

Critical First Aid in the Streets

How anyone can recognize and respond to life-threatening injury



NYCAM August 2022

This presentation is based on a combination of materials from the street medic community, and this is treated as a living document by NYCAM.

We thank the entirety of the street medic community for their wisdom and knowledge that contributed to these materials.

Contributors include Jason Odhner, RN, Elizabeth Diedrich, RN of Phoenix Urban Health Collective, Steel City Organizing for Radical Community Health in Pittsburgh, PA, National DSA Medics Health & Safety Handbook (March 2018), materials created by MC Erskine (April 16, 2017) from training written by Becca, Bugz, Amna, Shawn, David, Cea, Kenton, Greg etc., the Occupy Chicago Street Medic Manual (March 2012), and members of New York City Action Medical (2016-2022).

LAND ACKNOWLEDGMENT

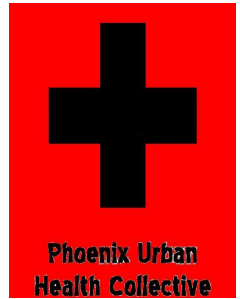
NYCAM recognizes that this training is being conducted on occupied Indigenous land. The land of the five boroughs that make up New York City is the traditional homeland of the **Lenape, Merrick, Canarsie, Rockaway, Matinecock, and Haudenosaunee Peoples**. These lands are also the inter-tribal trade lands, and are under the stewardship, of many more indigenous nations today.

New York City is home to the largest populations of Inter-tribal Native American, First Nations, and Indigenous individuals out of any urban city across Turtle Island (the United States).

We acknowledge the systematic erasure of many Nations and recognize those still among us today. We acknowledge the Peoples of these Nations: their cultures, their communities, their elders both past and present, as well as future generations.

We acknowledge and offer deep gratitude to Mannahatta - the land and waters on which we stand.

Courtesy of *American Indian Community House*.



✊ Justice for Breonna Taylor ✊

EMT Breonna Taylor

Killed by police in Louisville, KY.

You can donate to the Justice for Breonna Fund, who have stated their intention to use future funds for scholarships for those who want to pursue a career as an EMT or RN.

<https://bit.ly/3cCR7FY>



Scope of this training

This class is designed to give you the training to respond when someone near you has a **life-threatening** injury, or an injury likely to cause permanent disability.

What you learn **will** dramatically increase the likelihood that -- in a **worst case scenario** -- your friend makes it to the hospital.

What you learn **will not** substitute for any sort of professional medical care.

What you learn **will not** certify you in First Aid or any other formal medical certification.

The **assumption** for this training will be that **you saw the person get injured** or are with people who saw the injury occur. For this reason, we will be focusing on treating injuries, rather than checking for injuries.

This is **not a street medic training**; street medic training is a minimum of 20 hours. Often, street medics have additional training and certifications beyond that. Street medics identify themselves with patches, red duct tape crosses or stars, and always operate (*run*) in pairs.

We encourage you to let your comrades know you have **some first aid training** and may be carrying *supplies*, but ask that you **only mark up as a medic** in the streets **after** completing a **20+ hour training**. This is to avoid misrepresenting the scope of care which you can provide for patients and the general terms under which you will be providing it.

We **will not** be teaching the **CPR/ Heartsaver course**. Please contact the American Heart Association or a local provider for this training.



General content warning



Direct actions can involve **exposure to violence and/or trauma**.

As such, this training may include frank discussion and imagery of:

- ***Bodily fluids*** (blood, vomit, saliva, excrement, etc.)
- ***Body horror*** (i.e. severe traumatic injuries)
- ***Violence***
- ***Substance use, paraphernalia, and harm reduction techniques***
- ***Mental health conditions and crises***
- ***Poverty, medical neglect, and lack of access to medical care***
- ***our limited ability to prevent life-threatening harm***

We make conscious efforts to avoid morbid fascination.



Collective Care Practices



General

Be responsible for yourself.

Be accountable for your words and behavior.

Take care of each other.

Take the training seriously.

For discussion questions, use your imaginations, but try not to derail into “What If”s?

Be mindful of our time together.

Anti-Oppression

We do not tolerate bias or criticism based on race, ethnicity, religion, gender, sexuality, age, income, relationship to the means of production, body size, ideology, or any other bullshit reason.



Collective Care Practices



Expectations within this Space

- ❖ Be conscious how much space you take up. If you've been talking a lot, let others have the opportunity to speak. Respect stack, don't speak out of turn.
- ❖ Respect people's identities, backgrounds, pronouns, etc. If you aren't sure how someone wants to be addressed, ask.
- ❖ Apologize when you upset someone, considerately try to learn why, and then do better.
- ❖ Try to forgive people's honest mistakes.
- ❖ If you have questions related to the teaching material, consider leaving them until the break so as not to interrupt the training. If you have concerns, address them individually with trainers at the break.
- ❖ People make mistakes. Treat them with kindness and respect as peers and future medics. Leave general feedback for trainees related to medicking to the feedback session at the end of the scenario; for volunteers, don't break "character" while the scenario is ongoing unless it's absolutely necessary.

✓ Our Commitment to You ✓

- We will teach within our *scope of expertise* and your expected *scope of practice*.
- We will admit when we don't have an answer and we will name guesses as such.
- We will honor and respect the knowledge and experiences that you bring to this space.
- We will endeavor to greet critique with grace and appreciation, not defensiveness.



Agenda



- 1) Who is NYCAM, anyway?
- 2) What even is a street medic?
- 3)
- 4) Good Samaritan Law
- 5) Scene Assessment
- 6) Calling 911
- 7) Human Barricade/ Privacy Circle
- 8) COVID-19 Precautions
- 9) Wounds / Bleeding control
- 10) Shock
- 11) Special Types of Wounds
- 12) Live Shooter Safety / Gunshot Wounds

+ Who is New York City Action Medical? +

NYCAM is a collective of volunteer street medics active in NYC.

NYCAM's operations include providing first aid and emergency care at protests, marches, long-term occupations, and other sites of liberatory struggle, in addition to providing training in first aid and street medicine.

NYCAM is only one of many different medical volunteer groups who locally and globally support liberatory movements. We are not an authority, but a support for radical activists and other like-minded collaborators.

What even is a street medic?



Street medics are a community of people who, for the last sixty years or so, have provided medical support at protests, direct actions, uprisings, and natural disasters -- particularly those complicated by police or military targeting of the survivors.

