

20-Hour Street Medic Course

Student Companion Book

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Welcome

Lead Instructors

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Schedule

- Friday, 6pm - 10pm
- Saturday, 9am - 7pm
- Sunday, 1pm - 7pm

Ground Rules

1. Be responsible for yourself.
2. Be accountable for your words & behavior.
3. Take care of each other.
4. Take the training seriously.
5. Use your imaginations (role plays).
6. Have fun.

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.

We also expect you to

- Be conscious how much space you take up.
- Respect people's identities, backgrounds, pronouns, etc.
- Apologize when you upset someone, and considerately try to learn why.
- Try to forgive people's honest mistakes.
- Please don't ghost us—we want to know if something about this training makes you not come back. Maybe it will help us learn for next time.

Trigger Warning



Being a street medic can be traumatizing.

- Even street medic *trainings* can get intense.
 - Scenarios incorporate:
 - simulated violence, pain, cops
 - authentic randomness

- Learn to make the difference between death and life.
- Medics help each other through the stresses and trauma.

Housekeeping

- Bathrooms
- Breaks
- Meals
- Special needs
- The “What if...” sheet

Action Medical Intro

What is action medical?

An unconventional set of loose *protocols* and *affiliations* by which volunteer medical activists support social movements and communities in struggle.

- It's not an *organization*.
- It's not much of a *movement* itself.
- Perhaps it's a *collective mindset* or *unified approach*?

Roles in action medical

street medics

First aiders who patrol in teams at planned actions, providing care to "anyone in need".

embedded medics

First aiders who operate within an existing organization, who may or may not treat non-members. (a.k.a., "affinity group medics" or "medical monitors")

action clinicians

Medics who hang tight in a removed/protected facility, typically able to provide more advanced care, privacy, and security than street medics.

Roles in action medical

community medics

The true badasses who work in communities when crowds and cameras are nowhere to be found.

infrastructure/support

All the people and orgs that support us as we train and operate. Not everybody has to be willing to deal with blood!

(Street) First Aid Intro

What is first aid?

Assistance given to any person suffering a sudden illness or injury, with care provided to **preserve life, prevent the condition from worsening, or promote recovery.**

It includes **initial intervention** in a serious condition **prior to professional medical help** being available... as well as the **complete treatment of minor conditions...** (Wikipedia)

What is street first aid?

All the good stuff from the *first aid* definition, plus medical and **tactical** training oriented toward chaotic, potential **mass-casualty situations** disproportionately involving **marginalized communities**, where official **conventional emergency services may not tread** and **authorities may not be welcome.**

What is community medicine?

Street first aid, with permanence and a broader mission:

- Provide medical care to people actively or passively denied care.
- Fill gaps in the larger medical system, e.g.
 - alternative/holistic approaches
 - friendlier & safer for marginalized folks
- Organize medical workers.
- Provide a glimpse (“prefiguration”) of alternative models of care.

Learning first aid

- Blood and gore?
 - Consider how much worse it will be IRL.
 - *Vasovagal syncope* is a thing...
 - but medics don’t faint.
- Potentially traumatizing, i.e.
 - Some subject matter is difficult.
 - Scenarios get *real* sometimes.

Good Samaritan laws

By what right do we run around offering people first aid?

- So-called “Good Samaritan” laws protect volunteer first-aid providers for all rendered assistance short of “gross negligence”.
- If you do your best to help, technically you cannot be sued or charged with a crime.

- These laws also technically protect those activating 9-1-1 from any drug charges associated with the emergency.

Escalations & continuum of care

- *Street first aiders call for backup!*
- EMS is our first choice, with reservations.
 - a problematic solution
 - all the best gear, including a wicked fast ride
- Direct transport is an option.
- Advanced street medics are sometimes an option.

EMS

emergency medical services, coordinated by the 9-1-1 *first responder* system and *medical control*.

Activating EMS

- If possible, get patient's consent before calling 9-1-1.
- You may need to coordinate access.
- Get ready to advocate for your patient.

Street Medic Ops Intro



Why do street medics always work in pairs?

- extra hands
- second opinion
- safety
 - eyes in the back of your head
 - crowd control
 - direct protection while treating



A pair is not three.



In this presentation, the **black flag** symbol indicates wisdom of the ages that you will regret breaking when you inevitably decide you know better.

Pairing up

- **Compatibility** is key, e.g.
 - risk tolerance
 - arrest
 - injury
 - mobility
 - schedules

Pairing up

- **Complementarity** is also handy, e.g.
 - experience levels
 - medical
 - street/action
 - languages
 - genders

Syncing up with P E A R L

P

physical needs

E

emotional/psychological needs

A

arrestability

R

roles you might play *

L

loose ends

* *roles* include tactical lead, medical lead, communications

Scene Assessment

S T O P

S

Survey the scene.

T

Take precautions.

O

Organize help.

P

Proceed with caution.

Scan the scene.

- Halt! Do not rush in.
- Survey the area:
 - Is the *mechanism of injury* persistent?
 - How many people are injured?
 - What do you anticipate?

Take precautions.

- Consider repositioning.
- Put on protective gear.
 - body substance isolation
 - physical protection

Organize help.

- Check in with your team.
 - Who will perform which roles?
- Call for backup.
 - Other medics?
 - EMS?
 - Bystanders?
- Organize the crowd.

Proceed with caution.

- Medics do not run.

- Medics walk swiftly with purpose.
- Sometimes you have to walk swiftly *away*.
- Stay calm and confident.

More scene safety basics

- Never make a new patient!
- Continually reassess the scene for safety.
- Be prepared to move or protect your patient.

Consent

Street medics get consent for *everything*.

