minutes.

Use wet paper towels or gauze to apply a cooled tea of any combination of Calendula, Plantain, and Chamomile. Rewet as needed.

Do not use aloe vera on pepper spray burns. It may seal chemicals in, much the same way that it can seal in a staph infection in a wound. Also beware of using soap that has peppermint in it: pep-

permint will irritate skin that has been exposed to chemical weapons.

## Lungs

- Mullein leaf (*Verbascum thapsus*) provides excellent lung support. This should especially be used if someone is asthmatic or has a cough. Mullein leaf can be made into a tea or a tincture or smoked in a cigarette.
- Malva root (*Malva neglecta*), also known as Cheeseweed, is related to Marshmallow and Hollyhock. These are mucilaginous (slimy) herbs that soothe and coat mucous membranes. Mucilagens are especially important for people who inhaled chemicals like pepperspray or tear gas.

## Liver and general detoxification

Your liver needs to work overtime to filter out the toxins from pepper spray and tear gas. Here are some things you can do to support your liver.

- Drink at least 2 liters of water a day, more if you can. Squeeze some lemon in the water for added benefit.
- Use bitter, liver tonic herbs such as milk thistle seeds (*Silybum mariannum*), burdock root (*Arctium lappa*), and dandelion root (*Taraxacum officinale*) for about two weeks after being exposed to chemical weapons.

- Avoid alcohol, cigarettes, caffeine, fried foods, and foods high in fat.
- Your liver continues to work while you sleep, so having a regular sleep schedule is important.
- Eat whole grains and brightly colored vegetables and fruits.
- Take a hot shower. Follow with a thorough scrubbing with Epsom salts, which are then left on the skin for 10-15 minutes before a thorough follow-up wash. This can help draw toxins from the body. Be sure to accompany with much water consumption.
- Nettles are the perfect all-around support plants. Their high mineral content and mild cleansing action supports many body functions. The phytonutrients boost the immune system, the minerals soothe nerves and muscles and strengthen bones and connective tissue.

## DOCUMENTING INJURIES AND EXPOSURES TO CHEMICALS

*The material in this section is adapted from "Shooting the Wounded" by the Midnight Special Law Collective in San Francisco ([www.midnightspecial.net](http://www.midnightspecial.net)).*

### **Why do street medics need to know this?**

Street medics are often targeted by police and arrested and injured. It is important for you to know how to document your own injuries. You may wish to document your injuries for lawsuits and/or media coverage. Consult with a legal worker before emailing or posting photos or videos on the internet. You can also encourage people you help to document their injuries.

### **Why document injuries and exposures to chemicals?**

Police in many U.S. cities attack the individuals most oppressed by social inequalities, exploitation, and poverty – people of color, poor people, people who are transgender, etc. When police overstep boundaries, most victims do not have the knowledge or resources to seek “justice” in the legal system. Medics, activists of color, and transgender activists are often targeted and sometimes have worse injuries than other activists.

There is no guarantee that you will win your case against the police, but having photos or video of your injuries will improve the odds. Also, reports from a doctor at a free or low cost clinic can create a record of the injuries that do not show up on film like torn muscles and concussions.

Documenting your injuries simply means that you get written and visual proof of them so that even after they have healed, you have proof that

they existed. If you are thinking of suing the police or filing a complaint, evidence of brutality will help you build a stronger case. Below are a few tips to make documenting easier.

### **How to photograph injuries and the scene of the incident**

Even the marks of severe injuries can disappear quickly. Without good photos, you might lose those injuries as evidence of police brutality. Generally, the darker your skin is the less your injuries will show up on film, and the more important it is to follow these guidelines.

- Have someone take a picture of your whole body before moving in and getting close-ups of the injury.
- Take photos as close as possible to the injury to show the most detail.
- Try photographs from different angles and with different lighting.
- Be careful not to use a flash when taking a close-up photo. Flashes, bright light, and spotlights right on the injury tend to reflect off the skin and make the bruise or other injury appear lighter than it is.
- If the injuries are big, put a ruler next to it in one of the photos to show how big it is (but make sure you take some photos without the ruler, to show you are not hiding anything). If you do not have a ruler, use something with

a standard size, like a dollar bill.

- Do not rely on any one photo to show your injury. You should take at least four photos of each injury.
- Take photos every day or every other day to show how they change. For example, bruises can take a few days to fully darken.

### **Talk to health care professionals**

- Go to a doctor you can trust as soon as possible. If you cannot afford to pay, look for clinics that provide free or low-cost care.
- Make sure you know the names of all of the doctors, medics, and nurses that see your injuries.
- Tell every nurse, technician, and doctor who looks at you about each of your injuries (including less severe ones) and how you got them.
- Ask every professional who looks at your injuries to document them in detail, especially injuries you cannot take photos of, like sprains, strains, broken noses or broken ribs.
- If the doctor recommends follow-up care or appointments, it is important to go. This will let the doctors keep documenting your injuries and give you more credibility.
- Hold onto any forms or documents you get from anyone at the hospital or clinic.

### **Warning**

It can be risky going to a hospital right after being injured by the police, especially during large

protests. Emergency room workers often call the police if people who look like activists come in for help. More than one activist has ended up in jail after going to the hospital to have an injury documented.

There are steps you can take to keep yourself safe: go to a doctor you have a relationship with, go to a hospital or free clinic across town (or in a different town) from the protest, and be dressed up “nice.” Of course, if it is a potentially life-threatening injury, consider taking the risk of going to the closest hospital. If you have already been cited and released or gone to jail and been released, you do not risk as much by going to a hospital and telling them exactly what happened to you.