Becoming a member of the street medic community involves:

- completing a 20- or 28-hour training (or a bridge training for medical professionals)
- running at an action as an experienced street medic's buddy
- actively seeking out opportunities for continuing education
- maintaining relationships within the street medic community

A street medic...

- ...is part of a wider radical, abolitionist movement, grounded in the histories and healing practices of colonized and enslaved people
- ...specifically addresses the ways in which medicine as an institution has been weaponized to control and harm oppressed people—our bodies, our communities, and our struggle for liberation
- ...dismantles the control our oppressors have over us through the institution of medicine by practicing care within our own communities in order to restore our collective autonomy
- ...recognizes and foregrounds the experiences of oppressed people in our practice of medicine.



Medic Collectives

Medic Collectives have some sort of formal covenant which describes how decisions are made and how membership is defined.

These details may vary broadly from one collective to the next, but each collective must have them clearly defined.

Street Medic Collectives often engage in some form of radical community health work in between actions.

Affinity Groups

An Affinity Group is a team of people who come together to accomplish a shared goal.

Sometimes the goal of an affinity group is tactical, such as to block a bridge or to disrupt a speech.

Other times an affinity group's mission may be logistical in nature, such as to provide food, water, or medical support for protesters.

Affinity Groups may also be called Action Groups, Action Collectives, or Cells.



It's important to distinguish between **Affinity Group Medics**, and **Street Medic Affinity groups**, and **Street Medic Collectives** because they perform in different capacities.

Affinity Group Medics

Affinity Group Medics, sometimes called **Embedded Medics** are (usually unmarked) medics that are embedded in a specific affinity group.

While an affinity group medic may help people outside the team they are serving, their primary responsibility is to the group.

Other medic types: **action clinicians**, **community medics**, medics who serve as part of **infrastructure & support**

Discussion: what are some benefits of having embedded medics?



Street Medic Affinity Groups

Street medic affinity groups are affinity groups that exist to support a mobilization by providing action medical services.

Since a street medic affinity group is committed to serving all groups at an action, they would typically wear markings identifying them as street medics. This is known as **running marked**.

While marked, medics would not participate in other tactics other than Action Medical.





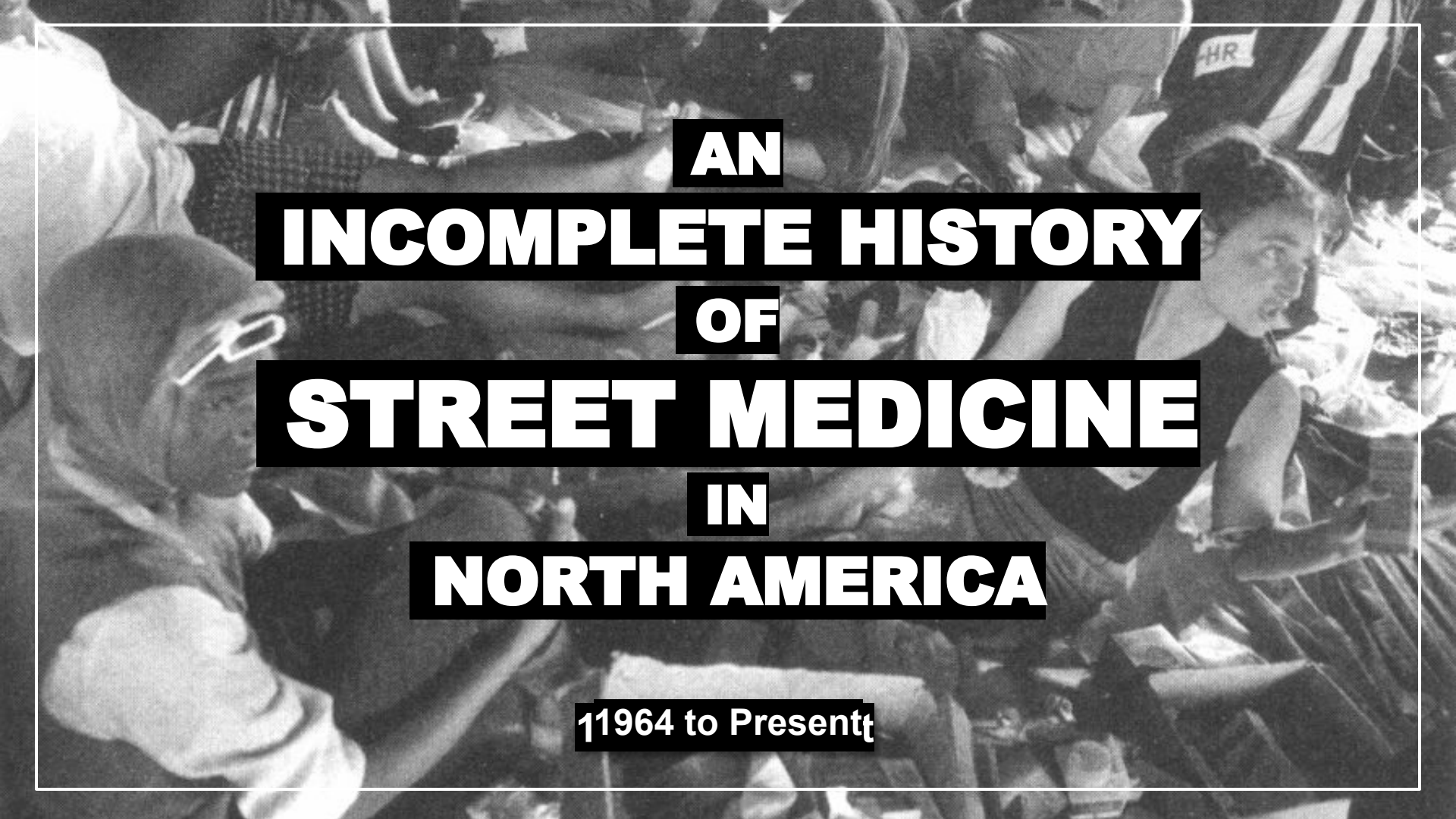
Street Medics & Community Health



Street medics have a history of supporting communities in health initiatives.

Setting up walk-in clinics, providing care for people without housing, assisting with larger health organizations for on-the-ground outreach, and promoting community health education are some ways in which street medics contribute.

Street medics also support community grassroots efforts in identifying and/or co-creating alternatives to the formal healthcare system for those most marginalized by it.