How we get consent

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



Hello, my name is Inigo Montoya and I know first aid. I can help you. Would that be okay?



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

Common reasons for refusing care

- caregiver's perceived gender
- worried medics are cops
- financial concerns
- modesty / fear of exposure
- fear of attracting attention
- doubts injury is "that bad"
- someone else must be worse — help *them*
- fear of contagion (you or them)

What's a street medic to do?

- Be persistent but not pushy.
- Validate and address the patient's concerns, e.g.
 - “I can understand how 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.

Body Substance Isolation

Also known as: *BSI*

BSI works two ways

- Keeps you safe from your patients
- Keeps your patients safe from you

What substances are we talking about?

- blood
- vomit
- saliva

Rules of glove

- Always change gloves between patients
- Dispose of gloves if they get dirty or damaged

Choosing gloves

- Always use *non-latex* gloves:
 - No allergic reactions
 - No need to inquire about latex allergies
- Color matters
 - Lighter colors show blood better
 - Black hides blood
 - Each offers advantages

Removing exam gloves:

► [assets/images/videos/glove-removal.mp4 \(video\)](#)

Other personal protective gear

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

Initial Assessment Intro

Purpose of initial assessment

To identify life-threatening or potential life-threatening conditions.

Initial assessment is a protocol

- We perform it in a specific order.
- We do *not* skip steps.
- We only interrupt it to perform *life-saving interventions*.

Red flags

- The initial assessment is a search for red flags: indicators of *potential life-threatening conditions*.
- As soon as you find a red flag, you'll need to call for backup.



There are lots of gray areas in first aid. Street medics tend not to rule conditions out. If it *could be* a red flag, it's a red flag.



In this presentation, **red flags** indicate absolute conditions in which to activate emergency response, whether this is your first course or you're an experienced emergency physician.

DEMO: IA Run-through

Tips for learning initial assessments

- Initial assessment is probably the hardest skill medics perform.
- You will screw up more than you get right at first.
- It can be harder in trainings than IRL.
- Ask your partner for help if you get stuck.
- Make your mistakes in settings like this.

Tips for performing initial assessments

- It's unintuitive, but *go slow*.
- Vocalize steps as you go.
- Only stop for *life-saving interventions*.

IA Overview

M

Mechanism of Injury

M

Mental Status

A

Airway

B

Breathing

C

Circulation

D

Disability

E

Environment

Mechanism of Injury

MOI

The *immediate* cause of an injury or sudden illness.

- Do *not* think like a radical at this stage!
- It's not the *root* cause, but the *direct* cause.

MOI determines

- Whether the danger persists
 - potential harm to you, e.g.
 - cops
 - traffic
 - continuing to harm the patient, e.g.
 - burns
 - ongoing brutality
 - vehicle

Cervical spinal injuries



Injuries to the vertebrae in the neck can cause paralysis, including fatal paralysis.



Positive MOI for C-spine injury

- fall from twice one's height
- severe motor vehicle accident
- motor vehicle to pedestrian
- direct trauma to the neck



If you suspect a C-spine injury, you must immediately initiate C-spine stabilization.

Intervention: C-spine stabilization

Principal: Prevent further injury to the cervical vertebrae and spinal cord by restricting movement.

- Approach from the front
- Tell the injured person to keep their head still.



More important than keeping the patient still is keeping the neck stable and in line.

(1/2)

Intervention: C-spine Stabilization

- Gently bring the neck into alignment.
 - STOP! if:
 - the patient feels pain
 - there is grinding (“crepitus”)
- Firmly hold both sides of the patient’s head.
- Someone must hold this position until advanced help arrives.

(2/2)

Persistent MOI

The other potential red flag for the MOI stage is a *persistent mechanism of injury*.

1. What is the MOI for a burn?
 - *Heat* — so that’s what we try to address.
2. How about MOI for an impaled object?
 - The *object* — we don’t remove these, so we’re going need further care.



Persistent MOI calls for intervention. If you cannot intervene safely or successfully, get help!

Mental Status

Is the patient alert and oriented?

- Has the patient lost consciousness?
- Do they respond readily and as expected?



Any prior **loss of consciousness** or current **altered mental status** is a red flag.

Altered mental status

A V P U scale

A

alert and oriented

V

responds to verbal stimuli

P

responds to painful stimuli

U

unresponsive

Procedure

1. If the patient is **alert**, assess their *orientation*:
 - What's your name?
 - What happened to you?
 - What month is it?
 - Where are we right now?
 - Did you lose consciousness at any point?
2. If the patient is not alert, try addressing them loudly.
3. If verbal stimulus doesn't work, apply some acute pain.
4. If this does not work, the patient is unresponsive.

Reasoning

We assess mental status for multiple reasons:

- The patient's critical medical needs.
- Our own safety in cases where an injured patient may be frightened or agitated.
- If we miss altered mental status or prior unconsciousness, we may be missing much more.

Notes on mental status assessment

- Stay aware of changes in mental status throughout treatment.
- Relay the patient's status history when handing off to advanced care.



Don't ask closed-ended questions, such as, "Do you know where we are right now?" Questions with existentialist interpretations are preferred, such as, "Where are we?" and "Who is in charge of the United States?"

Jail & Jail Support

Airway

MOI for airway obstruction

- choking
- injury to throat



An airway obstruction is a red flag. Call for backup immediately!

MOI for airway compromise

- injury to throat
- unconsciousness with fluids in mouth
- unconscious and lying on back



Airway compromise is cause for pausing your initial assessment to intervene.

Intervention: Choking (conscious patient)

1. Establish if the patient is choking.
2. Tell the patient to cough.
3. Apply 5 firm back thrusts between lower shoulder blades.
4. Apply 5 firm abdominal thrusts above the navel.