### **Other evidence**

- Keep a diary of all of your injuries as they progress and heal.
- Keep all evidence! Including rubber bullets or tear gas canisters. If you have bloody clothes, put them in a garbage bag and hold onto them in a freezer.
- Hold onto all paperwork you get from the cops or the court (e.g. arrest report, property receipts, booking photos, etc.).
- Tracking this information can be helpful when building your case. A police misconduct report is included in the appendix.

# 10 Herbal First Aid and Aftercare

## HERBALISM AND STREET MEDICINE

It is nice to have some quick fixes to use together with our assessment and first aid skills when people come to us for help. Giving a remedy to someone is a great way to start talking about his health, and can help him remember to take better care of himself.

Nobody carries all of these remedies. Do your research, play around with them, and decide which ones you want to work with. No matter what you carry, you will still need to be creative and adaptable. Use what you have and find ways of getting what you need. Remember how deeply your quality of care is intertwined with the way in which you provide care (it ain't called "care" for nothing!). Without any of these tools, you can still carry the same intention and help people feel better and restore dignity.

The same remedy may not have the same effect on two different people. Remember to ask about allergies, medications, and past medical history before giving remedies. Hang out with the patient for a while after giving a remedy to monitor for any unexpected reactions, and check in later to find out if he is still feeling better. You will learn more about these remedies from your patients than from any teacher.

## PRINCIPLES OF REMEDIES

Street medics look for different things than many other health workers in our choice of remedies. We choose remedies that are:

- Not regulated as pharmaceuticals.
- Inexpensive per dose.
- Versatile (each remedy has many uses).
- Small and lightweight or easily obtainable.

Each medic should only carry what she is comfortable using.

## SOME REMEDIES TO CONSIDER

- **Lavender essential oil.** Smelling the oil releases tension in the head and is relaxing and soothing. A dab of lavender on a bandana tied around the neck is a great way to spread calm on marches.
- **Peppermint spirits** is Peppermint tincture plus a tiny amount of peppermint essential oil. Administered in water, it settles the stomach and soothes most nausea.
- **Ginger.** Tea can be made from the fresh or dried root. It can be used in cooking, or crystalized (candied) ginger can be carried in the streets and handed out to provide energy. It settles the stomach, disperses cold, and warms the body from the inside.

- **White flower oil** is a Chinese remedy obtainable in Asian markets. This is an older, more effective liquid formulation of Tiger Balm. It is very grounding and anti-panic. Put it on your or your patient's hands and have him inhale deeply, and invite him to massage a little on his temples or the back of his skull for rapid headache relief (along with drinking a lot of water or rehydration drink). A dab under the nose will usually help clear congested sinuses, and massaged into the chest (like Vick's salve) it can break up chest congestion.
- **Wild oats.** Nutritive and a nervine; good for use as a tea, especially at convergence spaces during actions.
- **Ching wan hung** is another patent Chinese remedy. Use it or **honey** in place of burn cream or Neosporin on burn wounds, blisters, cuts, and old infected wounds. It is drawing, anti-infective, and wound healing.
- Gallons of **water** or **rehydration drink** for stress, anxiety, asthma, mild hypothermia, drug detox, fever, vomiting, diarrhea, headache, pain, etc. Rehydration drink is 8 teaspoons of sugar (or honey, maple syrup, instant mashed potatoes, etc.) and 1 teaspoon of salt per liter of water. It is even better with a potassium source like a banana or a splash of 100% fruit juice. Water is usually mostly absorbed in the intestines; rehydration drink moves the absorption site up to the stomach, meaning much quicker hydration. For vomiting, add a pinch of black pepper to quiet the nerves of the stomach and contribute an anti-infective action.
- **Clove bud oil.** Topical remedy for dental pain and infection (like a rotten tooth). It is an old dentistry standard that kills both birds with one stone. It works rapidly, but irritates the cheek and gums, so apply it precisely with a cotton applicator (have the patient clench it against the painful tooth for 20 minutes and give him something to spit his suddenly copious saliva into). Refer to a dentist for follow-up – you probably haven't seen the end of that infection.
- **Slippery elm bark.** Coats the throat and mucosa all the way down into the lower gastrointestinal tract with protective mucilage. Useful for soothing sore throats and aiding digestion.
- **Fire cider.** Garlic, horseradish root, ginger root, cayenne, and other ingredients to your preference steeped in apple cider vinegar for 2-4 weeks then strained. It is immune-boosting, intensely warming, and decongestant.
- **Cayenne.** Put cayenne powder in shoes (outside socks) to stimulate peripheral cap-

illaries, keep toes warm, and prevent frostbite. Consider putting some talcum powder in there too for dryness. For obstinate bleeds that will not stop, put cayenne powder directly in the wound and apply pressure and elevation to keep it there. Blood vessels will spasm shut.

- **Arnica** oil, salve, tincture, cream, or homeopathic pillules are the first 24 hours after an injury. Arnica mobilizes cleanup of bruising and subcutaneous tissue damage. Do not apply arnica preparations to broken skin.
- **Hypericum** (St. John's Wort) oil, salve, tincture, cream, or homeopathic pillules help heal nerves and old tissue damage. Use instead of arnica on broken skin.

## PREPARATIONS

You can use herbs in several ways:

### As a water extract

Externally – Make tea. Strain well and apply frequently as a wash out of a bottle or a spritzer; or dip a clean cloth in the tea and hold or tape it to the area for half an hour, 1-3 times daily. Will keep unrefrigerated for about 24 hours.

Internally – Drink 1-2 cups of tea a day.

### As a tincture

Externally – Many tinctures contain alcohol. These will burn open wounds when applied externally. If someone has just been assaulted they may react strongly if caused more pain.

For small injuries apply a dropper full directly to affected area. For larger areas dilute a dropper full in 1/4-1/2 cup water and apply as a wash or on a cloth.

Internally – Depending on the herb, anywhere from one drop to three droppers full 1-3 times a day.