**AN
INCOMPLETE HISTORY
OF
STREET MEDICINE
IN
NORTH AMERICA**

11964 to Present

The Medical Committee for Civil Rights

The Medical Committee for Human Rights (MCHR) was a group of American [health care](#) professionals that initially organized in June 1964 (as the MCCR) to provide medical care for civil rights workers, community activists, and summer volunteers working in [Mississippi](#) during the "[Freedom Summer](#)" project.



Early in the summer of 1964, MCHR members found themselves in situations where they had a duty to act. Since MCHR did not provide direct clinical services, a MCHR break-away group formed called the Medical Presence Project. MPP began preparing to provide direct first aid on the streets: the very first Street Medic Collective.

There were not enough medical professionals within MCHR willing to join the newly-formed MPP, so **Anne Hirschman Schremp** -- a nurse with a Red Cross family background -- began training civil rights workers to administer first aid at protests.

Among those she trained was a doctor of Chinese Medicine and Kung-Fu Instructor, **Ron Rosen**.





Medical Presence Project

There was, predictably, a struggle over the new Medical Presence Project and the training of the first street medics.

The struggle withered in time, with street medics cultivating a specific set of skills and ethics and a clear training which stands the test of time by adaptation and through emergence.

Late 1960s...



Anne Hirschmann-Schremp and Doc Rosen moved to New York City, where they founded the Broome Street Collective.

This was the peak of the anti-Vietnam War movement, and they worked with returning combat medics from Veterans for Peace to develop field protocols. Soon after, they began traveling extensively, training medics and planting collectives in Denver, London, Chicago, Portland, and many other places.

Late 1960s

Licensed professionals routinely attended street medic trainings in order to be cross-trained to work in the great variety of protest environments that emerged over the course of the decade.

The fields of pre-hospital care and peacetime paramedicine were born with the founding of two programs: one based out of a hospital in Baltimore, and the other a collaboration between an independent black-run inner-city community organization in Pittsburgh, civil rights organizers, and medical professionals.



FREEDOM HOUSE ENTERPRISE, INC. AMBULANCE SERVICE FIRST DAY, JUNE 16, 1968

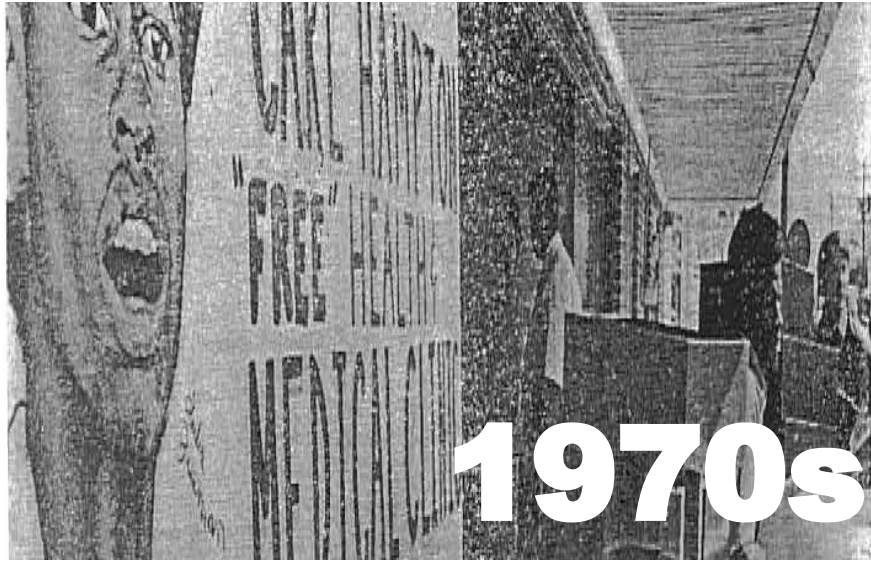
Lft to rt: Mr. Streams, Mr. Davis, Mr. Zepfel, Mr. Ragin, Mr. Clemons,
Miss Johnson, Mr. McCoy, Mr. Esposito, Don W. Benson, M.D.,
Mr. Draper, Mr. Scott.

Standing at Ambulance Entrance, Presbyterian University Hospital
Pittsburgh, Pennsylvania

The very first paramedic program in the US was Pittsburgh's **Freedom House Ambulance Service**.

A collaboration between an outgrowth of the United Negro Protest Committee, civil rights organization the Maurice Falk Medical Fund, the University of Pittsburgh School of Social Work, and the doctor known as "the father of CPR," Freedom House improved medical outcomes in the predominantly Black Hill District, and laid the groundwork for EMS training to this day.





Street medics considered medical knowledge a form of self-defense, and were deeply involved in health education and medical support during the Civil Rights Movement, the work 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. Street medics shifted from a focus on pre-hospital care to a focus on community health and mental health.

In the 1970s, street medics worked in community programs and People's Clinics led by the Black Panthers and Young Lords, as well as the American Indian Movement battle at Wounded Knee, and other revolutionary projects.

[Listen to the clip below for a story of how revolutionary Medics of Color in NYC took on the system](http://www.wnyc.org/story/lab-coat-afro-and-shades-taking-lincoln-hospital/)

<http://www.wnyc.org/story/lab-coat-afro-and-shades-taking-lincoln-hospital/>

A PROGRAM FOR SURVIVAL



Free Breakfast Program

Free Bussing to Prisons

In partnership with national liberation organizations like the **Black Panthers**, street medics innovated in the field of public health.

They helped to develop rat abatement programs, lead testing programs, children's free breakfast programs, and community drug prevention and treatment programs.

Street Medics helped force more equitable inner-city garbage collection, fire safety and firefighting, and they supported the long struggles to reform the VA hospital, recognize Agent Orange sufferers, define and acknowledge Post-Traumatic Stress Syndrome, close the asylum system, and end the diagnosis of homosexuality as a mental disorder.

1980s



Street medic collectives maintained their focus on non-protest long-term community support work, long marches, and extended backwoods campaigns through the 1980s and early 1990s.

For example, the Peoples' Medics did urban healthcare and protest healthcare in the Bay Area in the 1980s, and the American Indian Movement Street medics worked together with other medical professionals to train Mayan survivors of the civil war in Guatemala.

ACT-UP organized mass campaigns to force more equitable access to care for AIDS patients.