Intervention: Open airway (unresponsive patient)

1. If your patient is or becomes unresponsive, check for breathing.
2. If the patient is not breathing, open their airway:
 - If no C-spine injury is suspected, use the head-tilt, chin-lift technique to open the airway.
 - For suspected C-spine compromise, use the jaw-thrust maneuver.
3. If the patient does not spontaneously breathe, initiate CPR.
4. If the patient begins breathing on their own, roll them into the recovery position.

DEMO: Head-tilt, chin-lift maneuver

► [assets/images/videos/head-tilt-chin-lift-technique.mp4](#) (video)

DEMO: Jaw-thrust maneuver

► [assets/images/videos/jaw-thrust-technique.mp4](#) (*video*)

DEMO: Recovery position

► [assets/images/videos/recovery-position.mp4](#) (*video*)

skip to **0:20**

DEMO: Jaw-thrust maneuver

► [assets/images/videos/jaw-thrust-technique.mp4](#) (*video*)

DEMO: Recovery position

► [assets/images/videos/recovery-position.mp4](#) (*video*)

skip to **0:20**

DEMO: Recovery position

► [assets/images/videos/recovery-position.mp4](#) (*video*)

skip to **0:20**

Breathing

MOI for respiratory distress

- exertion
- aerosolized chemicals
- chronic condition, e.g.
 - asthma
 - COPD

Signs of respiratory distress

- shallow breathing
- rapid breathing
- slow breathing
- unsteady breathing
- strained breathing
- wheezing/gasping

Intervention: Respiratory distress

- If chronic, do they have medicine?
- Tripod position.
- Breathe along with them.
- Be calming and reassuring.



Severe or prolonged respiratory distress are red flags! If the patient does not recover after 3-5 minutes, or if the distress is extraordinary, call for backup!

Intervention: Respiratory arrest

- Rescue breathing.
- Learn it in CPR course.
- If you don't know CPR, somebody nearby does.
- Get them to do it.

Circulation

Pulse

1. Does the patient have a pulse?
 - If they're breathing:
 - They have a pulse!
 - If someone is breathing for them:
 - Check for a pulse.



Lack of pulse.

Bleeding

1. Is the patient bleeding severely?
 - This is also usually obvious.
 - Sweep unconscious patients.
2. Has the patient lost a lot of blood?
 - a. Check their pulse.
 - b. Check their perfusion.
 - c. Check their clothing, surroundings.



Severe bleeding or recent severe blood loss.

DEMO: Blood sweep

Intervention: Severe bleeding control

- Apply direct pressure to wound site.
- Conditions for tourniquet:
 - arm/leg amputations
 - massive arterial bleeding in a limb

Signs/symptoms of hypovolemic shock

- Skin: pale, cold, "clammy"
- Pulse: rapid, weak
- Breathing: rapid, shallow
- Dizziness, weakness
- Confusion, changing consciousness

Intervention: Severe blood loss (shock)

- Call 911!
- Lay the patient down.
- Make them comfortable.
 - Fluids are good.
 - Warmth is good.



Shock kills! Any patient in shock must receive hospital care.

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Disability & Environment

Disability

Is there *life-threatening danger* the patient unable to perceive or avoid?

- Most commonly caused by recent injury.
- Also consider loss of mobility/perception aids.



Disability in a life-threatening situation calls for intervention, which *may* require backup.

Interventions: Disability

- Chemically induced blindness:
 - Perform an eye flush (taught later).
- Lost glasses:
 - Take their arm, guide them out.



Only intervene if the life-threatening danger is not a danger to you.

Environment

Are the immediate surroundings a danger to your patient?

- Any threat that prevents or disrupts lifesaving care.
 - severe weather
 - hostiles
 - chaotic crowds



Think ahead: changing environments mean continually reassessing the threat.

Secondary Assessment

After initial assessment is complete and life-saving interventions administered, it's time for a secondary assessment.

Purpose

- Help catch factors that may inform your assessment or care.
- Gather information that may be helpful to further providers should conditions change, such as patient loses consciousness.

If your patient is alert, gather a **focused medical history**.

S A M P L E history

S

signs/symptoms

A

allergies

M

medications

P

past medical history

L

last food and drink

E

events leading up to illness/incident

Focused trauma assessment

Head-to-toe exams are administered whenever the mechanism of injury (MOI) suggests there may be injuries or signs you have missed.



Check for consent for focused assessments, even if the patient already consented to initial assessment.



Can I ask you some more questions about your medical history and what's going on?



Is it okay if I examine you some more to make sure there's nothing we're missing?



Explain what you're doing as you go!

Your unresponsive trauma patient...

- is already in C-spine stabilization, right?
- needs a head to toe blood sweep to see if undetected blood loss is collected in clothing or the ground.

Bleeding & Shock



Severe bleeding is always a red flag, no matter when it's discovered.

Signs of severe bleeding

- evidence or suspicion of massive blood loss
 - more than a pint in an adult at any rate
- arterial bleeding
 - bright red
 - spurting
- shock

Bleeding control

1. Apply direct pressure to the site of the wound, as long as doing so will not cause further injury.
2. If direct pressure does not control severe bleeding or cannot be applied, consider a tourniquet.

Direct pressure

1. Take body substance isolation precautions!
2. Apply direct pressure with a gloved hand until gauze is available.
3. Bleeding should stop within 3-5 minutes.



Removing gauze risks breaking any clot that is forming. Keep packing it on as blood soaks through.



Patients can apply direct pressure to their own wound in many cases, which can be empowering. Exercise good judgment.

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.



Get a manufactured tourniquet device and *learn to use it*.

How to apply a tourniquet

- Use a dedicated tourniquet when available.
- Makeshift from flexible strap or durable fabric.
- Apply tourniquet just above the injury site.