### As an oil or salve

Externally – Salves can be used on wounds that have been carefully cleaned. Don't use oils at demos since it can hold chemical weapons on your skin. Once you are home, however, oils are helpful since they are easy to spread over a large area.

**Don't take essential oils internally.**

## RULES

- Do no harm and stay within your scope. Don't give someone a plant that you are not familiar with and haven't taken yourself.
- Consider timing and environment when using plants on the street: giving someone a tincture for the liver will set the digestive system in motion.
- Know the proper usage, dosage, and contraindications for every plant you use.

# 11 Mobilizations

## PUBLIC HEALTH

Street medics need to think about public health during mass mobilizations or extended actions.

- When large numbers of people share close quarters (e.g. convergence spaces), things spread.
- Lots of protesters come from out of town, and many don't have access to resources some people still take for granted (shower and change of clothes, somewhere "safe" to sleep, hot water, etc.).
- The Lazy Medic's Code: If we do prevention right, we won't have to treat anything (For example: If we remind everyone to drink water and make it easy for everyone to drink water and pee, we have to deal with less dehydration, hypothermia, altered mental status, results of poor decision-making, respiratory infections, and urinary tract infections).
- Actions can be really stressful. Not enough sleep, weird food, hours sitting in a car: these and other factors can put a lot of stress on a person's nervous system and is taxing on his body. Dehydration means all those stress hormones aren't going anywhere; mild hypothermia amplifies this cascade. Together these factors make people more suscepti-

ble to illness, infection, and poor decision-making.

### **What can we do?**

Street medics have a special relationship of trust with protester communities. This trust allows us to do prevention work, to recognize public health problems before they get out of hand, and to work to educate people and encourage change. Our work all depends on actively maintaining our bond of trust.

We maintain our bond of trust by being available, approachable, kind, nonjudgmental, and radical. We give out things like candied ginger, hand warmers, ponchos, herbal tea, condoms, and cough drops, all of which give people a reason to interact with us and build trust. We meet people where they are with respect and understanding.

### **Street medic public health interventions**

- Harm reduction.
- Building relationships.
- Encouraging people to take better care of themselves.
- Find trends early.
- Identify vectors.

- Ask good questions.

### **Mind-altering substances**

Alcohol and other drugs make our spaces less safe. Some people have had traumatic experiences around these substances, and some people are recovering from alcoholism or other addiction and can't be around them for that reason. Many of these substances are illegal and can give the cops excuses to harass people. Intoxicated people are more likely to get dehydrated or hypothermic, to have accidents and falls, to sexually assault someone, to have airway or breathing emergencies, and to exercise poor judgment. Failure to define the boundaries of the spaces we occupy makes things way less safe for everyone involved.

A few things to keep in mind:

- Figure out what your own boundaries and triggers are. Discuss with your buddy.
- Intoxicated people may be unresponsive, withdrawn, belligerent, confused, out of it, needy, aggressive, or manipulative.
- Think about your skill set, and what your buddy team and other medics have to offer. How can we help people with substance abuse-related needs? What should we probably not do?
- What harm reduction and treatment options are available? Is there a needle exchange, a safer place someone can go, can someone

on your team administer Narcan? What is the local recovery fellowship (AA, NA) hotline, and where and when are the nearest meetings?

- Involuntary treatment does not work. Meet people where they are.

Remember to separate the behavior from the person. People who are abusing substances are often systematically looked down on and dehumanized. You are meeting someone at a certain point in his life; the substance abuse is not his whole life nor is it his whole personality.

### **Sexual assault prevention**

Conversations around sexual assault usually focus on crisis, but Lazy Medics like to prevent people from getting hurt. Here are some questions to consider when working with protest organizers to improve community sexual health and safety:

- Does the event explicitly discuss sexual consent in materials, meetings, posters, etc.? Do spaces have rules concerning consent? Are unrepentant perpetrators of sexual assault or harassment still in the space?
- Are there alcohol- and drug-free hang out and sleeping areas?
- Are people using misogynistic language?
- Are there any barriers to getting help: Are we accessible? Do people know that they can talk to us? Can we make our spaces safer

for survivors of sexual violence? Will LGBTQ survivors feel welcome? Might anyone else feel like they cannot come to us for support and care?

- Does every medic have the national domestic violence hotline number in their phone? Is it posted in bathrooms? Do people know that it is a great number to call for any kind of sexual violence, and that they won't take away your power or choice when you call?

## PLUGGING IN

If you are going to work as a medic at a large mobilization such as those that occur at political conventions, find out what the resources will be while you're in the city. Working within the network of those providing the resources provides opportunity to learn about serving as a street medic within the community-developed infrastructure.

That infrastructure can include a convergence center where people will attend trainings, get information, network, and rest, a kitchen that delivers food to events and other spaces, legal support, independent media, and a clinic or wellness space. It can be helpful knowing where all of these places are.

## Affiliating with the clinic or wellness space

Clinics and wellness spaces are often able to provide extra first aid supplies, trainings, food for medics and patients, and wellness needs such as a place to rest or people to talk to. They can also tell you how communications between medics and things like decontamination will be handled. When you arrive in town, drop by the clinic or wellness space to introduce yourself and find out how to plug in. Sometimes there are understandings about how the street medic will contribute to the clinic and interact with those working there. Some will expect you to contribute to the work at the clinic, such as keeping it clean, in exchange for any supplies you take. Interacting with street medics and other healthcare providers at a large mobilization allows us to broaden national/regional interaction and infrastructure for providing first aid to the community.

## Transfer of care

The same principle of not abandoning your patient applies to transferring care of your patient to a person in the clinic or wellness space. The person taking over care should have the same or higher level of training that you have.

