20-Hour Street Medic Course

Student Companion Book

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Table of Contents

Welcome

Lead Instructors

- Miriam Rocek
- Brian Dominick

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.

(1/2)

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!

(2/2)

(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

- **Compatability** 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 **v**erbal stimuli

P

responds to **p**ainful 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)*

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DEMO: Jaw-thrust maneuver

▶ assets/images/videos/jaw-thrust-technique.mp4 *(video)*

DEMO: Recovery position

▶ assets/images/videos/recovery-position.mp4 *(video)*

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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.

Intervention: Severe blood loss (shock)

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- Lay the patient down.
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    - Fluids are good.
    - Warmth is good.

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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.

Triage

Prioritization of care when patients outnumber available medics.

Purpose of triage

- Quickly perform initial assessment on *all* patients.
- Organize medic resources, prioritizing the most critical cases.

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

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.

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/deep objects 🏴

Impaled Object: Donut bandage

video::donut-bandage.mp4[]

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. 🏴
    - Patient needs to see a dentist ASAP. 🏴

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.

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 frost*nip*

- 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 frost*bite*

Following the signs/symptoms of frist*nip*…

- 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 factures (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

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

Figure 2. Multi-round 37mm grenade launcher

Figure 3. Grenade launcher in action (Ferguson, 2015)

Figure 4. Sniper rifle in Ferguson

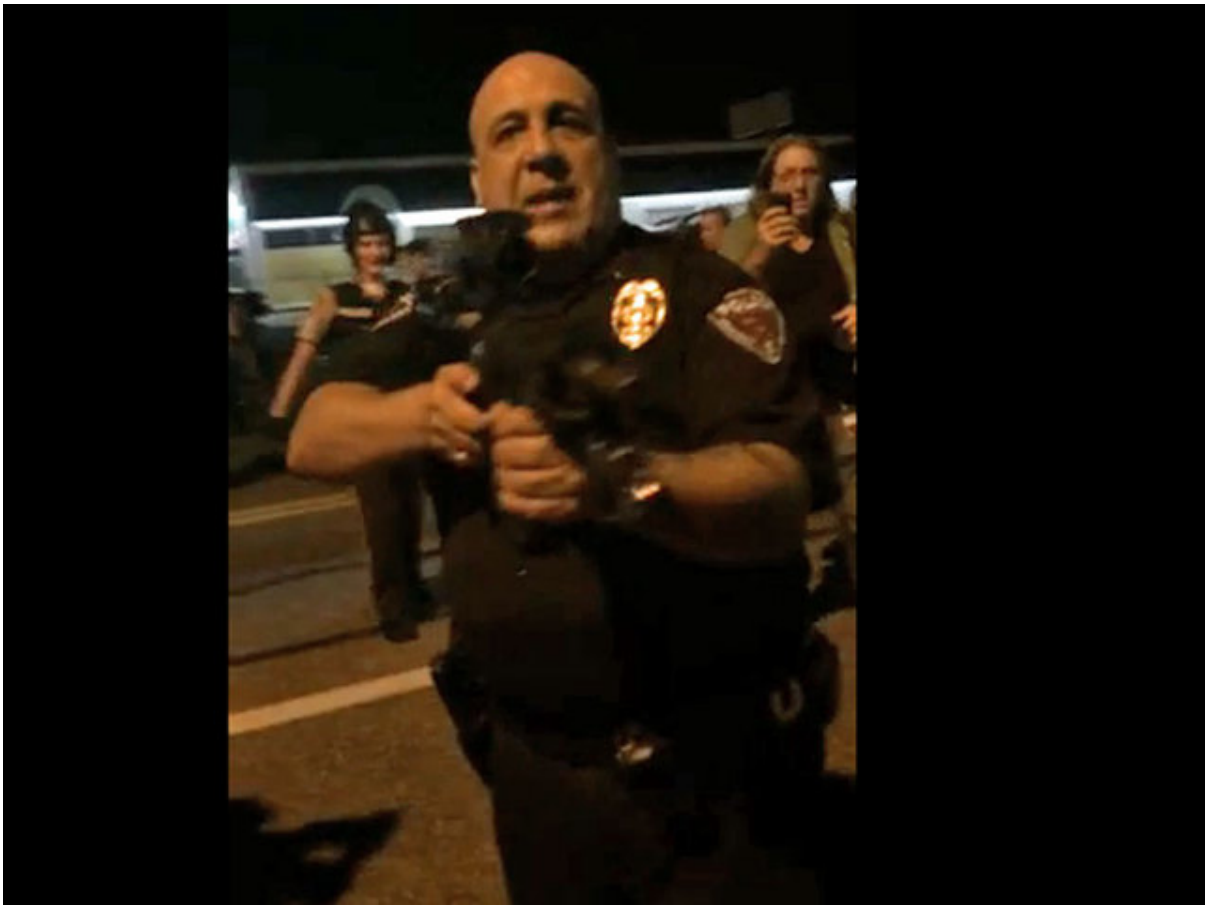

Figure 5. Officer “Gofuckyourself”, Ferguson

Figure 6. Less lethal 12-gauge shotgun

Figure 7. Plastic bullet wound

Figure 8. Militarized police horses

Figure 9. Protesters frighten police horses (Albequerque, 2017)

Figure 10. '3-percenter' militiamen protect Nazis/Confederates (Charlottesville, 2017)

Figure 11. Jewish Defense League thugs beat Palestinian (DC, 2017)

Chemical Weapons

Figure 12. Campus police officer pepper sprays students (UC-Davis, 2011)

Figure 13. 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 14. Turkish police spray woman with tear gas (Gezi Park, 2013)

Figure 15. 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 16. Protesters return tear gas (Quebec City, 2001)

Which effects of tear gas cause medics the most trouble?

1. blindness (**D**isability)
2. chaos (**E**nvironment)
3. canister injuries (blunt trauma, burns)

Street Medic Ops (Part 2)

Special Injuries

Diabetic Emergencies

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

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.

Fainting & Seizures

Street Medicking

Street Medic Gear