- Tighten till bleeding stops or becomes oozing.
- Affix the time you applied the tourniquet securely to the patient.
- Never release the tourniquet.

Signs/symptoms of severe internal bleeding

- obvious bruising in abdomen or chest
- blood in vomit, stool, or urine
- abdominal pain and swelling



This patient definitely needs follow-up care, but activate emergency response only if signs of shock are present.

Hypovolemic shock

Caused by internal or external blood loss — technically, a severe loss of *blood volume*.

Core organs compete for scarce or hard-to-get blood, causing slow overall decompensation.



Shock kills!

Signs of shock associated with injury

Early

Headache, dizziness, nausea, fatigue

Later/severe

- cold/clammy/pale/ashen skin
- pink parts are bluish
- rapid, shallow breathing
- disorientation / agitation / combativeness

First aid for shock

- Activate emergency response!
- Get them someplace warm if they can be moved and shelter is near.
- Lie the patient down.
- Cover them with a blanket.
- No food or liquids.
- Keep them as comfortable and calm as possible.
- Monitor level of consciousness and ABCs.

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Soft Tissue Injuries

Some injuries we treat in the field

- minor lacerations
- scrapes
- minor bruises



When no complications are associated with a superficial injury, street medics may provide complete primary care.

Open wounds (general treatment)

Once bleeding is controlled...

1. Irrigate the wound with water, saline, or diluted providone-iodine diluted in water (1:10).
2. Securely apply clean bandaging to keep wound covered, clean, and dry and maintain gentle direct pressure.



Never use peroxide or alcohol, which damage tissue and slow healing.

Refer lacerations for suturing under these conditions

- animal bite
- over a joint
- cosmetic concerns
- jagged edges / won't close easily
- half-inch or more depth

Puncture wounds

1. Do your best to irrigate.
2. Refer for care and warn of signs of infection.
 - high risk of infection (no self-irrigation)
 - difficult/painful to properly irrigate

Avulsions

- Replace the “flap” and bandage in place.
- Associated with increased risk of infection.
- Refer to ED or urgent care.

Impaled object



Never remove an impaled object larger than a splinter.

1. Loosely apply sterile dressing.
2. Bandage around object for stability.
3. Apply direct pressure near impalement without moving the object.
4. Refer to ED or emergency transport for large深深 objects

Impaled Object: Donut bandage

► [assets/images/videos/donut-bandage.mp4](#) (*video*)

Missing teeth

1. Replace lost tooth into socket or store in container with patient's own saliva.
2. Have patient bite gently on wad of gauze.
 - Do not touch the root of the tooth. [flag]
 - Patient needs to see a dentist ASAP. [flag]

Eye injuries

1. Cover the injured eye completely.
2. In stable environment, bandaging uninjured eye with a pinhole to decrease likelihood of injured eye movement.

Contusions

- Minor bruising is treated with rest and ice.
- Major bruising gets referred to ED or urgent care.

Burns

- Can be superficial, partial thickness, or full thickness.
 1. Remove the source of the burn.
 2. Cool the site with water.
 3. Apply loose, sterile dressing.
- Burn gels/pads are okay on first-degree burns.

Head Injuries

Hot Weather Ailments

What do we see when it's hot and/or sunny out?

1. sunburn
2. heat exhaustion
3. heat stroke



Freebie

Treatment for sunburn: cover up or get out of the sun!

Signs/symptoms of heat exhaustion

- fatigue
- cool/pale/ashen skin with profuse sweating
- headache / dizziness / nausea / vomiting



Children and elderly folks are especially at risk.

Intervention for heat exhaustion

- Get the patient to shade.
- Fan the patient.
- Remove excess clothing.
- Have them drink water; no hardcore sports drinks or powders unless heavily diluted.

Signs/symptoms of heat stroke

- Skin may be moist *or dry*, as in no longer sweating
- Disorientation / deliriousness
- Loss of consciousness

Treatment for heat stroke

- Get the patient somewhere cool right away.
- Remove clothing
- Apply cold packs to neck, armpits, inner thighs
- Fan and mist but do not soak skin or clothes



Always activate emergency response for heat stroke. An air-conditioned taxi to the nearest ED might be the best option.

Counsel prevention

To avoid these awful eventualities, on hot days encourage activists to:

- Cover as much of their body with light clothing as they can stand, slather the rest in sun block.
- Stay hydrated and within their physical limits — overdoing it costs medical resources

Cold Weather Ailments

Cold weather threats

- Hypothermia — body-heat loss that threatens organ failure
- Frostnip — minor tissue damage due to cold
- Frostbite (rare) — severe tissue damage, usually to extremities

Signs/Symptoms of hypothermia

- severe shivering
- pale/bluish where should be pinkish
- slurred speech / mumbling
- slow / shallow breathing
- clumsiness / drowsiness / fatigue
- disorientation / memory loss / loss of consciousness



Factor in wind and rain, and you may see hypothermia at temperatures as high as 50°F (10°C) or higher or in water up to 70°F (21°C).

Treatment of hypothermia

- Get the patient out of the cold.
- Remove dry clothes and dry the patient.
- Warm liquids by mouth are okay if patient is alert — no alcohol or stimulants (such as cigarettes/coffee).
- Use active warming with heat packs to the armpits / thighs.
- This may be a good time to bust out that space blanket.



Always activate emergency response for hypothermia. A hypothermic patient is best warmed under advanced medical supervision.

Signs/symptoms of frostnip

- reddened/lightened skin where exposed or in extremities (fingers/toes)
- itching / tingling / numbness

Treatment for frostnip

1. Get to a warm place.
2. Warm the area with moderate heat, such as warm hands or insulated heat pack.
 - Do NOT re-expose to cold.
 - Do NOT rewarm with friction.