A photograph capturing a moment of protest. In the foreground, several individuals are huddled together, some wearing dark winter jackets and hats. One person on the left is wearing a dark jacket with a white patch featuring a red cross. In the background, a police officer in full riot gear, including a helmet and visor, stands amidst a crowd. The scene is filled with a sense of activity and tension, with a hazy or smoky atmosphere.

1999

WTO protests

(Battle in Seattle)

The values and lessons of thirty-five years of learning and service 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, fairy farms and Pagan Cluster communities, and radical feminist health collectives.

The street medic model broadened through battle testing and new forms of horizontal organizing.



Anti-Globalization Movement

A new role developed, as medics trained tens of thousands of protesters in short courses focused on health and safety, eye flushes, critical incident stress management, and day-long Affinity Group Medic trainings.

Street medics functioned as a second tier of care to an informed public, and thousands were trained in the United States and Europe.



The early 2000's

The mass political work against economic injustice and political corruption in the the 2008 Oaxaca uprising, the 2009 Greek uprising, the Arab Spring, the occupation of the Wisconsin capitol, the occupations of universities in the UK and Chile to protest tuition hikes and program cutbacks, and the Spanish Indignante movement rapidly revitalized popular social movements around the world.

Disaster Response

Over time, the role of street medics expanded to include disaster response.

What medic collectives lacked in resources, they more than made up for in nimbleness, creativity, and flexibility.



Disaster Response

In 2004, a team of Native American medics responded to the impact of the 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.

Emergency Response

Street medics in emergency response extended in the last decade. 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 also worked with affinity groups during the early aftermath of the 2010 Haiti earthquake, and developed a temporary natural health clinic at the request of tribal leaders in South Louisiana after the 2010 Gulf oil spill.

Mutual Aid Disaster Response teams continue today, including in reaction to 2017 Hurricane Maria and current providing earthquake relief since Dec 2019 into Jan 2020 in Puerto Rico.



Occupy Wall Street (2011- 2012)

Occupy Wall Street led to a massive resurgence of street medics, with thousands of new medics trained, and over a hundred new medic groups formed. While most of these medic groups were short-lived, several have become a stable presence and continue to grow.



STANDING ROCK

The protest camp at Standing Rock brought together a remarkable team of Street medics, hailing from many different collectives and traditions. Led by indigenous elders, this affinity group came to worked together as the Standing Rock Medic and Healer Council.

Hong Kong Protests



Street medic organizing is decentralized (meaning there is no single “authority”).

We recognize our fellow medics outside of the US as well, who are fighting alongside protesters around the globe, using similar strategies and shared knowledge.



Street Medic Values





Anti-Oppression



- ❖ We believe in interdependence, relationships with other medics and patients and combating institutions which seek to isolate us.
- ❖ We see our work as acknowledging and resisting intersecting systems of oppression, including but not limited to white supremacy, heteropatriarchy, transmisogyny, and ableism.
- ❖ Our work is rooted in generations of resistance to systems of oppression and domination. We seek solidarity with those struggling towards personal and collective liberation.
- ❖ We collaborate with and support those working for a just and healthy society. We seek to work in collaboration with and support of patients to ensure everyone's ability for autonomous action and decision-making.



Radical Consent & Patient Autonomy



Street medics get consent for everything.

CONSENT is a continuous process. Always ask whether you can do something to a person and describe what you are doing, and only do so if they are responsive enough and say yes.

How we seek consent:

- Approach calmly and cautiously.
- Introduce yourself confidently and swiftly, e.g.

example: *“Hello, my name is Neo. I know first aid. I can help you. Would that be okay?”*

To discuss: What are reasons people sometimes decline medical care at protests or other street situations?



Security Culture



People trust street medics to keep their secrets.

- Signal App
- In-person comms is best
- Use a burner phone when possible, for comms on the ground
- Remember police can confiscate your phone if arrested
- More info on digital security at protests: <https://ssd.eff.org/en/module/attending-protest>
- Don't ask questions you don't need the answer to...
- Don't talk, don't brag, watch what you post online!



🤔 Autonomy of Risk 🤔



Professional EMS will stage outside a protest until the police declare the scene secure.

Street medics are accountable to no one except their buddy when deciding whether or not to enter a potentially dangerous situation.

It's not a bad idea to buddy up at an action, regardless of your training or intent. This way, in the event of total chaos, you have somebody's back and they have yours.

~ Horizontal Decision Making ~

Street medics organize and operate according to non-hierarchical principles of solidarity. We focus on how to creatively, effectively, and safely meet the needs of the communities we serve above all else.

Medical certifications and licenses, skill level, and experience are respected with regards to patient care, but do not translate into hierarchies of duty or administrative decision-making power.

We are learning organizations and must adapt very quickly to difficult environments. We cannot afford to neglect hidden talents within our ranks.

700 Commitment to the Cause 700

Street medics are unapologetically activists: we do what we do because we believe that infrastructure makes our movement stronger, and because we want the movement to succeed.

Street medics are anti-oppression, anti-fascist, and pro-collective liberation. A good street medic is involved with the activist movements in their own community.



Dick Reilly (left), dedicated activist and Chicago street medic, passed away Feb. 2020



COVID-19 Precautions



- Weigh your risks. Do not have close contact with someone with a non-life-threatening injury.
- Chemical weapons make people cough, increasing the spread of the virus.
- Wear a mask and bring extra to give out.
- Rescue breaths should only happen with EMS equipment, not mouth contact.
- Someone with pneumonia may already be in compensated shock or with a compromised airway for days. Recognizing that gets them treatment faster.



Good Samaritan Law



LEGALITY: You may perform interventions if you **act *within* your training & knowledge**, with **intent to save a life**. (Varies by state.)

CONSENT: It is a continuous process. Always ask whether you can do something to a person and describe what you are doing, and only do so if they are responsive enough and say yes.

Treating someone who has not consented is *assault*.

Implied consent if non-responsive to perform any action that assumes they want to live and you want that too.

ABANDONMENT: Once you begin helping somebody, you must **stay** with them until someone with more relevant or higher training takes over for you, your own life is threatened, or the patient withdraws consent.

Your goal should be to transfer the patient ASAP, with good communication.



Good Samaritan Law in NYS



Drug or alcohol overdose:

GSL allows people to call 911 without fear of arrest if they are having a drug or alcohol overdose that requires emergency medical care or if they witness someone overdosing

Use of defibrillators or CPR:

GSL protects those who perform CPR or use an AED in the case of a sudden heart attack or heart-stopping injury



Calling 911



Should you?