## AFFINITY GROUPS

There may come times when, instead of running as a medic pair in a mobilization or march, one or more people may take on the role of medic in an affinity group. In such situations, medic-patient dynamics and other aspects of a medic's role may alter.

An affinity group is a group of people who choose to attend an action together. They usually know one another before the action and share general goals.

Affinity groups provide their members with:

- Support during and after actions.
- Rumor control and spreading calm (because you work with people you know and trust).
- A diversity of skills so buddy pairs in the group can take on different roles (triage, advanced care, legal, scouts, mental health, supply runners, lookouts).
- Arrest and jail support (you know important info about one another like health issues, contact info, etc.).
- Having the back of targeted members of your group (genderqueer, people of color, disabled, etc.).

Preparations could include compiling medical profiles (perhaps carried with you, perhaps not) with necessary medications, information on allergies, medical conditions, and other pertinent details. Your role as a medic may also include en-

couraging all members of your group to take proper preventative measures relative to the groups plans and potential for run-ins with various environmental hazards (police included). An affinity group may be composed entirely of buddy pairs (recommended); a medic may buddy with another non-medic who is comfortable with assisting in simple tasks.

In all these cases, one of the greatest assets to a medic member of an affinity group is the opportunity to plan ahead and discuss.

Affinity groups that stay together over months or years often become collectives, and end up with cool names:

- City of Angels Street Medics
- Mutual Aid Street Medics (MASM)
- Colorado StreetMedics (CSM... as in circulation, sensation, motion!)
- Rosehip Medic Collective (in Portland, OR., the "City of Roses")
- Boston Area Liberation Medics Squad (BALM Squad)

In medic mobilizations involving larger numbers of medics, affinity groups and collectives often coordinate by forming a cluster. When action medical mobilization is logistically complex (when it includes clinical care, wellness care, decontamination, sexual assault response, or trainings as well as field medics), clusters sometimes section off into working groups. It sounds complicated,

but it's not in practice. Your buddy pair (if you're in the field) or working group (if you're in the clinic) is who you work with, and your affinity group is who you come back home to and debrief with every night. For example, if you are a field medic you might be a part of Team Knucklehead (a buddy pair), Mutual Aid Street Medics (a collective), and the street medic working group. If you are not working as a field medic, then you might be a part of the wellness team (a working group) and the medics who came down from Cincinnati (an unnamed affinity group).

Decisions are made by the people they will affect. Field medics will get together before an action to gear up and figure out roles: who plans to work where during the action, which buddy pairs want to risk arrest and which don't, and who is down to call off early so they can pull overnight jail support shifts. If they need to make any decisions as a group, they do it by consensus.

During an action itself a medic's role may begin to look a lot like other support roles—you may perhaps even be tied to a single individual or buddy team. This can alter the prioritizing process, should your medicking services be needed else-

where (another pre-action discussion point). Consent should always be asked, even if it seems like a mere formality among trusted friends.

It also may be harder in an affinity group scenario to separate oneself from arrestable positions. Even if one's role is purely medical, they may appear more closely tied to the action at hand and therefore be at greater risk for arrest than other scenarios. Once again, the exact nature of your role and plans should ideally be decided ahead of time to maintain trust and safety of all group members. Talk with experienced members and do your own research about safety and security protocols. Many infrastructure roles that turn up in large mobilizations (jail support, press liaison, police liaison, for example) may also be useful in smaller affinity group scenarios. Be informed. Be safe.

**Medic affinity groups** sometimes form to combine two or more sets of medic buddies. This connection may consist of shared equipment, skills, familiarity, protocols, and/or plans to stick together like glue. This may represent the entire medic contingent at an event or action—or represent a subgrouping in a larger mobilization.

# A Cool things

## KITS

New street medics frequently begin by packing their kit in ways that are not very useful. A street medic may identify medical supplies with social status and hoard unnecessary or rarely useful supplies, or supplies he does not know how to use. A chaotic bag means that he usually forgets important basics or loses them in his bag.

## IMPROVISATION

The only truly essential basic supplies are those you use to protect yourself (from weather, bodily fluids, etc.). If you have exam gloves, proper clothing for the weather, a change of socks for yourself in a ziploc bag, and a bottle full of your personal drinking water, you can improvise or quickly source much of the rest.

- Ask businesses for trash bags. Rip or cut arm and head holes in them and hand out homemade ponchos.
- Grab some free packets of honey from a Starbucks and use them for wound ointment.
- Ask a bar or restaurant for some free lemon or lime wedges for cold-fighting vitamin C.
- Ask a pizzeria for cayenne pepper flakes for keeping toes toasty.

## BASICS

These supplies are difficult to improvise in the situations where you need them, so you should keep them handy.

- 15 pairs of nitrile gloves that fit you (they come in s, m, l, and xl), packed in ziploc bags (2-3 pairs per bag). It is a good idea to keep a couple of pairs of gloves in a ziploc bag in your pocket in case you lose your pack.
- 30 nonsterile 2x2 gauze squares packed in ziploc bags.
- 5 sterile 2x2 gauze squares packed in a ziploc bag (one of these plus tape equals a band-aid).
- 5 sterile 4x4 gauze squares packed in a ziploc bag (one of these these plus wound ointment and roller gauze equals a dressing change).
- 5 gauze bandage rolls.
- 1 roll of 1 inch medical tape (micropore, transpore, or silk tape).
- 1 unit of wound ointment or wound salve like ching wan hung burn ointment, honey, or a salve recommended by your local herbalist.
- 1 liter of water in a sports-top bottle you don't drink from (for washing wounds, hands, etc.).
- 1 small bottle of liquid soap packed in a zi-

ziploc bag in case it leaks (for washing wounds and hands).

- 1 bag of cough drops, slippery elm lozenges, or slippery elm bark.
- Trauma shears.
- A change of socks.
- Lightweight high energy food (like energy bars, nuts, or dried fruit).
- Pen and paper.
- This handbook.