Signs/symptoms of frostbite

Following the signs/symptoms of frostnip...

- white/yellow/waxy skin
- blotchiness
- blistering/swelling
- clumsiness due to joint/muscle stiffness

Treatment for frostbite

1. Get the patient somewhere warm...
2. but do not warm and then allow refreezing.
3. Do not actively warm the site.



Activate emergency response or rush to emergency department; minutes count because tissue is at stake.

Counsel prevention

Properly dressed, fed, and hydrated activists rarely get hypothermia or frostbite.

- Extremities — including ears and noses — need coverage in cold weather.
- Water resistant clothing even in merely chilly weather.
- Layers, layers, layers, including a wicking layer on the inside.
- Send people indoors if they appear at risk; encourage them to rotate.

Musculoskeletal Injuries

Injuries to bones, muscles, and the stuff holding it all together, most especially:

- breaks (bone fractures)
- sprains (injury to the ligaments between bones)
- strains (injury to muscles and/or tendons)
- dislocations (dislodgment of long bone from joint)

Differentiating between breaks and sprains

Except in cases of obvious fractures (deformity/exposed bone), don't bother diagnosing — we treat them all the same.



Only an X-ray can rule out fracture, and it's never worth risking. Always refer what you think are sprains for immediate follow-up care.

Treatment is the same for all

1. Examine the site.
2. Check pulses/perfusion (compare to opposite side).
3. Treat any wounds at the site.
4. Treat with RICE.

R I C E

R

rest

I

ice

C

compression

E

elevation

- RICE treats pain, prevents exacerbation, and restricts swelling.
- **Rest** includes immobilization and protection of the injury site.
- **Ice** = 20 minutes on, 20 minutes off.

Principles for immobilizing musculoskeletal injuries

- For long bones, immobilize at least the joints “above and below” the injured bone.

- For joints, immobilize the long bones connected to the joint.
- Protect the injury site.
- Check perfusion before wrapping/splinting.

Dislocations in the field



If you have not been specifically trained to treat a specific type of dislocation, do not attempt to relocate a dislocated bone.

- Treat with **RICE** and refer to ED or urgent care.

Practical: Basic Splinting

Police Tactics & Weapons



Images of cops and other rightwing bullies ahead.



Figure 1. NYPD supervisor with “tonfa” side-handle baton



Figure 2. Sniper rifle in Fergusson

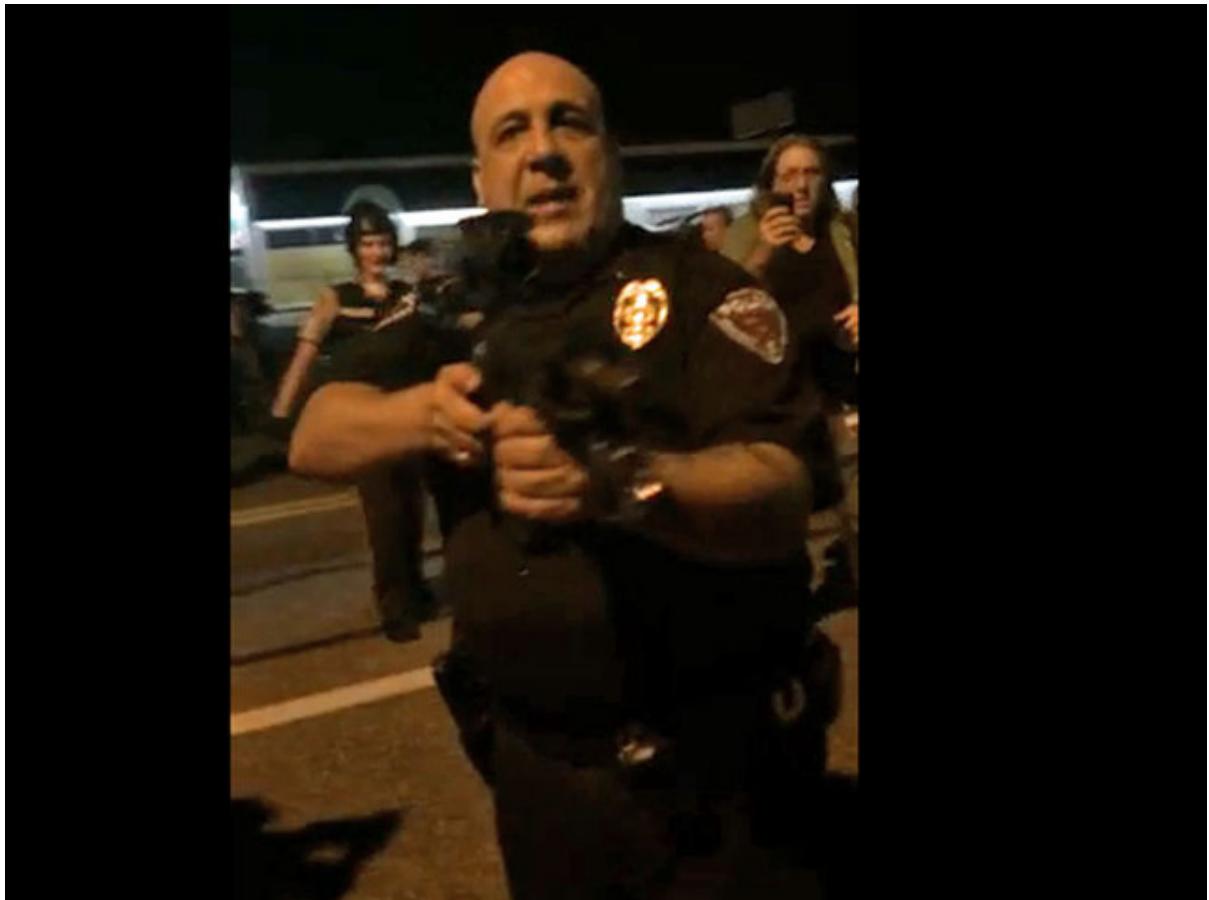


Figure 3. Officer "Gofuckyourself", Ferguson



Figure 4. Less lethal 12-gauge shotgun



Figure 5. Plastic bullet wound



Figure 6. Militarized police horses



Figure 7. Protesters frighten police horses (Albuquerque, 2017)



