



ALTERNATIVES TO
E M E R G E N C Y
M E D I C A L
S E R V I C E S

the rosehip medic collective

Alternatives to EMS



May 2011
version 1.0

Table of Contents

Acknowledgments

Special thanks to the Institute for Anarchist Studies for their recognition, grant funding and continued support. We'd like to thank the Mutual Aid Street Medics for organizing the Street Medic Conference, which was an incredible opportunity for learning and networking. We'd also like to thank everyone who interviewed with and guided us, Whitebird/CAHOOTS for taking us on an amazing tour, and the many people who helped us edit this document.

Additionally, we'd like to thank the members of the Black Cross Health Collective who have acted as mentors to The Rosehips since our wide-eyed beginnings.

Introductions

About Us	2
Why "Alternatives to EMS"?	4
A Brief History of EMS	5

Tried and Existing Alternatives

EGYHOP	15
Street Medics	17
Common Ground Health Clinic	19
CAHOOTS	20
Individuals/Unaffiliated Networks	21
Hatzalah and Faith-based EMS	22

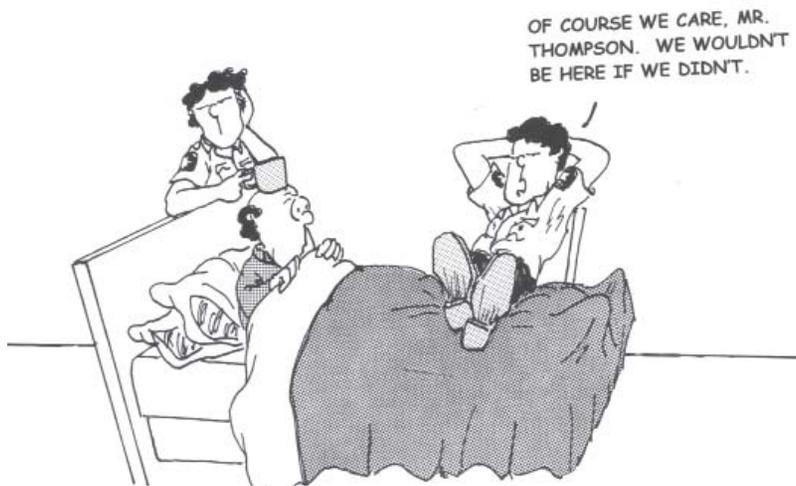
Our Thoughts

EMS Safety and Police	24
Horizontal Infrastructure/Tiered System	34
Patient Oriented Care	38

Conclusions

Visions for the Future	44
Further Reading	48

Introductions



- cartoons by Steve Berry EMT-P

About The Rosehips

The Rosehip Medic Collective is a group of volunteer Street Medics and health care activists in and around Portland, Oregon. We provide first aid and emergency care at protests, direct actions, and other sites of resistance and struggle. We also train other Street Medics and put on community wellness trainings. We believe in democratizing health care knowledge and skills, in reducing our community's dependence on corporate medicine, and that strong networks of support and care are essential to building a sustainable, long-term movement for collective liberation. We are working to create one facet of the healthy and diverse infrastructure we see as necessary if we are to build another world. Our group includes EMTs, Wilderness First Responders, herbalists, and more.

In summer of 2009, members of our collective attended a discussion facilitated by **Rose City Copwatch** (also of Portland) about their "Alternatives to Police" zine. While reading and discussing their project, we reflected on our work as Street Medics and care providers, and on how we interact with police and Emergency Medical Services (EMS) during emergencies. This led to discussions of alternatives to state and corporate EMS, critical analyses of our experiences, and attempts to understand our roles in community well-being. Inspired by the "Alternatives to Police" zine, we embarked on this project.

After beginning our research, we became aware of and applied for funding from the **Institute for Anarchist Studies**, hoping for help with this large undertaking. The \$500 grant we won has allowed us to travel for interviews around the Northwest and to Ohio, for the **Mutual Aid Street Medics**-sponsored Street Medic Conference (Summer 2010). The grant also allowed us to dream big in terms of printing and distribution.

About the Authors

While organized by Rosehip as a whole, this document is the work of four authors, and we feel it's important to locate ourselves in the landscape of privilege and oppression. Between the four of us, all are white, some of us are hella queer and trans, and all of us identify strongly with anti-authoritarian traditions. We come from varying academic and class backgrounds, and the ways we collected and organized information for this zine are heavily influenced by our training in history, anthropology, feminist studies, and medical care.

Much of our theory relies on the first-hand experiences of ourselves and our peers, including many interviews from within local and North American Street Medic social networks. Content from these interviews are presented throughout the zine and more background is given for these sources in the "Tried and Existing Alternatives" section.

Our research focuses on the EMS traditions with which we ourselves are most familiar: EMS as it has developed in the United States. What we are critiquing here is a system intricately tied to the state and industrialized medicine. There are many other kinds of care, and it is not within the scope of this project to explore them all. What we can do is offer our critique, ideas and hope, and make space for collective dreaming about what liberatory models do and what liberatory models can exist.

Why "Alternatives to EMS"?

As communities in Portland and elsewhere deal with the ongoing realities of police violence, discussions and projects have emerged to work towards accountable, non-oppressive, and community-driven alternatives to police forces. This work has connections with progressive, transformative and revolutionary social justice projects such as those for prison abolition and support for houseless communities. As we see it, this flurry of activity around policing is one of many interconnected struggles and aspirations. So while we dream of and start to build alternatives to institutions like the police, we cannot stop there.

As EMTs, first responders, street medics, and other care providers, we believe that efforts to create radical alternatives need to also include emergency medicine and wellness care. If we are serious about seeking ways to reform or abolish institutions for law enforcement and incarceration, we must also critically address the broader realm of state- and corporate administered health and safety. At the intersection of healthcare and emergency management, Emergency Medical Services (EMS) are frequently left treating those least served by other medical institutions—while further enforcing gender, race, class, political, and physical/mental ability categories on people experiencing emergencies and chronic illness.