- We are assuming that the person in question would die without EMS. Respect that there are reasons people might not want EMS called.
- Street medics have training to assess this need.

If you must:

- Direct a bystander to call 911:
 - *“you, [PERSON] call 911, tell them we need an ambulance, tell them this person [SIGNS/SYMPTOMS] then come back and tell me what they said”*
- Focus on the injury, as opposed to what happened:
 - *“There is a large wound in their chest,”* rather than *“they got shot,”*
- Key language:
 - *“they’re not breathing,”* or *“they’re unresponsive,”*
- Designate a bystander to deal with the police when they undoubtedly arrive
- Direct other bystanders create a privacy circle



Red Flags to Tell 911



- Any amputations
- Any impaled objects
- Bleeding you can't control
- *Any* arterial bleeding
- Any sign of shock
- Head injuries
- Any penetrating wound to the abdomen
- Any spinal injury



Patient Care & Transfer of Care



Most importantly, once you start care, STAY WITH the patient until:

- 1) They confirm care is completed or say they do not want further treatment.
- 2) You transfer them to a higher level of care (more experienced medics, EMS, hospital, etc).



Radical Consent & Patient Autonomy



Always get consent for everything.

CONSENT is a continuous process. Always ask whether you can do something to a person and describe what you are doing and only do so if they are responsive enough *and* say yes.

How we seek consent:

- Approach calmly and cautiously.
- Introduce yourself confidently and swiftly, e.g.

example: *“Hello, my name is Neo. I know first aid. I can help you. Would that be okay?”*

To discuss: What are reasons people sometimes decline medical care at protests or other street situations?



Common reasons for refusing care



- the caregiver's perceived gender
- worried that medics are cops
- financial concerns/ are uninsured
- modesty / fear of exposure
- fear of attracting attention
- doubts injury is "that bad"
- perceives another patient as doing worse, so help them first
- fear of contagion (you or them)

Remember: CONSENT is a continuous process.

Always ask whether you can do something to a person and describe what you are doing, and only do so if they are responsive enough and say yes.

Treating someone who has not consented is assault.



Ways to encourage consent



- Be persistent but not pushy.
- Validate and address the patient's concerns, e.g.
 - "I can understand this might be scary."*
 - "Would you prefer if my partner takes care of you and I mostly keep watch?"*
- Establish privacy barriers.
- Innovate!
- Always take "No" for an answer.**

Special Note about Altered Mental Status and Implied Consent:

Implied consent: if non-responsive, perform any action that assumes they want to live and you want that too.

NO ABANDONMENT: You must **stay** with someone once you start helping them, until you hand them off to someone with higher training or your own life is threatened. Your goal should be to transfer ASAP, with good communication.



Consent: Special Cases



Minors: Minors cannot legally consent. Seek a parent or guardian to provide consent if possible. However you may provide treatment if a guardian is not available and treatment is in the best interest of the patient.

Implied Consent: If a patient is unable to give consent we can *assume that the patient would want life-saving treatment* were they able to give consent. We **DO NOT** call 911 for people who are intoxicated or experiencing a mental health emergency or crisis.

Radical Consent is Required: However, even if we have legal consent through a guardian or through implied consent, we always require that our patient agrees to our plan of treatment *except* when our patient is incapable of expressing a preference one way or the other.



Consent and Survivors of Violence



Consider how **your identity/presentation** inherently **shifts power** in an interaction and **affects a survivor's ability to give consent**.

Don't put the patient in the position where they have to enforce boundaries. Invite them to set boundaries.

Is their flight, freeze, or fawn response activated?

Signs to look out for:

- Flight:** putting space/distance between you and them, flinching from touch
- Freeze:** dissociation, being tense/silent/still
- Fawn:** saying yes to everything, trying to accommodate /not be a burden, expressing gratitude to an abnormal/excessive degree ("hero worship")

Positive vs. negative consent – look for both

Positive: "Enthusiastic yes" a.k.a. saying yes through clear words/actions

Negative: "No means no."



Consent and Disability



People may have limited ability to give or express consent due to temporary or permanent disability.

Legal Complications: We assume the legal competence of all our patients unless we are forced to accept evidence to the contrary.

However:

- It is possible for an adult disabled person to have their bodily autonomy rights violated by a court of law. (guardianship)
- Caregivers frequently assume they have decision making powers over a disabled person even when legally they do not.
- **We require consent from the patient in any case regardless of the law.**



Consent and Mobility Devices



- Do not touch a person's wheelchair or other medical device without their express consent
- Never move a mobility device or other piece of accessibility equipment outside the reach of its user, even if they give you permission to touch and move it
- Recognize that a mobility device, prosthetic, infusion pump, or other medical device is often an especially sensitive part of the patient's body and requires extra care when approaching it

👁️👁️ Scene Assessment 👁️👁️

You witness something *really* bad.

You can tell this person needs help *immediately*.

First, practice **situational awareness!**

- 1** *Look out for number one**!
- 2** *What happened to you?*
- 3** *Don't get any on me.*
- 4** *Are there any more?*
- 5** *If we can survive, let's keep them alive.*



*Operating from a Street Medic ethos, "look out for number one" is a "put on your air mask so you can help others" behavior, not a rugged individualist orientation.

The Human Barricade/Privacy Circle



It's not uncommon for journalists to try to record media of people receiving treatment. Politely request that they respect the privacy of your patient.

If that doesn't work, don't get in arguments with the media or demand that they leave (that never works). Instead, ask other protesters to form a wall around you with signs.

NOTE: These images predate the COVID-19 pandemic.

Please be mindful of physical distancing and transmission vectors when forming a barricade. Consider the use of signs, umbrellas, etc to help shield the patient.





The Human Barricade



(DISCUSS: How could they improve this barricade?)



Body Substance Isolation

BSI works two ways

What substances are we talking about?