Pack your kit in a few quart-sized ziploc bags to shield it from leaks, weather, and contamination. Put these bags in a convenient location – a fanny pack, fishing vest, small backpack, or shoulder bag.

## ADDITIONAL ITEMS

The kit lists below are included to get you thinking about how important the same basics are in a great variety of situations. Most of these situations are outside the scope of this training, but you may be familiar with them as a nurse or an herbalist. You can learn more about dealing with these kinds of situations in Wellness Worker trainings.

If members of your group are trained to manage these situations, you may want to carry some of the supplies below, stockpile them in a bin, toolbox, or locker at your housing site, or keep them in your car. If you carry them, pack them underneath the basics, so that you can get your most important

supplies most easily.

Most street medics prepare only for the situations they see most often. If you do not have the supplies for a situation, be safe, support the person's dignity, use community resources, and collect the supplies to be prepared for it the next time.

## Cold weather care

### **These items are useful to have on hand for cold-weather care.**

- Your own personal preparation, including a buddy, so you do not become an additional casualty.
- Hats and dry socks packed in ziploc bags; emergency ponchos.
- Water; especially hot water in thermoses with refill options and disposable cups. Instant hot chocolate, instant miso soup, instant hot cider, ginger tea with honey, or Jell-o (with sugar) for the hot water; something to stir with.
- Candied ginger and other snacks.
- Instant handwarmers or a rice bag hand-warmer.

### **These additional items can come in very handy.**

- Talcum powder.
- Cayenne powder or flakes.
- Mylar emergency blankets and other insulating materials.

Do not dispense or administer any pharmaceuticals. If the person wants Burow's solution/Domeboro from the pharmacy for a foot soak, give her directions to the nearest pharmacy. When she returns, draw the water and let her mix the remedy into the foot soak basin.

### Care of infected wounds

#### These items are useful to have on hand for dressing change and care of infected wounds.

- Plenty of nitrile gloves or vinyl gloves that fit you (packed in small ziploc bags for your carry kit).
- Plenty of clean sterile or nonsterile gauze squares packed in small ziploc bags (2x2, 3x3, or 4x4 are good sizes).
- Soap, water, and a basin or sink.
- A way to heat water for a wound soak or compress (an insulated container to carry hot water from a nearby friendly business; a cookpot and stove, hotplate, can of sterno with 2 bricks to elevate your pot, camp stove, etc. Don't forget a lighter or matches if you will need it and fire safety equipment like a fire extinguisher, wool blanket, or bucket of wet sand).
- A big container of table salt (poured into a labeled ziploc bag) and (optional) a small container of bleach.
- Cling wrap or a clean plastic bag.

- Individual packets of honey, a tub of drawing salve, or a tube of ching wan hung ointment.
- Sterile gauze squares (3x3 or 4x4), preferably Telfa non-stick dressings.
- Roller gauze, silk tape, and a permanent marker (for labeling dressings).
- Biohazard trash bags.
- Antiseptic surface cleaner and paper towels or antiseptic surface wipes.

### ACQUIRING SUPPLIES

The most expensive place to get supplies is at a pharmacy. Good local medical supply companies are much better, and you can put in a big order then pick it up. Internet ordering is also a good idea. Try [allmed.net](http://allmed.net), [galls.com](http://galls.com), and eBay, or call manufacturers and ask for factory seconds or overstock as a donation. If you have a nonprofit sponsor it can be tax-deductible for the donor. Consider keeping a supply dump somewhere for your medic group with an inventory person who keeps everything organized so medics can resupply on the fly, and who can periodically replenish the supply dump when anything gets low.

## CODE OF CONDUCT

Affinity groups or collectives may agree to hold each other to a code of conduct. This example is the code of conduct used by Occupy Wall Street's Red and Black Cross street medic working group.

1. **We do no harm.** We make every reasonable effort to give treatment that will not negatively affect the health or well-being of our patients. If no such treatment is available, *no treatment whatsoever is given.*
2. **We work only within our own individual scope of practice,** while trusting and respecting the abilities of the other medics in their work – we do not impose ourselves upon the care being offered by other medics. We explicitly inform patients of our own qualifications and limitations.
3. **We obtain clear and explicit consent from our patients** and anyone affected for every action we take as medics, including any physical contact or performing any procedure. If a patient in an emergency situation is unable to offer consent for treatment, as through a lack of consciousness, we strive to take whatever action we believe is most essential to their wellbeing. We respect all patients right to refuse any treatment or transport to any medical facility.
4. **We maintain our work areas as Safer Spaces,** and actively challenge the perpetu-

ation of any form of social domination or oppression. This includes, but is not at all limited to sexism, racism, transphobia, ableism, classism, ageism, and any other institutional oppression. We cultivate an awareness of our own privilege and work to create a welcoming, safe and comfortable space for all, while calling out any actions of other medics that perpetuate oppression.

5. **We respect and actively protect the privacy of our patients** and the confidentiality of their treatment to the greatest extent possible. We do not allow photography, videography, audio recording, or any other non-private record of our patients care.
6. **We practice exceptional sanitation and hygiene** in our work as medics and in our working areas. This includes using appropriate protocols of Bodily Substance Isolation (BSI) in caring for patients through gloves and other means, as well as thoroughly washing and/or sanitizing hands, surfaces, supplies and containers when they may be contaminated, even imperceptibly. We thoroughly wash and/or sanitize our hands immediately after using the restroom, and immediately before touching any medical supplies or patients. If a medic suspects that they may currently host any readily transmissible disease, they do not act as a medic un-

til the risk of transmission is abated. If we are unable to take such measures, *we do not take any action* that would require them.