This zine will examine the history of modern EMS, examine some of its strengths and weaknesses, and discuss actual and possible alternatives that might better meet communities' needs. Ultimately, we hope to broaden discussions of community alternatives to systems of domination to include health, wellness, and safety and to provide a starting place for developing real communities of care.

A Brief History of EMS

Emergency Medical Services are systems intended to provide prehospital care and transport for injured and ill patients. While many traditions of healing exist and deal with the incidence of traumatic injury and illness, we have focused here on those which produced EMS systems in the United States, most of Europe, and other areas affected by US and European imperialism. While the need for such systems today may seem obvious, less than 50 years ago prehospital medicine in the United States was almost exclusively the domain of soldiers and undertakers (and hearses the convenient predecessors to today's ambulances). Examining the rapid rise of contemporary EMS in the United States and much of the global North is useful in explaining both its functions and place within institutions of medicine and emergency response (police, fire, disaster management).

The role of battlefield medic is one of the earliest and longest documented roots of this kind of care, with several independent lineages from before the European middle ages up through today. In Europe, Napoleon Bonaparte's chief surgeon designed a "flying ambulance" (carriage) system of medics that would treat and then gather up injured soldiers. Similar principles were implemented for cholera epidemics in Great Britain and eventually spread throughout Europe and to the United States. Several late 19th century physicians, disturbed by the lack of care on increasingly bloody battlefields, advocated for protection of captured and wounded soldiers, non-combatants, and medical providers. These efforts led to the Geneva Convention and the International Red Cross and Red Crescent Society.

Radicals in pre-revolutionary Russia also recognized the need for support infrastructure, with vast numbers of political dissidents imprisoned by the tsarist government.

In the early 1900s the social-democrat influenced **Political Red Cross** and the **Anarchist Red Cross** (later “Anarchist Black Cross,” to avoid confusion) formed to provide food and medical care to political prisoners and revolutionaries.¹ After the Bolshevik Revolution, the Anarchist Black Cross spread across Europe and the United States, largely due to heavy repression and forced emigration of anarchists from the Soviet Union. Although ABC (and the prisoners they supported) eventually vanished from the USSR, chapters in Spain, Italy, the United States, and Germany continued supporting (and sometimes evacuating) radicals.

Through the course of the World Wars, increasingly brutal weapons demanded greater sophistication in equipment and training, including integration of automobiles, dispatch systems, and ride-along doctors. Having in the last decade of the 19th century revised their scientific approach and created a professional certification system, the allopathic or “Western” doctors of most hospitals and universities systematically invalidated other traditions of medicine, including ‘heroic’ (eg. leeching), homeopathy, eclecticism (western botanical medicine), and indigenous and folk traditions worldwide. Combined with its battlefield roots, this meant that the new civilian EMS model was firmly grounded in both military and allopathic approaches as it slowly began making appearances in larger cities. In 1950s Chicago, Drs. Farrington and Sam Banks formally introduced military medicine into civilian EMS training with a trauma (injury) program for the city’s fire department—a prototype for the first Emergency Medical Technicians (EMTs).

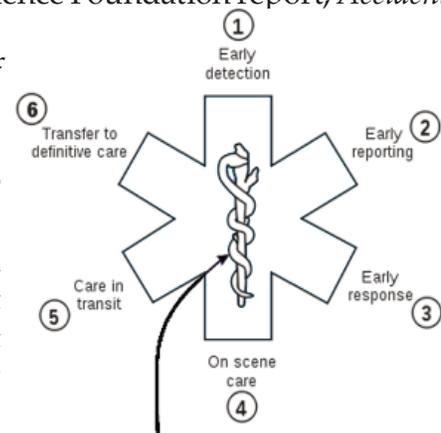
In the late 1950s and ‘60s early EMS systems grew more widespread but remained unstandardized, developing

1 “What is the Anarchist Black Cross?”; “Yelensky’s Fable: a History of the ABC”; www.abcf.net

along distinct paths according to circumstance and need. In some urban centers, a handful of fire departments and urgent care hospitals began trial “paramedic” programs, which went beyond basic care and transport to include administration of medications and specialized care for severe injury and illness.

Meanwhile, amid the Cold War’s entrenched conflicts in Korea and Vietnam, resources and training allocated to U.S. military medics continued to increase, with more advanced protocols and equipment coming into wider use, including tiered medical response, advanced techniques (eg. intravenous therapy and minor surgery), and helicopter ambulances. So successful were these improvements (and so poor their domestic analogs) that in 1966, the National Science Foundation report, *Accidental*

Death and Disability: the neglected disease of modern society, found that patient outcomes were generally better among brutally-injured soldiers abroad than among civilians caught in car crashes, heart attacks, and everyday injuries and illnesses—primarily due to lack of education, research,



The Rod of Asclepius - Ancient Greek symbol of healing

Star of Life - symbol of professionalized training, funding, and organization for emergency medical infrastructure.² The study offered 24 ambitious recommendations for EMS as it exists today, including: *prevention* (including education and safety standards), *tiered and integrated trauma systems*

2 *Accidental Death and Disability: The Neglected Disease of Modern Society*, Institute of Medicine, NSF (1966), p 12

(first aid, ambulance services, emergency departments, rehabilitation), *disaster response*, and ongoing *research* into injury mechanisms and care. A seven year flurry of federal laws and acts established nationwide EMS training standards with increased scope, automobile safety standards, and millions of dollars for training, facilities and research. However, left to state governments, implementation and development of EMS systems remained uneven and slow, in part due to a general lack of awareness and demand. Today, many EMS workers remember the '70s TV series *Emergency!* as key to the popularization of paramedic programs. While producers portrayed LA County firefighter/paramedics with '70s-era exoticism and melodrama, they also went to great lengths making the show authentic, sending actors through paramedic training and consulting frequently with a local fire chief. The show's influence was so great that some paramedic programs used the TV show for training purposes.