Rules of glove

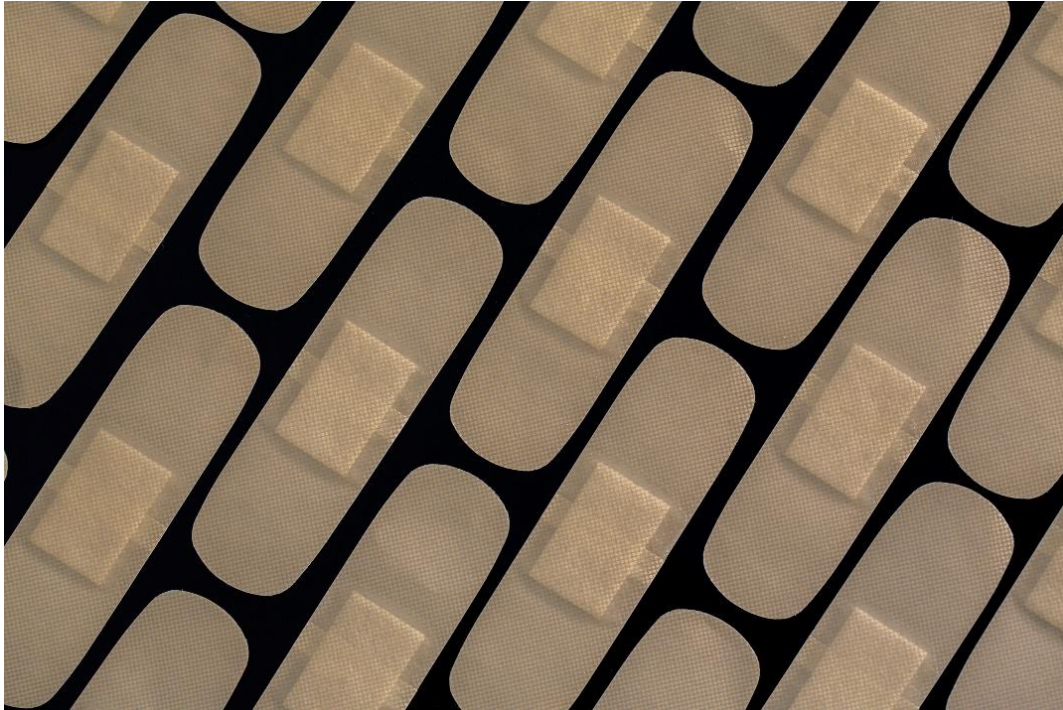
Choosing gloves

DEMO: Removing exam gloves

Other personal protective gear

- goggles (chemicals, projectiles, and body substances)
- poncho (chemicals and body substances)

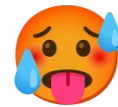
Street Medic Gear



Medic
Show & Tell!



Heat Ailments



Heat Exhaustion

SIGNS & SYMPTOMS: Muscle cramps, fatigue, dizziness, sweating, cold skin, nausea, thirst, panting

TREATMENT: Move to shade, drink water / clear juice / sports drink, dampen, remove layers, cold cloth to neck, fan.

Heat Stroke

SIGNS & SYMPTOMS: confusion, trouble speaking, hallucinations, seizures, fainting; throbbing headache; hot, dry, red skin, high temperature; vomiting.

TREATMENT: **CALL EMS.** Shade, remove clothing, dampen, cold packs in armpits, groin, neck. SIP water.



Cold Ailments



Frostnip

Body part is red, swollen, painful, hard to move.

TREATMENT: gentle friction, dry insulation, warmth.

Frostbite

Waxy, immobile, hard, numb.

TREATMENT: Bandage.

DO NOT REWARM.

CALL EMS.

Grumbles: Irritability, blue lips.

Mumbles: Slurred speech, shivering, pale, bluish.

Fumbles: Clumsiness, sleepiness, less shivering.

Stumbles: Confusion, fainting.

Tumbles: Unconsciousness.

TREATMENT: Hot, sweet drinks (no alcohol). Dry clothes in layers. Barrier between body and cold or wet ground. Transport to warmer space.

Stumbles or Tumbles: bundling and EMS.



Chemical Weapons



ONLY USE WATER in eyes!

Other substances (milk, antacid, baking soda, saline, baby soap, sugar, etc.) require extra prep time and may cause reactions, mark people as targets, and/or get hella funky in the hot sun (or the holding pen).

The goal is to **physically flush the substance out of the eyes**, not to counter or neutralize the chemical reaction.

Water is cheap, easy, safe, and widely agreed upon.

WATER.





Eye Flush Demo



1. Introduce yourself, offer help, and gain consent;
2. Put on gloves;
3. Contacts? Ask them to remove with a glove;
Glasses? Remove glasses and give them to the patient to hold;
4. Have them kneel and hold their legs to prevent them touching their face;
5. Tilt head back and slightly toward side of first eye. Hold eye open.
6. Aim from bridge of nose across eye. Squeeze bottle hard to push strong stream into the eye, from inner to outer, away from tear duct.
7. Repeat with the other side, mirrored.
8. Repeat process until they can blink and see. (They may still be in pain.)
9. Rinse mouth. Wash glasses before putting them on again.
10. Wash bare skin with soap & water.
11. Discard and replace gloves for next flush.



Eye Flush Aftercare



Exposure to chemical weapons can be **traumatic** and **disorienting**.

After treating a patient, make sure to share these aftercare steps:

- 1.Remove** and bag clothing*
- 2.Discard or wash PPE**
- 3.Wash hair** thoroughly first by leaning backwards into water
- 4.Shower** with soap and water
- 5.Take emotional** and **physical care** of yourself
- 6.Your liver & skin** will process the exposure – be kind to them

***Wash clothing separately** from all other clothing.

***Do not wash** in *public laundromats*.

abc **Assessment Order** abc

When treating injuries that do not constitute an **immediate life threat**:

check for **A – B – C**

Airway: Making sure the airway is clear

Breathing: Making sure the patient can maintain their breathing

Circulation: Bleeding control

abc **Assessment Order** abc

When treating **IMMEDIATE, CRITICAL TRAUMA** injuries:

check for **C – A – B**

Circulation: Bleeding control

Airway: Making sure the airway is clear

Breathing: Making sure the patient can maintain their breathing

🔴 Wounds / Bleeding Control 🔴

For this training, we will discuss interventions for **wounds that constitute a life threat**.

Care for specific minor wounds and aftercare are beyond the scope of this training.

In a trauma situation (knife, gun, car, explosion, etc.) **treat bleeds *first***.