Figure 8. ‘3-percenter’ militiamen protect Nazis/Confederates (Charlottesville, 2017)

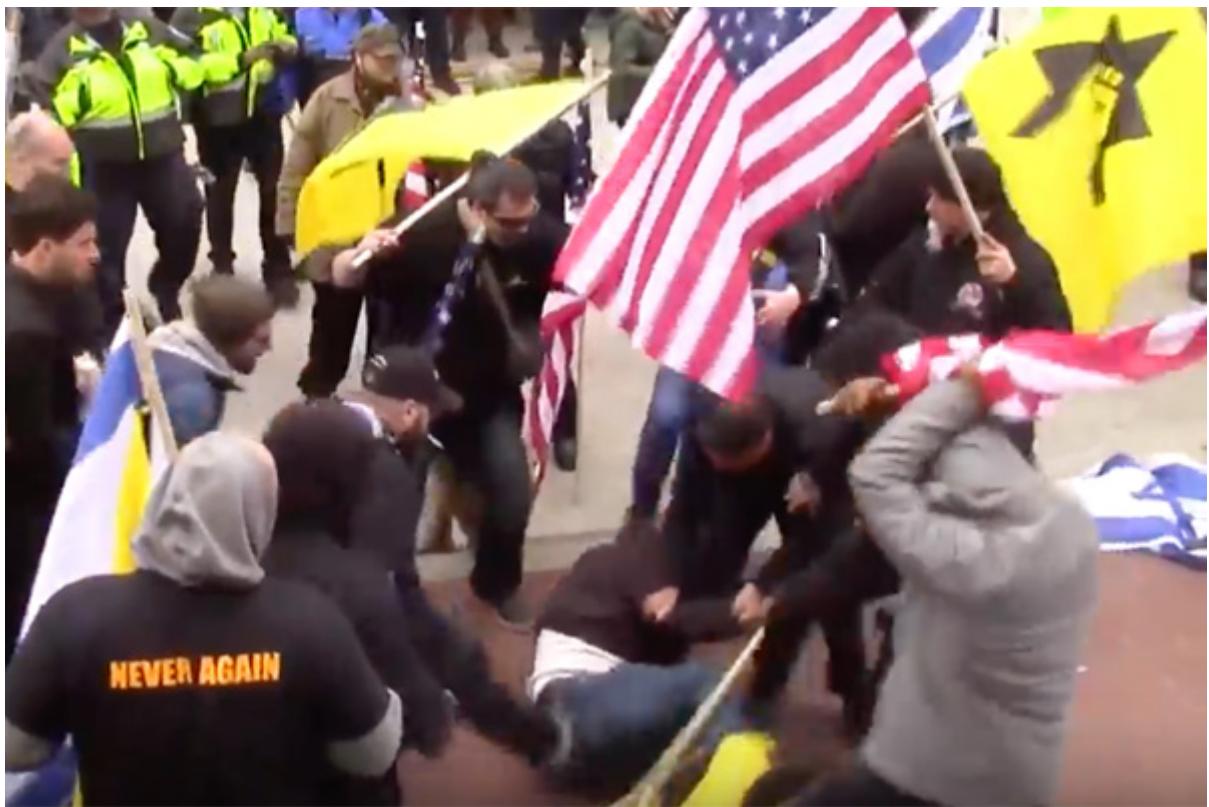


Figure 9. Jewish Defense League thugs beat Palestinian (DC, 2017)



Figure 10. Grenade launcher in action (Ferguson, 2015)

Chemical Weapons



Figure 11. Campus police officer pepper sprays students (UC-Davis, 2011)



Figure 12. NYPD officer pepper sprays unsuspecting bystanders

Pepper Spray (OC)

Irritant	oleoresin capsicum (OC)
Delivery	mainly direct spray, sometimes projectiles
Primary effects	pain, blindness, sometimes respiratory distress, mucous discharge
Secondary effects	irritation, dryness, certain sense of singular injustice
Primary treatment	water
Secondary treatments	“LAW”, air



Figure 13. Turkish police spray woman with tear gas (Gezi Park, 2013)



Figure 14. Palestinians under fire from Israeli troops (Bethlehem, 2015)

Tear Gas

Irritant	CS, CN, other aerosolized/particulate agents
Delivery	mainly by canister (launched or thrown), sometimes direct spray
Primary effects	pain, blindness, tearing, and mucous discharge
Worst effects	respiratory distress, blunt trauma from canisters, secondary injuries, hand burns, panic
Primary treatment	water
Secondary treatment	air



Figure 15. Protesters return tear gas (Quebec City, 2001)

Which effects of tear gas cause medics the most trouble?

1. blindness (Disability)
2. chaos (Environment)
3. canister injuries (blunt trauma, burns)

Protocol

Street medics perform eye decontamination using a specific protocol.

4. Take precautions.
5. Introduce yourself and check for consent.
6. Check for and remove contact lenses.
7. Explain the procedure.
8. Perform an eye flush.
9. Repeat on the other eye, as necessary.