In most areas, however, EMS programs remained scarce and insufficient. Even in served areas help was often delayed or absent, depending on how quickly (if at all) responders were notified or available. In recognition of a need for greater community involvement, multiple states (starting with California in 1959) began passing *good samaritan laws*, intended to discourage spurious lawsuits and encourage voluntary service. Offering protections to lay responders, these laws continue today to recognize a significant "gray area" in which many alternative EMS structures operate—more or less independently from the medical establishment.

One outgrowth of volunteer medicine developed in response to new kinds of injuries occurring in remote and challenging environments of North America and Europe, where recently protected wilderness spaces drew thousands of outdoor enthusiasts. In the early

'60s, educational materials for outdoor activities began recommending advanced techniques and administration of controlled medications—outside the scope and training of most urban EMS. The concept of "second aid"—provided by ski patrols and recreationists with or without independent medical training—was intended as a sort of place-holder for both urban EMS and early advanced care at hospitals. Beyond the reach of conventional medical systems and standards, wilderness medicine has since become a medical field in its own right, expanding with outdoor leadership roles (guides, Search and Rescue, etc.) to gain semi-professional status. As it remains legally unregulated, wilderness medicine continues to offer a flexible set of protocols with comparatively short medical training for situations where other EMS systems are impractical or unavailable. This has made it a favored choice among many radicals, community medics, and disaster responders.

Also during the '60s, members of oppressed and social justice communities combined the military practice of partisan care with the flexibility of Good Samaritan laws to provide for their own popular struggles. Formed to challenge white-supremacist exclusion of African Americans from access to healthcare, medical education, and jobs in Mississippi, the Medical Committee for Civil Rights (MCCR) in its beginning lobbied and picketed against the American Medical Association and other segregated medical institutions. Yet starting in the March on Washington (1963) and Mississippi Freedom Summer (1964) members of the MCCR and the nation-wide Medical Committee for Human Rights (MCHR—composed of doctors, nurses, med students, and others) began filling more specialized roles, offering emergency and ongoing care to demonstrators, arrestees, and activists in what came to be called the Medical Presence Project (MPP). Many of these volunteers, though licensed in other

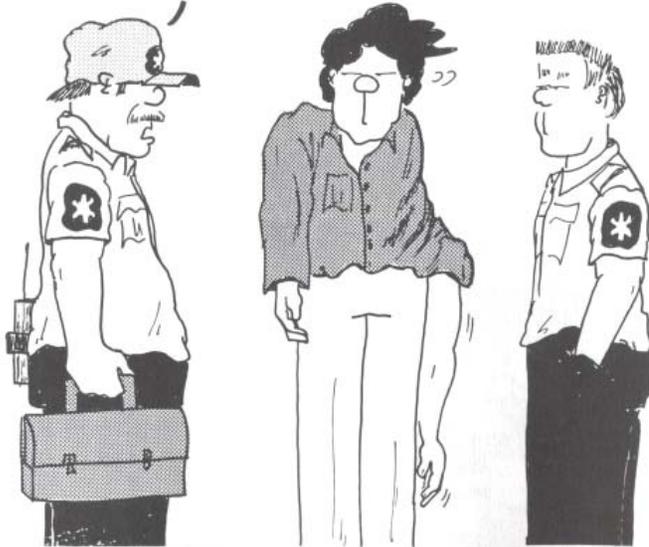
states, chose to provide care illegally or under auspices of Good Samaritan law—at times literally under fire from police, KKK members, and others. Along with the care MPP activists offered, Civil Rights organizers also found that it encouraged greater participation and feelings of safety in their struggles—that the mere “presence of... health... personnel has been found extraordinarily useful in allaying apprehensions about disease and injury in the Civil Rights workers”. After Mississippi Summer, MCHR’s work expanded to include public education, supply acquisition, community clinic development, documentation, advocacy, sanitation work, and more. MPP-style street/activist medicine also continued to play a part in further civil rights marches and demonstrations.

From equal rights agitation in the South, focus on alternative infrastructure spread to other human rights, student, self-defense, and liberatory movements, often engaging both licensed professionals and community-trained members of various movements. Throughout the ‘60s and ‘70s, medics played roles in demonstrations and power-building activities of the Black Panthers, American Indian Movement (AIM), Young Lords Party, Vietnam Veterans Against the War, and in student protests, to name a few. Many of these movements as well as early Street Medics considered self-defense critical and cross-trained in martial arts.

The roles of medics and clinicians in caring for and sustaining these movements has in turn proceeded to inspire the street or action medics of ‘80s, ‘90s, and 2000s. The role of Street Medics is explored below in the “Tried and Existing Alternatives” section.

Tried and Existing Alternatives

HEY! WE'RE THE PROFESSIONALS, HERE...
WE'LL DECIDE IF YOUR SHOULDER IS
DISLOCATED OR NOT!



(EGYHOP) Emma Goldman Youth and Homeless Outreach Program

“EGYHOP’s mission is dedicated to bringing direct service items and resources to the homeless and low-income populations living on the streets or who self-identify as part of the street population.”³

Every evening in Olympia, Washington, EGYHOP volunteers go out on bikes with trailers to do exactly this. An ad-hoc group of volunteers and coordinators ensure that medical and hygienic supplies are available for nightly runs. Beyond simply distributing resources, EGYHOP volunteers are intent on being “a friendly and familiar face to talk with” for people who are often treated in dehumanizing ways by police and service providers. Volunteers see EGYHOP as a form of mutual aid, rather than charity. This is reflected in EGYHOP’s non-uniformed and relatively informal approach, and in the way volunteers go to and cultivate relationships with people on the streets. EGYHOP volunteers consciously avoid judgmental or patronizing attitudes, and don’t have a religious agenda. They don’t see themselves as “experts” or as in a place to tell others how to live.

Though it is a relatively autonomous project, EGYHOP works with and relies on other Olympia-based groups. Local shelter Bread and Roses, for example, provides storage space for supplies. EGYHOP also refers people to crisis hotlines and other services, including the Olympia Free Herbal Clinic, which also supplies EGYHOP with herbs. When absolutely necessary (as in a medical emergency), EGYHOP volunteers will call EMS and offer to advocate for patients, if possible.