7. **We maintain a continuity of care for all of our patients.** We do not leave or cease caring for any patient until a treatment is completed, except to transfer the patients care to another medic of equal or greater qualification – or to provide immediate and urgent care to a different patient in dire need, when no other assistance is available.
8. **We organize ourselves horizontally,** without institutional hierarchies of command, experience, ability or level of involvement. Every medic has equal power in all decisions affecting them.
9. **When acting as medics, we remain *completely neutral*.** The only role of a marked medic is to provide care for the injured or ill – we do not attempt to direct the actions or personal choices of anyone else for any tactical or political purpose, and we do not participate in any ideological or political action while marked.
10. **While working as a medic, we present ourselves with a positive and calm attitude.** While on duty, our interactions with patients, other medics, and passers-by are guided by trust, respect and solidarity, in the same way that those qualities are essential

to our own standing in the community. Rather than telling others to do something, we *ask* them to do it. Patients in our care are treated respectfully and are spoken to or with, not at. We do not gossip about or judge any patients in our care.

11. **We all benefit from an orderly, clean working space,** and we all contribute to keeping it in that condition. If we re-organize any materials in a medical space, we make every reasonable effort to inform the other medics of those changes.
12. **We do not use intoxicating substances while on duty,** and we do not tolerate the use of intoxicants or smoked tobacco in any medical space.
13. **We are all capable of learning and improving our skills, and we all can make mistakes.** Each of us remains accountable to any guidance or correction, and we receive the input or critique of other medics respectfully, with good faith that our common goal is to provide the best care possible.
14. **We understand that when anyone is marked as a medic, they are considered to be on active duty, and their behavior is accountable to this code of conduct.** Should we wish to act outside of the principles in this code, we remove all markings or other indications of our role as a medic be-

forehand. If any medic acts outside of this code, they may be accountable to the other medics, the general assembly, or others.

## WHEN YOUR AFFINITY GROUP GOES TO JAIL

*A guide for activists on the outside with buddies on the inside or, When Your Affinity Group Goes to Jail (In a Handbasket).*

### **Keep yourself safe**

You can do more good on the outside than going down with your buddy.

### **Go to your safe space**

Retrieve the paper where your buddy wrote down his legal name (or his intent to use J. Doe) and whatever needs he has.

### **Take care of those needs**

Find someone to feed the cat. Figure out where the car is and use the spare key which was left with the note to move it to a safer place. It could take hours before your buddy will be released – take care of urgent needs before settling in to make calls and wait.

### **Get the phone number for the jail**

Call and check on your buddy's status. Especially in a mass arrest, it may be a few hours before your

buddy hits the system. Call every hour or so to check on his status – find out if bail is set, and how much, and when it can be posted, or find out when the arraignment or bail hearing will be. This helps people in jail remember that people are waiting and caring.

Mass pressure can be a good thing. If a vegan isn't getting vegan food, if a trans person is in the wrong jail and wants to be moved<sup>1</sup>, have every person around you call every number you have – the main jail number, any other jail numbers you can find, the police non-emergency line, the county sheriff's office, the mayor's office, and anyone else you can think of.

Be clear about what you want. Demanding the release and charges dropped of everyone who was mass-arrested is hopeful and fun, but it may be more important to demand that a certain person be kept somewhere safe, that all vegans receive vegan food, and that everyone be arraigned within the time limit of that jurisdiction (usually 24 hours).

### **Utilize the jail support phone number**

If there isn't one, hopefully the community will learn the lesson and set it up next time.

Call jail support and leave your buddy's name (if your buddy is going to use J. Doe, arrange a

---

<sup>1</sup>Be careful about outing a trans person: rumors fly. The best way to know is to talk beforehand about where he wants to be housed and what he wants to do if he's in the wrong place, and to confirm with the jail where he actually is housed before outing him.

code name that you can use with jail support) and messages, such as, “The rest of us are out, the cat got fed and we’re waiting for you” or whatever your buddy might like to know. Call back to jail support to see if your buddy has contacted them. It’s likely that’s the only number your buddy can call at first (because it’s a legal support number, and will be local and accept collect calls and all that).

### **Utilize Inmate Calling Services (ICS)**

Make an account where your buddy can make outgoing phone calls. This service is not part of the jail system. It works kind of like prepaid phone minutes except instead of being attached to a cell phone, those minutes are set up to be used between a specific jail and a specific phone number (your cell, your house, whatever). The number for ICS is 1-888-506-8407 and you should have a credit/debit card ready to set up the account.

The person in jail won’t know when the account is set up. All she will have to do is dial the number, and if the call goes through, the account is working; if it doesn’t, it’s not working. Anyone in the same jail can dial that number and get through.

Have a plan before the action for what number will be set up with an account. Write this number on your body along with the jail support number. At larger mass-arrest-likely actions, it may be best to leave one person’s cell phone at the safe place with the info sheet, and already have an account

set up that runs to that phone from the local jail – then, as soon as someone gets arrested, someone else can go get that phone and be ready for calls. These paid accounts can be cancelled for a refund when you’re done.

### **Do courtroom support**

If your buddy will have a hearing before being released, plan for as much support in the courtroom as possible. Hearings are open to the public, but you may have to show ID to get in, and often you cannot bring any type of bag or electronic stuff in with you (this includes cell phones, but sometimes you can bring in a laptop). Bring pen and paper to write down important details. Your buddy will NOT walk out of court with you; even if the judge orders a PR (free) release, it may still take hours to be processed out.

### **If your buddy will be held a few days**

In a mass arrest, or if she is held on high charges, write her letters and stick them in the mail immediately so they have a chance to get there before your buddy is released. Even if they do not get to your buddy, it really helps people on the outside to write them. If your buddy has been released when the letters arrive, they will probably be returned to sender. Remember, no crayon or colored markers, just ballpoint pen, and no information that you

don't want the police to have. Hand-drawn pictures of nature are really nice to receive.