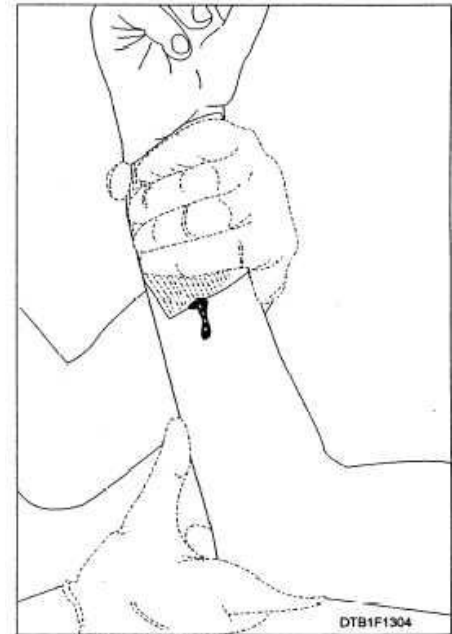
Arterial

bright red, pulsing or spurting, forceful

! Always a life threat !

Venous

dark, leaking or oozing or flowing





Bleeding Control



- Direct **pressure** (heel of palm, kneel into the wound, body weight pressure)
- Layer **gauze on top of the wound** if it bleeds through
- Change out the top layer **only** if it bleeds through
- Never remove gauze on the wound (may rip clotting)
- Note how much material was used to **assess seriousness of bleed** (bled through 10 4x4s, 2 abdominal pads, etc.)
- Bleed should **slow after 7-10 minutes** of pressure
- Note if patient has taken **anticoagulants/blood thinners** (Coumadin/heparin/warfarin, Plavix, daily use of aspirin, NSAIDs, etc.)

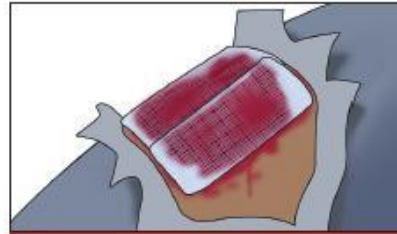
💔 What are Life-Threatening Bleeds? 💔



Blood that is spurting out of the wound.



Blood that won't stop coming out of the wound



Bandages that are soaked with blood



Loss of all or part of an arm or leg



Blood that is pooling on the ground



Clothing that is soaked with blood



Bleeding in a victim who is now confused or unconscious

Source:
stopthebleed.org



Tourniquets



Indications for tourniquet:

- Amputation above the wrist or ankle
- Severe bleeding not stopped by direct pressure
- Direct pressure cannot be applied to site of wound



How to apply a tourniquet:

- Get a manufactured tourniquet device and learn to use it
- Use a dedicated tourniquet when available
 - Makeshift from flexible strap or durable fabric
- Apply tourniquet just above the injury site or two inches above the joint
- Tighten until bleeding stops or becomes oozing
- Write the time you applied the tourniquet securely to the patient
- NEVER release or loosen the tourniquet – that happens in the hospital

Tourniquets

Do **NOT** do this lightly

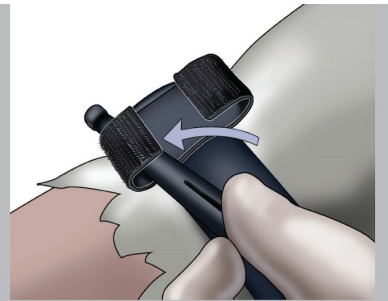
- Tourniquets are **extremely painful** and **cause damage**
- They can also be **ineffective** if **applied incorrectly**



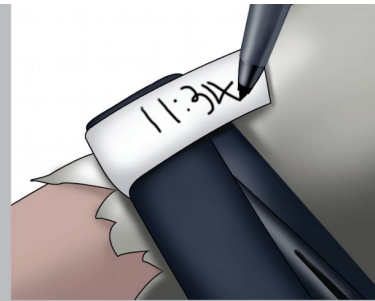
WRAP



WIND



SECURE



TIME

♿ Improvised tourniquets ♿

You'll need three components to craft a tourniquet:

Material:

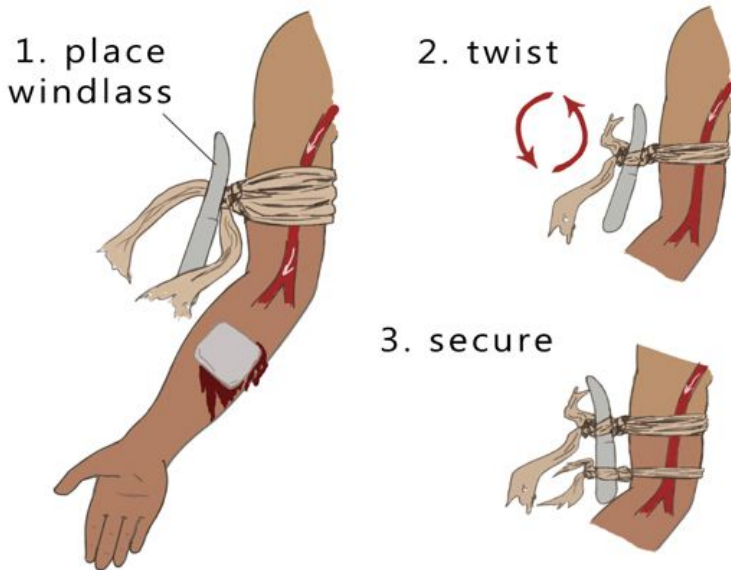
any clean cloth, bandage, necktie, ace wrap, nylon webbing

Do not use: belt (not flexible enough for pressure), zip ties (tissue & nerve damage)

Windlass (the turning mechanism): carabiner, trauma shears/scissors, broom handle, folded pocket knife, etc.

Do not use: breakable wood (rulers, pens), your hands (just using your strength to keep it tight and closed is not enough!)

Securing material: second bandana, hair ties, key rings, hooks or straps.



🔪 Improvised tourniquets 🔪

- 1) Take a broad piece of cloth and **wrap it around the limb**, two inches **above the joint** that is **above the wound**.
- 2) Tie a **square knot** around the limb, with a stick or something else that will not break in the center of it.
- 3) Turn the stick as a crank **until the bleeding stops**.
- 4) Use the ends of the cloth to **tie the stick** in place.
- 5) Mark with the **time applied**.
- 6) **RUSH THIS PERSON TO THE HOSPITAL.**
- 7) Do **not** undo or loosen tourniquet.