-image from an EGYHOP poster

3 <http://www.oly-wa.us/freestore/EGYHOP.php>

EGYHOP volunteers emphasize the benefits of the trust they have built with the community. Making runs regularly means some folks on the street will “have their back” when needed, and volunteers in turn may try to help negotiate situations with EMS and copwatch⁴ police stops. In addition to mutual safety, community ties improve services: folks acquainted with EGYHOP know when and where to find it. This trust is also important within EGYHOP teams. Volunteers going on runs need to know they can trust each other to communicate well and prioritize their own needs as they arise.

EGYHOP is in some ways similar to the homeless outreach that Canadian Street Nurses do as a part of the national health care system. For information on them, see the “Further Reading” section.

⁴ Non-interfering observation and documentation of police interactions. see.rosecitycopwatch.org

Street Medics

Street Medics – also known as “action” or “activist medics” – are first aid responders, healthcare workers, and other wellness enthusiasts who volunteer to provide care at political events like marches, demonstrations, sit-ins, and occupations. Medics usually work either on foot with kits or in temporary clinics.

Street medicking emerged in its current form during the U.S. movements of the 1960s and 70s (see History section above). Since then, medics have supported a wide array of political, social, and environmental movements around the world.

As volunteers, street medics are not formally integrated into EMS systems (though familiarity with their services is sometimes essential) which can be a valuable quality when urgent medical care is required at sites of political conflict. When police or military decide to use violent crowd control tactics, ambulances and other resources may not be allowed to enter what authorities declare an “unsecured scene.” (Remember, calling 9-1-1 activates medical services *and* police!) Even when available in the middle of a protest, treatment and/or transport by EMS professionals may give authorities greater ability to identify, detain or arrest protesters. In contrast, street medics usually share sympathies with participants and may work directly with organizers and other infrastructure. This often gives street medics greater access and motivation to help in situations where EMS workers are unavailable, uncomfortable, or unwanted.

Shared anti-oppression and other principles also may make street medics and clinicians the preferred choices for those who feel alienated or endangered by corporate/state-controlled medicine. Street Medics also generally share a strong emphasis on consent, mutual aid, patient-oriented care, confidentiality, and non-cooperation with

police.

In the U.S., street medics often identify themselves with red duct tape crosses on clothes and packs. Usually working in buddy pairs, medics sometimes coordinate as teams for larger events and clinic spaces. A generally-accepted minimum level of training to work as a street medic consists of 20 hours of basic first aid, particulars of medicking at political events, and how to deal with police weapons and tactics. However, many Street Medics also have other kinds of formalized training—as EMTs, nurses, Wilderness First Responders, herbalists, acupuncturist and others. Street medic groups, independent medics, and similar or allied providers exist all over North America and many parts of the globe—adapting their training and practices to local needs.⁵



-Star of Resistance

5 See: http://medic.wikia.com/wiki/Street_medic

Common Ground Health Clinic

“The Common Ground Health Clinic started on September 9, 2005 just days after hurricane Katrina devastated the Gulf Coast. Due to the humanitarian disaster and apparent lack of governmental response, two community activists, Sharon Johnson and Malik Rahim put out a call for healthcare workers to help meet the overwhelming need. The clinic started as a first aid station with the arrival of street medics, best known through the anti-globalization movement. The clinic was originally set up in a mosque, with space being generously donated by the Masjid Bilal. Nurses, physicians, herbalists, acupuncturists, EMTs, social workers, and community activists came from around the world to volunteer at Common Ground Health Clinic. To date, the clinic has recorded over 60,000 patient visits- all at no charge to the patient.”⁶

In addition to receiving patients at the clinic, the Common Ground healthcare workers acted as mobile first responders to emergencies in the weeks and months after the hurricane. As Noah and Grace share with us in their interviews, the community also possessed a large and informal preexisting network (unaffiliated with the clinic), which allowed individuals to rely on one another for early response to crises, as well as limited treatment and transportation in the event of non-life-threatening emergencies.

With an explicitly radical and anti-oppression



6 <http://www.commongroundclinic.org/>

approach, Common Ground Health Clinic is an important example of many individual providers coming together from separate communities to work with local activists on an organized level. They also provide important lessons about working alongside existing (though severely diminished) state and for-profit emergency services as both a viable alternative and a provider of complementary care (including prevention).

Crisis Assistance Helping Out On The Streets (CAHOOTS)

Founded by self-described hippies in the 70's, White Bird Clinic and CAHOOTS approach their work in Eugene, Oregon with a critical lens toward community care and police. They recognize that they have a unique position to take calls that would otherwise go to the police or EMS, and find that they have an opportunity to provide better care to people in crisis. CAHOOTS takes many of the police's "psych" calls, which are often public intoxication involving marginalized people, but can be any situation where a person is causing a "disturbance" and hasn't committed a crime.

CAHOOTS website⁷: "CAHOOTS is a mobile crisis intervention team integrated into the City of Eugene's Public Safety system. Free response is available for a broad range of non-criminal crises including intoxication, disorientation, substance abuse and mental illness problems, dispute resolution and street facilitation. The CAHOOTS van can be dispatched through the City's 911 department. Transport to treatment is also provided. The service is confidential and voluntary."

7 See: <http://whitebirdclinic.org/cahoots.html>

Individuals/Unaffiliated Networks

Grace: "One small and simple alternative [to EMS] from just a few weeks back was simple neighborliness in the bayou country of South Louisiana."

A: "It sucks to be woken up by these calls, and it's scary."

With or without certification, one of the more common current alternatives to EMS is the individual who, for any of a number of reasons, gets called when emergencies occur. These people often respond alone or as informal crews and provide whatever care and transportation they feel they can offer.

From earaches to stab wounds, we interviewed these first responders across the country with a wide range of training including Wilderness First Responders, EMTs, herbalists, nurses and those trained in post-disaster situations. Many of them expressed feelings that these networks could be formalized, but that their strength comes largely from calling on friends and community members as individuals and not as part of a larger organization. This sometimes means performing services without legal certification. However, offering care to patients who are legally or financially unable to access formal healthcare can be considered "harm reduction." Ultimately, community ties frequently allow enough trust between providers and patients to let them operate outside formal medical systems.