Purpose

An properly administered eye flush physically drives chemical irritants from the eye.

Practice

The eye flush is a mechanical *sweeping* of the open eye with water, from the inner corner (near the nose) to the outer.

10. Take precautions.

Put on gloves, consider mask/goggles.

11. Introduce yourself and check for consent.

I'm Danarys Targaryan of House Targaryan, I'm a street medic, I can help if that's okay.

12. Check for contact lenses.

Are you wearing contacts?

- a. If yes, help them **remove their lenses immediately**.

Practice

4. Guide them into position.

Have them kneel on the ground and have them sit on their hands.

5. Explain the procedure.

“I’m going to pry your eye open and squirt it with water, okay?”

6. Administer a forceful flush.

- a. Tilt their head toward the eye you are flushing.
- b. Pry their eye open by pinching the eyebrow.
- c. Administer firm squirts until you definitely make good contact.

7. Repeat on the other eye.

Street Medic Ops (Part 2)

Establishing scene safety

- If you do not have a safe treatment zone, find one nearby.
- Ask for help from nearby businesses or residences.
- Find semi-public space to
 - hide patients
 - organize medical assets
 - establish resupply, and
 - access definitive care.

Be resourceful in the field

- Organize everybody on scene.
- Maintain morale of medics, wounded, comrades.
- Constantly reassess scene safety.



The street medic's number one piece of gear is our brain. Second is our ability to collaborate. Engage bystanders and innovate solutions in the field.

Conventional police violence

During ongoing counterinsurgency violence campaigns (lasting hours or days), organize medical evacuation (*medevac*) operations.

- Purpose: Transport at-risk patients to the *most definitive care available* as securely as possible.
- *At-risk* may include:
 - critical trauma or illness or
 - people in need of *sanctuary*.
- Transport in stages as needed.
- Remain free and safe to keep operating. 🚨

Rampage violence

In *active-shooter* scenarios with no expectation of reason on the aggressor's part...

1. Run if you can.

Do not stop to play hero and create another casualty. Your duty as a street medic is to get to safety.

2. If evading the area is not possible, **hide** in the most secure place available, such as a room or building with locked door.
3. Arm everyone available and organize a response in case of discovery.

4. If discovered, you must **fight**.

Special Injuries

Mass Casualty Incidents

As marked and equipped first responders to a potentially lethal *mass casualty incident* (MCI), street medics have a responsibility to perform *triage*.



A *mass casualty incident* is any trauma scenario in which the number of serious injuries outnumbers the *organized responders*.

Street medics will see bystanders as *unorganized* responders, and EMS will see marked street medics as *unorganized* responders.

Triage definition

Prioritization of care when patients outnumber available medics.

Triage purpose

Organize medical resources to prioritize the most critical cases.

Who does it?

Triage should be performed by the highest trained/most capable medic on scene.

Triage procedure

1. Have anyone who can walk on their own and is not actively providing care move to a “green” area.
2. Perform rapid ABCDE assessment on all remaining patients.
3. Assign available medics to perform life-saving interventions in critical cases as you go.
4. After checking all patients, assign medical resources according to severity.

Triage tips

- After initial round, triage “officer” should monitor the scene.
- Dispatch bystanders to sweep for unreported casualties.
- Plug new medic teams in as they arrive.
- Resist hyperfocus on any one case without a damn good reason.
- When police arrive... assert any medical credentials and state the most critical injuries.
- When EMS arrives... convey the triage stack and insist they let marked street medics continue providing care until EMTs can replace every first aider.

Difficulty Breathing

We know *respiratory distress* is a red flag during initial assessment, but activating 9-1-1 does not have to be our only intervention.



Respiratory excitement from physical exertion does not typically turn life threatening. Distressed breathing should improve with rest, or else

Respiratory distress defined

Breathing that is inadequate to sustain proper perfusion of vital organs.

- too shallow / rapid (more than 25 breaths per minute)
- too infrequent (fewer than 8 breaths per minute)
- too strained (asthma, anaphylaxis, COPD, injury)
- too inconsistent (agonal, apneic)

Causes of respiratory distress at actions

- injury to airway or chest
- asthma
- shock (mental or physical)

General interventions for respiratory distress

- Seat the patient upright, leaning forward, elbows on knees (“tripod”).
- Breathe along with the patient, exhibiting calm and confidence.

Airway/chest injuries

- Treat as directed in **Special Injuries**, then apply general treatment for respiratory distress.
- Remember, most basic interventions for airway trauma will decompensate quickly.
- Rapid intubation, chest decompression, and drainage saves lives.
- Tripod position may not be appropriate, depending on injury.

Asthma overview

Asthma attacks are spasms/constrictions of the bronchioles.

Signs/symptoms of asthma attack

- person suffers from asthma
- severe wheezing (both in and out)
- mucous production
- non-stop coughing
- rapid / shallow breathing

- chest tightness / pressure
- tightened neck / chest muscles (called retractions)
- difficulty talking
- sense of anxiety / panic

Asthma intervention

1. Help them use their inhaler.
2. If distress continues/worsens, activate 9-1-1. 
3. Treat with general intervention.



Do not use someone else's inhaler unless the patient can affirmatively identify it as the same prescription.

Anaphylactic shock overview

Allergic reaction including severe swelling that constricts the upper airway.

Signs/symptoms of anaphylactic shock

- person suffers from anaphylaxis / knows source of reaction
- skin reactions (hives / itching / paleness)
- swollen lips, tongue, or throat
- tightness in the throat / sense of airways closing
- hoarseness / trouble speaking
- nausea, abdominal pain, or vomiting
- rapid pulse / low blood pressure
- dizziness / loss of consciousness

Anaphylactic shock intervention

1. Help them administer epinephrine using epipen.
2. Activate 9-1-1. 
3. Treat with general intervention.



Do not administer epinephrine for hemorrhagic shock or for any purpose other than anaphylactic shock.