### **Bail**

In most places, bail must be paid in actual green cash, no checks or cards taken. Prepare for this: know where the money is and how to access it. There is usually a daily limit on ATM withdrawals, but sometimes if you call your bank and tell them you need more than that, they'll lift that limit and you can get what you need.

### **Waiting**

Waiting outside the jail can be hard on people, but walking out of jail into the arms of your affinity group means so much. Take care of yourself while waiting outside – be warm, eat good food (usually not a problem at jail support, usually it is provided), share love. Be aware that sometimes people will get dropped off somewhere away from the jail – be ready with a phone your buddy knows the number of to get a call from them somewhere else in the city.

### **When your buddy gets out**

When your buddy gets out, be aware of potential damage done to him. It's tempting to rush him and tackle him to the ground, but that may be exactly what the cops did to him. Ask before touching, hugging, grabbing and mobbing, and continue

checking in about whether it's still okay. Celebrate, but remember your buddy's physical needs – food, water, medical care, sleep. Advocate for your buddy to get what he needs now that he's out. Being listened to is very important when someone gets out of jail. If you can't handle hearing your buddy's stories, help him find someone who can. Sometimes there are peer counselors at activist clinics, sometimes you can find one at jail support, or maybe a medic or legal observer or just another familiar face can listen.

### **Let people know your buddy is out**

Call the jail support number and tell them your buddy's out. Call the friends back home, the people at the clinic, and whoever else knew your buddy was in and let them know she's out.

### **Help your buddy get her stuff**

Deal with getting your buddy's possessions back if they weren't released with her. She should have a sticker or tag or tracking number or something to identify her belongings. Call the jail and find out where the property is and when it can be picked up. It probably has to be picked up by your buddy. Make arrangements to get her there and help her deal with whatever is missing in the meantime (house keys, wallet, etc.).

## **Going back out**

If your buddy wants to go back out on the streets, don't try to talk him out of it based only on "you were just in jail." If there are reasons for him to not go ("you need stitches in that cut; you just said you haven't slept in 40 hours") then present them in a reasonable and loving way. If he's going out and you can't go with him, help him find another safe and reliable buddy to go. Being arrested twice at one action doesn't necessarily make it worse the second time, although it does increase the chance of having a charge that sticks or goes to trial.

If your buddy doesn't want to go back out, support that decision. If he wants to help, maybe he can do clinic work or jail support during the remainder of the action. Remember to help him take care of himself during this time: to eat, rest, and utilize the support community, but also remember that working may be exactly what he needs to help heal and feel normal again.

## **It doesn't end here**

Remember that it doesn't end here. There may be a trial, there may be court solidarity, there may be a civil suit. Let your buddy choose what direction to take in all of this, and support whatever decision she makes.

People are often overwhelmed with the system. It's designed to make us feel powerless. Your buddy may need help doing even simple things like

calling the public defender's office, finding a lawyer, checking on court dates. It may help to assign one non-arrested person from the affinity group to aid each arrestee personally, or maybe one person in the group can coordinate with all the arrestees. Remember that this can take months to sort out: this is not a day-long commitment.

## **Ask what your buddy's needs are**

Ask frequently what your buddy's needs are over the coming weeks. Maybe she needs help replacing things still in police custody. Maybe she needs continuing medical care for injuries. She will probably need to keep being around friends and support people who will keep listening to and sharing in her stories.

# B Resources

## RESOURCE LISTS FOR ACTIVISTS

### During Protests/Actions

- Emergency Services: 911
- Non-Emergency Services (emergency food and food pantries, transit information, etc.): 311
- National Lawyers Guild: 1-212-679-5100 (Main office in NYC); <https://www.nlg.org>

### Hotlines

- National Domestic Violence Hotline (for sexual assault referrals) (24/7): 1-800-799-7233; TTY 1-800-787-3224
- Veterans Crisis Line (24/7): 1-800-273-8255 (Press 1)
- Suicide Hotline (connects you to local resources) (24/7): 1-800-784-2433
- Mental Health Crisis Hotline (24/7): 1-773-769-0205

### Warm Lines

- Georgia Peer Support Warmline (Mental Health) (24/7): 1-888-945-1414
- Cincinnati Peer Support Warmline (Mental Health) (24/7): 1-513-931-9276
- Veterans Peer Support Warmline (Mental Health) (24/7): 1-877-927-8387
- San Francisco Sex Info Line (M-Th 3p-9p, F 3-6p, Sa 2-5p PST, except holidays and holiday week-ends): 1-415-989-7374
- National LGBT Hotline (M-F 4p-12a, Sa 12p-5p): 1-888-843-4564
- Backline Pregnancy Options talk line (M-Th 8p-1a, F-Su 1p-6p): 1-888-493-0092

### 12-Step Addiction Groups

#### Alcoholics Anonymous: [www.aa.org](http://www.aa.org)

- Denver: 1-303-322-4440 (24/7), en Español: 1-303-433-2080; [www.daccaa.org](http://www.daccaa.org)
- Grand Junction: 1-970-245-9649, toll-free: 1-888-333-9649; [www.aa-westerncolorado.org](http://www.aa-westerncolorado.org)
- Phoenix: (24/7): 1-602-264-1341; [www.aaphoenix.org](http://www.aaphoenix.org)

- Tuscon: 1-520-624-4183, TDD: 1-520-882-7422, en Español: 1-520-622-5112; [www.aatucson.org](http://www.aatucson.org)
- Salt Lake City: 1-801-484-7871, en Español: 1-801-347-5803; [www.saltlakeaa.org](http://www.saltlakeaa.org)