Hatzalah and Faith-based EMS

Between autonomous and state or corporate-run EMS, there exist a number of faith-based volunteer associations which provide emergency medical services to meet the needs of their communities.

Hatzolah EMS should be called for all medical emergencies. If you are unsure [...] whether a medical emergency is “big enough” [...] always call (even on Shabbos) and let the dispatcher know that you are unsure.

— Hatzolah of LA

Hatzalah (Hebrew for “rescue”) is an international Jewish EMS organization formed in the 1960s, when members of a large, religious and Yiddish-speaking community in Williamsburg, Brooklyn recognized a need for faster and more culturally sensitive response to medical and traumatic emergencies in their community. At the time Hatzalah volunteers came from the same linguistic, cultural, and religious communities as their patients, and therefore were able not only to care for their neighbors but also negotiate religious laws and customs that sometimes posed barriers to accessing appropriate care.

Hatzalah is the world’s largest volunteer ambulance service, with chapters in the United States, Mexico, Canada, England, Belgium, Russia, Israel, and occupied Palestine. Organizing at the neighborhood level has meant that chapters differ according to scale, resources, and need. In the US, most responders are trained to EMT-Basic standards or higher, carry extensive “jump kits” in personal vehicles, and respond to emergencies in pairs based on availability and proximity. Many chapters operate ambulances as a second-tier response and

routinely transfer patients as an independent auxiliary. With a large number of volunteers over geographically concentrated areas, some Hatzalah chapters boast uniquely rapid response times of as little as 1-1 1/2 minutes, averaging 2-4 minutes in New York City (according to a 1992 US News and World Report) as compared to the 9-11 dispatch median of 9 minutes.⁸

Anecdotally, in some areas Hatzalah responders are frequently called for non-medical emergencies as well—, including domestic and community conflicts, “keep[ing] conflict resolution and other issues within the community—and out of the legal system.”⁹. Although Hatzalah services are paid for and dispatched separately from 9-1-1 emergency response, they are free and available to everyone within their districts. Many chapters also provide community classes in first aid and safety, and have mutual aid relationships with regional EMS systems for larger emergencies.

The **Sovereign Order of Malta** and its British equivalent **Order of St John** are other examples of medical and service-oriented religious entities, which date from the Middle Ages and today offer popular education and humanitarian aid missions to Catholic and Protestant communities, in similar ways as the Red Cross, Red Crescent, and other national aid organizations.

8 Hatzalah: “2-tiered system”; hatzalah.org/twotiered.php

9 Anonymous interview

Our Thoughts

EMS Safety and Police

The quality of care afforded patients of EMS is directly impacted by the mental wellness of their healthcare workers, as well as by real and perceived safety risks in the field. There is a large body of research on the subject, and the takeaway message is grim: *all first responders have horror stories*, and an alarming percentage have major issues with trauma, addiction, and various psychosocial issues that fully impact their work. Often exposed to violent patients, bystanders, and other hazard; a paramedic's workplace is often dangerous and unpredictable. Violence from patients and bystanders is commonly reported, which helps condition EMS workers to rely on the police to create safer conditions for their work.

"Get up, get, get, get down, 911 is a joke in your town" (Public Enemy)

EMS v The Community:

Police, fire, and medical services work together to respond to emergencies. For many communities which are impacted by police violence, EMS workers are less accessible to patients because the threat of violence and arrest shows up right along with (if not before) the medical help. The emergencies that EMS responds to are often in the neighborhoods most impacted by racism, poverty, crime, police surveillance, and most under-served by public institutions. In our discussions on work safety with EMTs and paramedics from around the country, most reported experiencing threatening situations on a regular basis. Even EMS workers who are police abolitionists spoke to feeling a reliance on the police for safety. Community healthcare, self-defense and justice



are clearly and inextricably linked.

How do we as a community make sure that people who need life-saving care get the care they need in a way that respects their identity, safety and desire to avoid arrest, detention or deportation? How can we make sure *those providing that care* feel safe enough to do their job every day without burning out? It's a long term project, but it starts with trying to understand how we got here and where exactly "here" is.

J, an EMT from the Pacific Northwest talks about his relationship to the police:

"I'm not gonna go into a party where there was a fight, which happened, where there's like 60 people hanging out drinking booze and I know there's potential for violence there and who's got my back? Somebody needs to have it and that's why I like firefighters, that's why I like the police to show up."

J's fears are pretty reasonable; an article in the *Emergency Medicine Journal* found that "International studies have shown that some 60% of paramedics have experienced physical violence [from patients] in the workplace" (Boyle, June 2007).

Secondary Trauma

In addition to risk of violence from patients or bystanders, EMS workers are exposed to human pain and suffering daily. Many suffer from secondary trauma, including post-traumatic stress conditions and depression resulting from continued exposure to the cruelest and saddest sides of our world.

The high prevalence of secondary trauma and its related problems among healthcare workers points to a systematic lack of access to care and support for those doing healthcare work. How can our visions for a

liberatory approach to emergency medicine incorporate not just physical safety for providers, but also emotional well-being?

CAHOOTS, A Non-Oppositional Approach:

G and H, EMTs who work with CAHOOTS, explain that because CAHOOTS began with a partnership with the Eugene police department, the police view CAHOOTS as a resource.

"The police call us all the time for intoxicated subjects where there's no crime, ...[such as] someone who's intoxicated and stumbling down the street we can send them to a sobering station to sleep it off, no tickets, no fines they're just safe and can sleep it off and walk away."

Although CAHOOTS operates through police dispatch, and they rely on the police for backup involving threats of violence, "in the vast majority of cases," they said, "we're out there without the police. It makes an enormous difference as to how we're perceived in this community."

