

# Alternatives to EMS Anthology



Compiled and edited by  
Rosehip Medic Collective

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## About the Rosehips

The Rosehip Medic Collective is a group of volunteer Street Medics and health care activists active in 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.

To request our group's support at an action or event, for general information and questions, or to ask about our trainings, please email us at [rosehipmedics@gmail.com](mailto:rosehipmedics@gmail.com).

## Statement of Values

- We support all people's rights to understand, access, & direct their own health and wellness.
- We envision a world free of all oppression and seek solidarity with those struggling towards personal and collective liberation.
- We believe that the personal is political and that self-care & mutual aid are necessary to sustain resistance.
- We embrace a philosophy of harm-reduction and non-judgmental care.

## About this Project

Nearly four years ago, the Rosehip Medic Collective explored institutional Emergency Medical Services and existing alternatives in our original Alternatives to EMS zine. This project presented case studies, history and theoretical discussion of EMS and those working to build alternative models for emergency care. In creating that zine, we sought input from street medics, disaster responders, outreach workers and others—but mostly we critiqued different methods of providing emergency care and dreamed about what could come next. This project inspired us with the knowledge that alternative crisis response systems exist and function, and provide care that is patient oriented and community specific. And it sparked dreams of what else might be possible, and what sustainable community networks of care might have in common.

Since releasing that zine, we have been approached over and over by individuals who have told us their stories – stories of working within the system, of building alternatives, of filling unmet needs, of creating community resources, of burnout, of reflection, and of moments that helped them keep going. From the beginning, we knew we would need a sequel to our first zine – not another systems-level analysis, but a collection of these individual stories.

As so many of us run into similar barriers while providing and receiving care, we hope that by printing these stories we can share our lessons learned, celebrate our successes, and reduce the isolation institutional medicine produces. Our call for submissions for this anthology asked for stories of individual and group successes or learning moments in working towards community-directed care.

In line with Rosehip's core values, we defined this as being care that:

- Believes consent and best practice are equally important
- Respects the parameters of care set by the communities with whom we work
- Supports all people's rights to understand, access and direct their own health and wellness
- Embraces harm reduction and non-judgmental care
- Prioritizes self-care of providers

We asked also for stories of individuals and groups that have organized to confront, challenge, dismantle, or subvert harmful and oppressive healthcare systems – stories of broken rules, collaboration, re-appropriation of resources, insubordination, and lessons learned the hard way.

We received submissions from professional and volunteer disaster responders, street medics, nurses, EMT/Paramedics, outreach workers, village healthcare workers, herbalists, doctors, and people of other backgrounds and healing traditions. Some participants submitted written work, while others chose to be interviewed.

In this zine, we share the words of these individuals who have inspired us through their stories, their work and their vision. The anthology is divided into two sections – the first explores healthcare workers creating change and finding paths to patient directed care within the healthcare system, while the second celebrates moments of challenging oppressive systems, subverting ineffective care, and building alternative networks of mutual aid and support.

We hope these stories will serve as a reminder of the strength, resiliency, and resourcefulness within us all; whether we are, at any given moment, caregivers or patients, workers within or subjects of a broken system, these writings prove to us that, collectively, we have agency, knowledge, and power. Here's to sparking more visions, dreams and possibilities.

Take care, give care,

The Rosehip Medics





# Section One: Working Within the System

Working within the healthcare system can be a frustrating, alienating and isolating experience. As street medics focused on patient-oriented care, we see so much that is broken about our healthcare system, and sometimes feel we can't do much to confront the problems. But every once in a while, as we strive to do our work in the best and most patient directed ways possible, we find unexpected sources of hope.

This section presents stories about working more or less effectively within the system – moments of revelation, of learning, and of witnessing systems that function in sometimes surprisingly positive ways. We look to these stories for ways of building space for our beliefs inside unfriendly systems, and ways of learning from each other how to provide care in complex environments. These authors remind us of the moments of possibility, when we are able to find the compassion and empathy that we so often see lacking.

These stories tell us about the moments of success that sometimes feel few and far between. The authors demonstrate how they find the strength to keep working, to break down social isolation, to recognize chronic emergencies, and to treat their patients like family. We share these experiences here as a source of strength to anyone working within a problematic system.

# Finding Compassion in the Dark

by laurel peña

Compassion is as necessary for this job as a strong back. Both get destroyed by repetitive motions.