**Narcotics Anonymous: [www.na.org](http://www.na.org)**

- Denver: 1-303-832-3784; <http://www.nacolorado.org/denver/>
- Grand Junction: 1-970-201-1133
- Phoenix: 1-480-897-4636; <http://arizona-na.org/meetings/valley.php>
- Tuscon: 1-520-881-8381; <http://www.natucson.org>
- United Wasatch Area (Salt Lake City): 1-801-252-5326, en Español: 1-801-332-9832; <http://uwana.org/>

CLINICS FOR UNINSURED

**Cook County**

- ACCESS to Care: 1-708-531-0680
- Stroeger Hospital: 1-312-864-6000
- Fantus Clinic: 1-312-633-6000

**Kane County**

- Tri County Health Partnership: 1-630-377-9277
- Kane County Health Department: 1-630-723-5414
- Aunt Martha's Clinic: 1-877-692-8616
- VNA of Fox Valley: 1-630-892-4355

**DuPage County**

- ACCESS DuPage 1-630-510-8720
- DuPage County Health Dept 1-630-682-7400

**McHenry County**

- McHenry County Health Department: 1-815-334-4510

## LEARN MORE

### Recommended Reading

- First Aid and Basic Medical Care
  - The First Aid chapter of *Where There Is No Doctor* published by Hesperian, available for purchase or as a free pdf online at [http://en.hesperian.org/hhg/New\\_Where\\_There\\_Is\\_No\\_Doctor:Chapter\\_3:\\_First\\_Aid](http://en.hesperian.org/hhg/New_Where_There_Is_No_Doctor:Chapter_3:_First_Aid)
  - *Common Simple Emergencies* by Buttaravoli & Stair, available for purchase or as a free ebook at <http://www.ncemi.org/cse/contents.htm>
  - *Backcountry First Aid and Extended Care* by Buck Tilton
- Herbalism
  - *The Practice of Traditional Western Herbalism* by Matthew Wood, for a general introduction to western herbalism
  - Herbalist 7Song's first aid handouts: <http://www.7song.com/index?page=Handouts>
  - *Botany in a Day* by Thomas Elpel, for an introduction to plant identification.
- Community and Camp Health
  - *Where Women Have No Doctor* published by Hesperian, available for purchase or as a free ebook at [http://en.hesperian.org/hhg/Where\\_Women\\_Have\\_No\\_Doctor](http://en.hesperian.org/hhg/Where_Women_Have_No_Doctor)
  - *Community Guide to Environmental Health* published by Hesperian, available for purchase or as a free ebook at [http://en.hesperian.org/hhg/A\\_Community\\_Guide\\_to\\_Environmental\\_Health](http://en.hesperian.org/hhg/A_Community_Guide_to_Environmental_Health)

### Email listservs

- Action Medical: <http://groups.yahoo.com/group/action-medical/> Medical and health list for activists
- Bay Area Radical Health Collective: <http://groups.yahoo.com/group/barhc/> Currently inactive as a collective; listserv established August 2001)
- UK Green and Black Cross Medics: <https://lists.aktivix.org/mailman/listinfo/gbc-medics-announcements/>

## Websites and blogs about street medics

Some of these websites have not been updated in several months or years but still provide useful and interesting information.

### In the US

- Street Medic Wikia: <http://medic.wikia.com> Online resource for street medics that anyone can edit
- Chicago Action Medical: <http://chicagoactionmedical.wordpress.com/>
- Colorado Street Medics: <http://streetmedic.wordpress.com/>
- Rosehip Medic Collective: <http://www.rosehipmedics.org/>
- Seattle Street Medic Collective: <http://seattlemedics.org/>
- Phoenix Urban Health Collective: <http://puhc.wordpress.com/>
- Northstar Health Collective: <http://northstarhealth.wordpress.com/>
- Katuah Medics: <http://katuahmedics.blogspot.com/>
- Occupy Wall Street Medics (inactive): <https://we.riseup.net/ows-medics/>
- Occupy Boston Medical (inactive): <http://wiki.occupyboston.org/wiki/Medical>
- Seeds of Peace: <http://www.seedsofpeacecollective.org/>
- BALM Squad (collective inactive): <http://www.bostoncoop.net/balm/>
- StormNYC (collective inactive): <http://www.freewebs.com/stormnyc/>
- Madison Community Wellness Collective: <http://madcwc.org/>
- Black Cross Health Collective (collective inactive): <http://www.blackcrosscollective.org>

### Outside the US

- UK Action Medics (collective inactive): <http://actionmedics.org.uk/>
- Green & Black Cross: <http://greenandblackcross.org/>
- Autonomen Demosanis (collective inactive): <http://www.nadir.org/nadir/initiativ/sanis/>
- Demosanitäter Ludwigsburg: <http://www.demosanitaeter.de/>
- Street Medics for Tahrir: <http://m4t.wikidot.com> Information on protest safety, first aid, and medical issues

## Facebook

“People”: Mutual Aid Street Medics, Colorado Street Medics, Katuah Medics

“Places”: Madison Community Wellness Collective

**“Pages”**: Occupy Medical Team Collaboration, Occupy Herbalism, Phoenix Urban Health Collective, Occupy Philly Medic Support Committee, Green and Black Cross, Medicine for All Seeking Herbal Healing, Occupy Providence Medical, Occupy Austin Medical Team, Occupy New Haven Medical Team

**“Groups”**: Medic Committee of Occupy Charleston, UC Davis Occupy Health and Medical Sub-Committee, City of Angels Street Medics, Vermont Street Medics, Occupy Vancouver Medical Committee

### **Further training**

- CPR training: American Red Cross, American Heart Association
- Wilderness First Responder (WFR) training: NOLS, WMI, First Lead, and more
- Peer recovery specialist
- Community Health worker
- Doula
- CERT
- Sexual assault/domestic violence hotline operator
- Food safety and handling
- MI/MET
- CNA
- EMT