We asked CAHOOTS about conflict with the police. They told us they and the people they serve actually have more problems with firefighters and EMTs. This story illustrates how the problems are larger than the police. David explains that in Eugene a 911 call often brings firefighters who are also paramedics, and that CAHOOTS often has conflicts with those firefighters who are often not very compassionate or people-oriented. He gives this example of:

" [a call] that I was on a number of years ago: [there was] a man who was middle aged, had an IQ of about 70, had schizophrenia and a long term alcohol

problem, had been homeless for many years, and didn't get along well with the police. The man got into a mental health oriented residential program, not totally sober but doing very well. [...]

So one day on the weekend they hadn't seen him for a day or so. There was only one staff so she went and knocked on his door and he was there but he was behaving strangely. She was not somebody with graduate degrees but [she had] a lot of experience working with these communities. He had been drinking, but this wasn't behavior due to alcohol, not strange behavior due to schizophrenia – she didn't know what it was so she called 911.

The 911 system caught the flags from the old days when he was a multiple officer response, so they sent multiple officers who barged into his apartment, took control of his kitchen cutlery, got into an oppositional attitude, and brought in fire and EMS. The multiple paramedics on the scene looked at him and decided he was a “drunken Indian” and called CAHOOTS to take him to detox. The young woman who was the staff was not listened to, her impression that this was a change of behavior not explained by alcohol or schizophrenia is information neither police nor paramedics took seriously. She was just shoved off to the side.

When we pulled up I could see various health staff up there. I caught up with a paramedic and asked her what was going on. What was this changed behavior? I'm not even an EMT and I sat down to look at the guy; he was partially dressed and with the kind of difficulty he was having getting his clothes on, it rang a bell – I'd seen this before. Buttoning, zipping, etc. – you can do all that while listening to the radio, talking to your partner, drinking coffee. He could still do that, but he had to think about it. And sitting down talking to him, his pupils were uneven,

his grip was weak. Theoretically I should've called EMS and had them come back to do it but we just unloaded the trunk and sat him down with triage.”

It is little surprise that race and class are very good indicators for the quality of care a person is likely to get from First Responders. A serious injury or acute illness masked by drunkenness is potentially lethal for anyone, but the fact that the man was Native, had a criminal record, and a long history of homelessness and alcoholism directly impacted the quality of care he received.

“We operate in the gray” -G

Most healthcare workers receive some self-defense and crisis resolution training, but functional alternatives to EMS have to address the question of safety in crisis situations. Our discussion about danger and safety with CAHOOTS' EMTs reveals a different approach than traditional EMS. G said:

“The team has the decision, if anyone threatens us we consider that a danger, but that's kind of gray. We operate in the gray. Everybody has their limits that they're comfortable with... If someone shows me a weapon and says, 'I'm going to stab you with this knife,' I'm gonna leave. But if someone's just loosely threatening it and their body language isn't showing that they mean it, and they nonchalantly say, 'get out of here or I'm going to stab you,' I'm like, well, do you really mean that... If there's immediate danger that we can't get away or if the person is in danger themselves, like laying in the road and then threatening us with a weapon so we can't get to them then we would request the police department to come help us with this situation, get the weapon away from the person.”

CAHOOTS has a strong preference for hiring EMTs and crisis counselors with strong de-escalation abilities, from word choice to vocal inflection and body language. The result of this practice is a team of responders who are more confident in their ability to operate without the police, and are good at keeping each other safe. CAHOOTS also cross-trains their EMTs and crisis workers, so that EMTs who originally had little interest in being crisis workers end up seeing how those skills are vital for good medical work.

CAHOOTS demonstrates that it is possible to respond to mental health and medical crisis in a way that is more sensitive to people's needs than traditional EMS and police. They show that there is no substitute for good training and a true desire to meet people where they are at. They recognize that their success is influenced by the kind of community they serve; they described Eugene's population as significantly less intense than that in Portland or other larger cities, so much so that CAHOOTS' model of working with police might not work as well in communities with more users of multiple drugs and violent crime.

J: "Something I don't think radical people think about a lot is that there are violent, mean, scary people out there... and there's a way to protect people responding to that scene so that you don't get jumped by the drug addicts in the corner for your [ambulance's] drug box, or you're not responding to a [domestic] violence call and the boyfriend comes walking in with a baseball bat, so that there are people [the police] there to respond to that."

We want a world without police, but if we're going to ask the people doing emergency medical service work to do their jobs without the police, we are going to need to participate in creative solutions and be there to back them up.

Horizontal Infrastructure/Tiered System

J: "So, about this title, 'Alternatives to EMS,' there won't ever be an alternative to EMS because when you're sick and you're actively dying, that's what you need. You need an ambulance and fire truck whether or not [...] culturally, you are in line with those folk."

Regardless of how organized our networks become, J is correct: we cannot replace the current structure of EMS without the kind of funding that comes from the state. Our reliance on cars, laws designed to protect profit instead of human lives, and mass-production of toxic goods present us with dangers that necessitate heavy rescue equipment and hazmat teams. Without fundamental changes to our society, any alternatives to EMS will be incomplete, unable to adequately respond to all the dangers of our world. But as a part of a larger movement, with a functional "vertical infrastructure" of radical alternatives, we can (and do) provide alternatives to certain parts of the tiered system and can increase our ability to provide more urgent forms of care as we gain skill and structure.

Horizontal infrastructure: Working along side other medical providers to widen the range of existing services and create services where they don't currently exist. Horizontal infrastructure bridges gaps between existing medical services and those that don't yet exist. Focuses on the ignored spaces instead of contesting ground.

Vertical infrastructure: Working with other groups to connect different services. Links ideas like alternatives to the police, reformative/transformativ justice, and environmental activism with healthcare.

The idea that there is already a range of services available, for example, someone with good access to healthcare might follow a path like this:

0. Get primary and preventative care.
 1. Buy an over-the-counter product.
 2. Call and ask a nurse/doctor questions through their providers office or HMO.
 3. Make an appointment with a doctor within a few days.
 4. Go to urgent care that same day.
 5. Go to the Emergency Department of their preferred hospital in a car or taxi.
 6. Call 911 and go to their insurance's preferred hospital in an ambulance.
 7. Call 911 and go to the nearest hospital with the service they need in an ambulance.