We call it the “Mike phenomenon” in my paramedic class, after a student who admitted to truly not caring about most of the patients who call when he is trying to sleep. He works 24 hour shifts in a city where heroin and meth have destroyed many of the community’s resources. Burnout is expected and turnover is high. I work in a quiet rural system with a supportive crew. But don’t I also have a moment just after opening my eyes when I can’t find compassion in the dark? We get up, we put our boots on, and we try not to let our patients know. We could have named it after any one of us – he just admitted it first.

EMS serves as the safety net. We pick up the people who have fallen out of the system. We also deal with the consequences of broken communities. When a community can’t deal with the illness of a member, we are called. Sometimes the threshold is high, for instance an elder being cared for at home who suddenly gets sick and needs more care than family can provide. Other times a person’s simple existence seems to be more than a community can deal with. The threshold is lower for the disenfranchised. And sometimes the community itself is so disempowered that it does not have the resources to deal with members in crisis, medical or otherwise.

Out of bed at 3 am, responding to an address my crew knows well. The man is having nightmares and is all out of his psych drugs. All I can do is drive him 2 hours to a hospital that will do absolutely nothing for him. It’s not even the sleep deprivation that gets to me - it’s the futility. The patient called because he was having an emergency, whatever that means to him. My job is to respond. I just wish I could get back into quarters feeling like I had actually done some good.

Someone has to pick up the pieces. It’s what we sign up for when we become EMTs. The problem is that we are so bad at it. It

is not our fault. We are not given the right tools and information. We are not empowered to make the right decisions. We are trained for the high-threshold calls - the ones where someone is in crisis and their usually sufficient resources are overwhelmed - the car wrecks and heart attacks. This is usually what gets people into the work, and the realization that it is a small percentage of what we do is often what gets people out of it.

“What percentage of the people who call you really need you?” my paramedic instructor asked one day. “I mean, sure, they all need you, but what percentage need the skills you are here to learn?” Ten percent was the number we agreed on.

Most of our calls involve the other two situations: the person the community is unwilling to care for, or the community unable to care for its members. In both cases the power dynamic is unbalanced. EMS forms its own little community and places itself outside and above the communities it serves. If the community is disempowered, or the individual patient disenfranchised from the community, the power dynamic is exaggerated.

The medic leaned over the drunk man on the gurney. “You can’t sleep,” he said. “If I can’t sleep, you can’t sleep.” He rubbed the man’s sternum with his knuckles, a technique to elicit pain used on unresponsive patients. The man groaned and opened his eyes, then closed them again. “Hey,” the medic said, and rubbed him again. When the patient tried to twist away, the medic grabbed a large nasal airway. “If you go to sleep, I’m going to put this up your nose.” One of my classmates was riding along and told this to me later as a funny story.

It’s these calls that we suck at. Often involving chronic health issues, behavioral problems, and/or lack of access to health care, we just don’t like them. It’s especially hard to care for these patients when there is no time to take care of ourselves.

The worst sound I’ve heard is the wail of parents who have been told their child is dead. The worst feeling came right after the code was called and there was nothing more to do. Clean up, get out of the way, go to the next patient. Nausea and vomiting. Probably food poisoning. Listen to the story, start the IV, push the Zofran.

Pretend to care.

How can we change the situation? The change needs to happen on a large scale – in our workplaces, and in the communities we serve. Healing people means healing the world; for instance, making sure everyone has access to good food and emotional well being. It's not our job to make this happen, but placing my work in the larger context helps me keep going and not settle for picking up the pieces. It reminds me how my activism for forests and salmon relates to what I am doing right now, how the joy of planting a garden is linked to the sorrow and frustration of this chronic illness I am seeing.

Work wherever you can to change the system (perhaps by agitating for community paramedicine programs – but that's a whole other article). Even more importantly, keep in mind the power structures present in every patient contact, and do your best to overcome them by treating everyone with compassion and respect. We also need to take care of our own minds and bodies and hearts in order to have the energy for compassion.

When I went out dancing after two days of ICU shifts, I felt burdens I hadn't even been aware of fall away. I danced down the sorrow and frustration and the exhaustion, stomping it down into the floor of the bar. Then I let myself take joy in having a healthy body that could dance, feet that could walk out of the hospital at the end of the day, a heart that could speed up and slow down without concern. I hadn't realized how cramped and slow I had been feeling, as if taking on the posture of my patients could somehow relieve their pain. I will have to learn how to cultivate joy in an intentional way so I can do this work for the long haul.