Anaphylactic shock with epipen administration

► [assets/images/videos/anaphylaxis-real.mp4 \(video\)](#)

Fainting & Seizures

Sometimes—especially in crowds and stress—people pass out.

Sometimes people who pass out experience dramatic muscle spasms and convulsions called seizures.

Fainting (syncope) overview

Sudden extreme weakness/collapse due to sudden dilation of blood vessels.

Treatment

1. Monitor alertness and ABCDEs.
2. Raise patient's legs at least 12 inches.
3. Remove/loosen clothing.
4. If they do not come around within 30-60 seconds, activate 9-1-1. 

Epileptic seizure overview

What to expect with seizures

- sudden confusion may precede onset
- body stiffens, person collapses
- loss of consciousness, possibly prolonged

[seizure intervention comic] | *seizure-intervention-comic.gif*

Treating seizures

1. Time the seizure.
2. Protect the patient.
Clear the area of hazards and gawkers.
3. Help maintain a clear airway.
4. When they stop seizing, place them in recovery position.
5. Calmly talk to them until they regain alertness.

Activate 9-1-1 for a seizure if...



- the person is unknown to you and everyone present
- this is their first seizure
- the severity of the event is known to be extraordinary for this person



Do *NOT* restrain the patient.

Do *NOT* insert anything into their mouth.

Diabetic Emergencies

Complications of diabetes occur in conditions of high and low blood sugar.



Hypoglycemia pursuant to missed meals and high exertion is among the most common medical conditions encountered by street medics.

Signs/symptoms of diabetic emergency

- missed meals
- recent high activity
- bracelet/necklace labeled DIABETES
- fatigue
- hunger / severe thirst
- pale / sweaty / clammy skin
- may seem and even smell intoxicated
- sudden loss of consciousness

Treatment

- If patient is alert, administer glucose (sugar) in the form of fruit juice, energy bar, or similar beverage/snack.
- Diet soft drinks do not count.
- If effective, patient should know what to do next.
- If ineffective:



If patient is not alert, place in recovery position and activate emergency response.

Street Medicking

Principles of action-medical patient care

1. First do no harm.

Stick to what you know.

2. Treat everyone in need, in order of criticality.

Perform unbiased triage, with two exceptions:

- i. Treat other medics first if they can be returned to duty.
- ii. Do not treat anyone who will harm others (see first point).

3. Patients are our comrades.

Treat every patient the way you'd want a loved one cared for.

Principles of action-medical patient care

4. Spread calm and confidence.

Perhaps short of actual cheer leading, do a little cheer leading.

5. Document, debrief, analyze.

Give back to the community by keeping track of what you do and how it works.

6. Honest evaluation of self and fellow medics.

Offer feedback and accept constructive criticism gracefully.

7. Commit to continuing education.

Keep your skills fresh through training, and hit the streets with experienced medics.

Respond during local/regional crises

- When the next disaster happens, get in touch with local action-medical activists.
- Respect local leaders and organizations first, as well as experienced medical organizers, then plug in as requested.

Remote solidarity during crises

- Help with communications/dispatch when a neighboring medic group is operating in chaotic conditions.
- Organize mutual aid logistics:
 - resupply
 - transport
- Raise funds.

Local Street Medic Scene Overview

Street Medic Mental Health

Address PTSD causes in yourself and fellow medics.

Street medics have a responsibility to take care of their mental health so they may continue to provide care to others.

There is no silver-bullet method for defeating PTSD before it sets in, but for most people ignoring trauma and pretending “everything is okay” is not optimal.

Rule of thumb on post-traumatic mental health

- If you feel eager to express yourself after a traumatic experience, find a safe and able person or group to whom you can talk, as soon as possible.
- If you are terrified to relive a traumatic experience or do not know what to do, don’t force yourself to talk.
- Do make a point to tell a trusted friend to help you seek a suitable course of care soon.



There is little evidence that early “debriefing” is the right solution for most people immediately after experiencing/witnessing a critical incident.



Do not burden anyone you’re not fully confident is happy to help you process traumatic incidents.



Do not be so afraid of creating a burden that you don’t speak up when in need.



Other street medics will at least help you get the resources you need.



Help other medics who reach out in need of resources.

Street Medic Gear

Basic first aid supplies

- water (and extra containers)
- roller gauze
- gauze pads (assorted)
- bandaids (assorted)
- Tagaderm strips
- SAM splint / wire splint
- wrapping supplies like Ace bandages
- burn treatment pads/gel
- instant ice packs

Basic street medic gear

- cell phone
- red duct tape
- nitrile exam gloves
- trauma sheers
- medical tape
- street medic designation insignia
- more gloves
- energy bars / gel

Advanced first aid supplies

- CPR face mask/shield
- airway adjuncts
- pen light
- tourniquet
- valved/occlusive dressing
- epipen
- skin adhesive
- LAW
 - small bottle for drops, swabs, mouthwash

Personal protective equipment (PPE)

- gas mask
 - must be military grade

- respirator
 - must filter particulate and organic irritants
- swim-goggles
 - good seal, silicone not foam
- bandana
 - soaking with apple cider vinegar filters tear gas
 - dust mask underneath recommended
- helmet
 - military or construction grade

Street medic attire

- Dress for patient trust.
- Dress for “authority drag”.



There is no uniform or hard/fast rule to attire other than exhibiting best practices in coverage, preferred fabric, and reliable footwear. But balance not looking like a cop with not looking like you don't bathe.



Military gas masks look pretty intimidating.