Each of these steps represents an increased level of urgency in their condition. Deciding which of these steps is needed can be a highly subjective process, and training can help make the "best" call by recognizing red flags. Often those without concern for legal, social and/or financial repercussions receive the care they need with the least amount of delay.

For someone without affordable or accessible healthcare this process becomes increasingly expensive. However, many people without health insurance lack the ability to call a nurse/doctor advice line, make an appointment with a doctor, or access an urgent care clinic, which forces them to skip directly to the Emergency Department. Additionally, those lacking primary and preventative care are more likely to experience urgent and emergent situations that could have been avoided with earlier access to treatment.

The best alternative to EMS wouldn't be just be "our own" ambulance service, it would be care that prevents a life-threatening emergency. This would be care that prevents an infection, monitors high blood pressure and diabetes, and provides education so that emerging conditions are recognized while they can be handled in

a way that is empowering, instead of the often-traumatic experience of receiving emergency care. This would also include responding to people where they are, and have a transportation option when further care was needed.

Noah from Common Grounds Health Clinic: “We pop up everywhere and sometimes we are able to make things easier for some people, and as institutions like the Common Grounds Health Clinic gained more ground and capacity... people came and talked to us and we continued to try and radicalize people about how they view the medical system... how it should be working instead of how it does work.”

Noah discussed community alternatives in the form of helping people make decisions about when to enter the medical system, preventing chronic conditions from becoming emergencies (especially after Katrina when people were off their medications), and helping make connections between medical providers and people who can not or will not formally enter the medical system. None of this replaced ambulances, but bought time when ambulances weren’t available and at times prevented the need for them. They provided services using a model similar to an urgent care clinic with a mobile component, dispatching medics on bicycles and on foot to neighborhoods and community gatherings in the weeks following the floods and breakdown of state services.

Grace: “On the other hand, I personally remember the first auto accident I witnessed after Hurricane Katrina in New Orleans. Common Ground Health Clinic received the call as the 911 system was not operating, and several of us responded on bicycles. There was MOI for c-spine injury¹⁰ and, while we had a backboard, we did not have a transport vehicle. We acted as on-site first responders while frantically

working our contacts, trying to reach the personal cell phones of on-duty paramedics or dispatchers. When a rescue squad finally responded, we got each responder’s cell phone number as well as multiple contacts within dispatch. When you really need EMS, you really need EMS!”



“When you really need EMS, you really need EMS!”
- Grace

¹⁰ Possible injury to spine; can result in paralysis or death.

Patient Oriented Care

For us, “patient-oriented care” means attempting to address the real issues that affect our patients and community members, in ways that are humanizing and thus effective. We believe in “radical” care in the sense of getting to the root of things, and treating the symptoms as well as the cause of the problem: an asthma inhaler, for example, does nothing to reduce the neighborhood air pollution that triggers attacks in the first place. Causes for medical issues are many, and are often interrelated in complex ways. The inequitable biases of society, healthcare institutions, and individual care workers always somehow come to bear on a patient in ways specific to their own particular, intersecting social statuses (physical/mental health and ability, class, race, gender, etc). We therefore cannot effectively give care without insights into both the personal and social issues at hand.

Practicing patient-oriented care can be quite difficult. As the stories of J, CAHOOTS, and others in this zine illustrate, caregivers are often forced to make tradeoffs and compromises. This means that well-intentioned care workers may treat people in ways that are less than ideal but seem to be the best possible for the situation. The reasons for these compromises are also complex and not easily resolved. As discussed in the EMS Safety and Police section, such complexities can result from the very real concern that the care worker needs to ensure their own safety while providing patient care, which often means involving police and others who may not help or may actively exacerbate the situation. Another reason is the perceived split between medical and emotional care. EMS (and first responders especially) are often more focused on fixing the immediate symptoms of trauma and illness than on mental health and how it relates to other bodily issues. Finally, good patient-oriented care takes time and

sustained relationships, which care workers in general and EMS in particular are not designed to do, especially given the market-style setup of healthcare.

Here are a few ways that people we talked to address some of these tensions in their work:

Encouraging self-care: As a paramedic, J is more interested in solving the problems presented by symptoms (stopping dying) and logistics (transport) than with EMTs/caregivers being friendly and supportive. But he also doesn't want people to go to the Emergency Room if that is not what they really need, and finds that there is too much emphasis on immediate transport. He argues that EMS needs more discretion legally and in their protocol to not transport, and should instead give people the tools and knowledge to fix and monitor the small stuff. J says: “It's a sticky situation because you're going to get into an idea where a provider has security to deny service to somebody and that's going to fall back to racism, sexism, homophobia and all that stupid shit, but it would be nice to see that kind of responsibility given to folks, that way it would lessen the strain on the system.”

Knowing the backstory: CAHOOTS does “mobile crisis intervention,” and has medical and psycho-social care delineated. They are proud that many of their staff are cross-trained in both. They have roots in “rock medicine,” and grew out of the community following bands like the Grateful Dead, so they are familiar with the interrelated medical and psychedelia-related aspects of that environment. In their regular care work, knowing patient history is critical. See the story about when EMS workers mis-identified what was going on with their patient (“drunken indian” p.28) and called in CAHOOTS. They emphasize how they spend lots of time (~ 1 hour) per call to really be present with people and provide the best care possible.

Establishing trust: EGYHOP relies heavily on trust between buddies (teams on the nightly run) and with the community they work with. This is built over time, personally, with people deciding they can rely on each other. For CAHOOTS, there is a high degree of confidentiality built into their processes, “Having a counselor come to your door is better than a police officer,” — or fire/EMS — “they’re not very people oriented, not very compassionate.”

Conclusions



-art by Josh MacPhee/justseeds.org

Visions for the Future

“Disaster threatens not only bodies, buildings, and property but also the status quo. Disaster recovery is not just a rescue of the needy but also a scramble for power and legitimacy, one that the status quo usually-but not always-wins.” (Rebecca Solnit, *Uses of a Disaster*)

Education as a part of prevention: Some of the most exciting work of creating communities of care today involves support for people experiencing chronic conditions, and for good reason. The long-term healing process requires a massive amount of practical and emotional support. But while we resist the glorification of crisis response and heroics in the face of danger, let’s challenge ourselves to be better prepared for acute conditions, to intervene in escalating crises, and to be ready with infrastructure capable of supplementing or replacing current emergency systems.