One Last Note: Tourniquets



Whether you use a commercial tourniquet or an improvised one –

these are **PERISHABLE SKILLS**
and **MUST BE PRACTICED!**

😱 Shock 😱

Heart unable to pump enough blood/oxygen to brain and organs

Shock is an immediate life threat

Compensated

- Sweaty, flushed skin
- Blue nail beds, inner lips, inner eyelids (conjunctiva)
- Panting (quick shallow breaths)
- Nausea
- Extreme thirst
- Rapid pulse
- Dizziness
- Confusion
- Panic

Decompensated

- .Slow breathing
- .Cool, clammy skin
- .Pallor ("pale" in light skin tones or "gray" in darker skin tones)
- .Weak pulse
- .Fainting
- .Unresponsive





Hypovolemic Shock



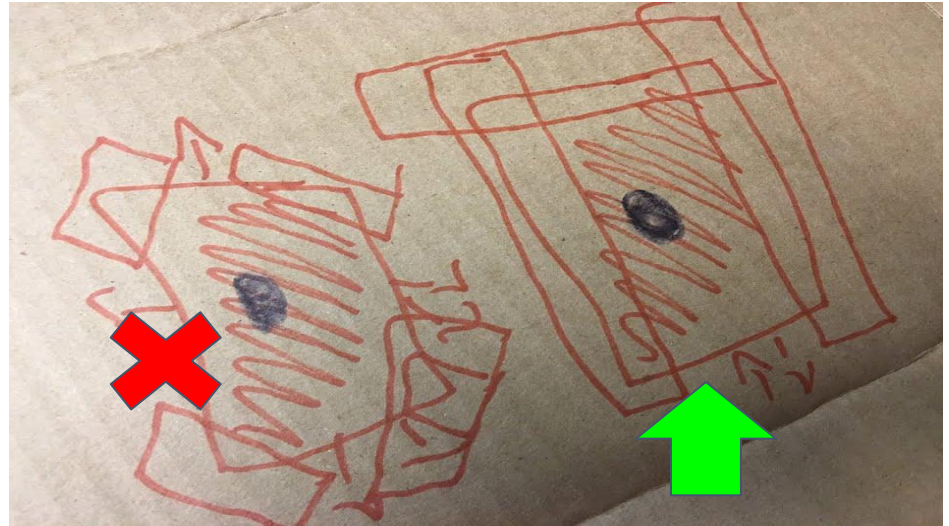
- Is the patient **bleeding severely**?
- Has the patient **lost a lot of blood**?
 - Check their **pulse***
 - Check their **perfusion***
 - Check their **clothing and surroundings***

Treatment

- Keep warm
- Control bleeding
- Keep still and lying down
- Transport quickly to higher care
- Keep airway open, and give rescue breaths if applicable
- Will need oxygen and blood infusion

😱 Special types of wounds 😱

- Punctures 🕳️
- Impalements 🏹
- Knife wounds 🗡️
- Burns 🔥
- Amputations 🦶
- Head Wounds 🤕
- Gunshot Wounds 🔫



a very punk illustration of an occlusive bandage with flutter valve (right) and also how NOT to do one (left)

😱 Airway & Breathing 😱

Why might someone not have an airway?

- asthma
- choking
- jaw or neck injury

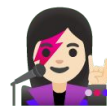
Unconscious and not breathing:

.head tilt chin lift

.jaw thrust

(only for neck injury)





Spinal Precautions



If someone is...

- struck in the head or neck by a big thing with great force;
- thrown or fell a long distance;
- in a weird, “unnatural” position;

assume that their **cervical spine** (neck vertebrae) is compromised.

Moving this person without stabilizing their neck risks severing the spinal cord (the nerves that keeps them breathing and moving) leading to paralysis, other long-term disability, or death.

Live Shooter Safety

1) **RUN.**

During active gunfire, **your safety comes first.**

Don't become another patient!

2) **HIDE.**

Get behind a solid wall or object that bullets cannot penetrate, like brick walls or concrete.

Bullets can and do **penetrate vehicles**, enter through **doors/windows**, and **ricochet**.

*If solid cover isn't available, **get behind visual cover.***

3) **FIGHT.**

Gunshot Wound Treatment

- Bullet **entry wounds** tend to appear much **smaller** than exit wounds.
 - Skin closes around a bullet wound upon entry
 - Important to find the wound if causing major bleed
- Bullets can **ricochet** unpredictably inside a body, causing **multiple** – sometimes unexpected – **internal injuries**.
- Bullets can become **lodged** in the body, where they can **continue to cause injury**.

Gunshot Wound Treatment

What have we learned about treatment of traumatic injuries?

Remember assessment order: C – A – B

Circulation. Airway. Breathing.

Treat “C” first if gunshot is a perceived life threat that overcomes airway / breathing.

Gunshot Wound Treatment

- **Pressure on lungs/heart:** holes in the chest caused by GSW can cause a tension pneumothorax (sucking chest wound) as outside air enters & causes pressure in the chest.
- **Make occlusive bandage:** clean plastic and tape three sides, leaving third side open in the direction of gravity. Gorilla tape or duct tape very effective.
- Less urgent than treating any life-threatening bleeds
- Can also carry chest seals



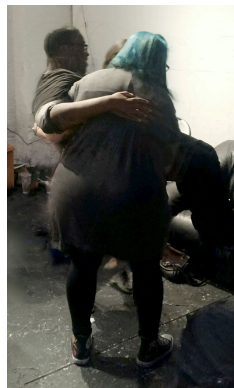
Other ways to help



- If someone is *better able* to provide care (EMT/paramedic/doctor), **ask how you can support** them.
- Carry an injured person to safety and care. There are more carries than we can cover, look them up and practice with pals.
- Spread **calm by projecting calm**, yourself.
- **WALK** from danger...
 - *except* in **active gunfire** – then **GTFO**.



Emergency Carries



Take c-spine at the head and direct.

SCRIPT FOR 7-PERSON CARRY

I need 👉👉👉👉👉👉.

Line up, three on each side.

Taller people at the torso.

Get down on one knee and alternate hands palm up like a zipper. Now do that again under their body.

On the count of 3 we will lift.

Is anyone not ready? 123.

Now shuffle in the direction of their feet. If anyone says stop we stop. STOP.

On the count of 3 we drop back to one knee.


Opioid Overdose

In the **NYC** area...

to train in the use of and carry **NARCAN** (naloxone)...

please get in touch with **NYC DSA Medics**

 nycdsahr@gmail.com

 **908-543-4986**

or

NYSDOH OOPi

 www.nyoverdose.org





We hope that understanding how to respond quickly and appropriately in worst case scenarios will help you be better resourced to look out for each other and exercise some agency when outside authority is either absent or the threat (or both).

See you in the streets!



Presented by NYCAM

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