In moments of crisis, natural disasters, and medical emergencies, conditions change dramatically and the immediate response can have lasting effects on the recovery process. After Katrina the failure of the government on many levels to respond to the needs of the most vulnerable in the community caused immeasurable suffering, but also created space for collaboration and alternative options, such as the Common Grounds Health Clinic, which sprang up in response to those unmet needs.

We all deserve the best care, and if we are to provide emergency services to each other it has to be done within our scope. But each effort to provide a more intensive level of care expands our abilities. Knowledge sharing, training, and accountability have to be central to every attempt to create new services or replace existing ones.

Care for the healers in your community: There are radical doctors, nurses, paramedics, and other types of emergency medical providers working in and around the radical community. Some of them are activists doing other types of organizing work, some of them focus their work on medical activism, some of them are incredibly burnt out. When we’re left alone together or space is made for us to be honest about our work, the stories start to flow and the damage that our work does to us becomes apparent. Working for pay or volunteering inside our broken medical system is often the only way to increase the skill level of an individual, and thus the community, but that work can take an immense physical and physiological toll. The statistics for drug use, back injury, and mental health crisis are depressing. The danger of physical assault from patients is real. High stress and dangerous situations are a bonding experience for those involved, and can make it hard for those involved in medicine to get help from friends outside of medicine. If the only support after these experiences comes from supervisors and co-workers inside a broken and oppressive system, it becomes easier to identify within this system than outside it. If we don’t have a process for supporting the emergency health care workers in our community we will lose many of them.

Retain healers in the community: There is a massive push right now to enter more young people into nursing and medical school, and many people from the resistance movement are signing up. It’s critical that we as a community seize this opportunity to maintain ties with these individuals and support them as they go through a difficult educational experience. We cannot provide certain types of care without the knowledge and resources that these future nurses, doctors, paramedics and physician’s assistants will have. Working with a broader community base that includes people who are already practitioners is important as their experiences and

collected knowledge are invaluable, but watching radicals become isolated in their studies without the support of the community they're studying to serve is discouraging and leads to burn out. We need to make an investment, a radical scholarship of sorts, to ensure that those drawn towards healing professions have the support they need if we expect them to leave those programs ready for the hard work of creating, expanding and maintaining community alternatives for the long haul.

Baby steps and adding medical services to already existing crisis response infrastructure: Without massive funding and an influx of dedicated, highly trained service providers committed to full time work we are a long way from providing urgent care transport to definitive care, much less the emergency medical procedures currently provided by the state and for profit ambulance services. But there are crisis lines, walk-in clinics and informal networks that can be drawn on when dealing with minor emergencies and interpersonal conflict. There are communities of friends and collectives that have already developed the trust needed to rely on each other in times of urgent need. Finding already existing organizations and services ready to add a medical component to their care will allow greater focus on care and provide greater access to a broader number of people.

Finally, here is a short and sweet list of some concrete ideas we have for the future:

Advice lines/Dial a Medic: A number to call to discuss and plan support for non-life-threatening medical conditions. These already exist but could be focused on specific communities or set up as an additional resource attached to a crisis line or community clinic.

Medical Advocates: Available by dispatch. Trained to give emotional support at urgent care or Emergency

Departments, document the actions of pre-hospital and hospital providers, coordinate the first stages of homecare after discharge, and provide transport. This is especially important for communities at risk of medical discrimination or legally vulnerable.

Non-ambulance home care and transport: Dispatched with medical kits, food, and a functional vehicle. Able to provide first aid and transportation to definitive care for non-life-threatening medical conditions, transportation back from definitive treatment, and limited home care. Or show up, help assess that transport isn't needed, make a pot of tea, assist in coordinating the care needed, make some soup, and check in the next day to see if the patient needs further care.

We All Get Sick and Hurt

This zine is an attempt to raise awareness around the many ways that communities can grow towards better self-sufficiency and self-care, but there are countless more we haven't explored here. The most powerful resource we have is our capacity to build trust and resilience together, to take risks and tap into creative solutions to the crises that surround us.

What alternatives to the EMS system can you envision? This project is an ongoing dialogue, and you can share your stories and ideas, find out about street medic trainings, or help build radical networks of care with us at:

rosehipmedics@gmail.com

www.rosehipmedics.org

"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has." – Margaret Mead.

Further Reading

Alternatives to Police. Rose City Copwatch. 2008. Portland, OR:
<http://rosecitycopwatch.wordpress.com/alternatives-to-police/>

Where there is no doctor: a village health care handbook. David Werner, Carol Thuman, and Jane Maxwell. 1992. Palo Alto, CA: Hesperian Foundation.

The Spirit Catches You and You Fall Down. Anne Fadiman. 1997. New York: Farrar, Straus, and Giroux.

Sick: A Compilation Zine on Physical Illness. Ben Holtzman. 2009. Microcosm.

Bevel-Up: A Documentary Film about Drugs, Users, and Outreach Nursing. 2008.

Emptying Beds. Lorna A. Rhodes. 1995. Berkeley, CA: University of California Press.

A Paradise Built in Hell. Rebecca Solnit. 2009.

Info on Street Nurses

Kathy Hardill. "From the Grey Nuns to the Streets: A Critical History of Outreach Nursing in Canada." *Public Health Nursing* Vol. 24 No. 1, pp. 91–97, 2006.

Bevel Up: Drugs, Users and Outreach Nursing. DVD. British Columbia Centre for Disease Control and the National Film Board of Canada, 2007.

"Street nurses help the homeless survive." *Victoria Times Colonist.* March 30, 2008. <http://www.canada.com/victoriatimescolonist/news/story.html?id=0ee5e3ca-a628-41c5-8144-2a24465ac7d0>