## Stethoscope

by Christina Moore

*Christina Moore lives on the side of a hill in the Green Mountains of southern Vermont. She spends her days writing software, writing technical documents, walking the land and when necessary, responding to other people's emergencies. You can follow Christina at [stormpetrellc.blogspot.com](http://stormpetrellc.blogspot.com)*

The stethoscope connects the ears of one to the sounds of another's heart and lungs. What the ears hear begins a journey – only related to the translation of pressure waves to nerve impulses traveling through axons, cresting action potentials and the release of neurotransmitters. The journey begins at this phrase: “The heart beats.” The listener transforms to student, the student to journeyer.

In March of 2008, our EMS service fluttered into its first recognizable beat, a “lub-dub” generated on its own in a room of fourteen souls. Each affixed a signature below archaic language: “Be it resolved \_\_\_\_\_ authorizes itself to incorporate, conduct business meetings.” Our purpose was to improve the speed and access to emergency medical services in our town of 40 square miles. At town meeting, we stated we would reduce EMS response time and improve the level of care. In the years prior, EMS response times typically measured 30-45 minutes. The implicit contract bound the squad to the community in an equation that involved funding and improved medical care.

In those early days, I misunderstood the impact of the stethoscope on the listener. I invested time in the minutia of regulations, licensing, equipment, and raising funds, missing signs of vitality.

Few raised in our town pursue college educations. Our town has 70 miles of dirt roads and ten of paved in the rural hills of Vermont. We have no retail businesses. The few local jobs involve house cleaning, construction, and logging. There are almost 900 properties in town yet we have under 400 residents. The neighboring town,

also of 40 square miles, has four retail businesses. In the next years, we expect to lose our post office. We struggle to fund our school and its 55 students. The nearest hospitals are located in river valleys 45 minutes away. One to the west is on the New York border, one to the east on the New Hampshire border and one to the south in Massachusetts. Traveling east and west requires crossing hills and driving through narrow hollows. Two years ago, we lost one of the two dairies. The remaining dairy will not survive this decade. The family who own it will remain on the land as they have for three hundred years, yet they will not likely continue to farm.

That family's nearest neighbor called 911 twice during November with weakness and stomach pain. At the conclusion of the first November visit to the ER, he still required nursing assistance to walk. The ER nurse supported him while placing him in a waiting ambulance for the trip home. The next day, our local bus driver found him unable to stand. The bus driver stoked the fire, added wood, and called 911. Like the ER, I was about to again misdiagnose malnutrition, instead wrapping the symptoms in lengthy Latinate words. This week, we sent him back to the ER with a significant gash on his pate, a wound caused by firewood, the only heat source for his 150-year-old home, falling from where he stacked it in his dooryard. Over the years, he and his neighbors sealed all but four rooms with plastic sheeting in an effort to hold in the warmth. The electrical wiring has had few modifications since the Second World War. Daily, our crew sees images that resemble the sepia toned photographs of Appalachia in the early 20<sup>th</sup> century. The challenges of heating homes, filling bellies, and educating our youth are not so different as they were 100 or 50 years ago. **I have yet to find “malnutrition” and “cold” on the nationally standardized templates for EMS diagnostic codes.**

Our food pantries are full. Buses painted with the white-and-black of Holstein dairy cows transport seniors to one hot meal daily. State law redistributes educational funding to a precise average for each pupil. Problems persist.

My ungloved handshake tells me more about a patient than

a narrative. Elderly Yankees raised in these hills rarely offer complaint unless one discusses roads, taxes, politics, and modernity. Of the six fingers lost from various hands in the last five years, none were re-attached. Not a Yankee amongst that lot called 911 for assistance.

Those few that do call for help delay dialing 911. They greet our squad with apologies. We hear phrases like: “I know you are so busy, but I didn’t know what else to do, the pain just won’t go away,” or “My doctor told me to call 911, I tried to argue but they said they would call if I didn’t.” My hand feels their thick callouses. My fingertips bounce on strong pulses, crooked fingers squeeze gently around my hand. Uniformly, hands are cold. Loose skin tells me of chronic dehydration. We listen to the story of the recent hours while we examine the house for medications, instructions, and discharge notes from hospitals.

To the body, we attach EKG electrodes. We measure the rhythms of breathing, and electrical heart activity. We put the stethoscope to our ears and then listen precisely to the corners of the chest.

Our emergency medical service has an EKG. Every member carries a stethoscope and the tools for rapid emergency assessments of sick and injured neighbors. In those first years, I begged for money. To raise money for the EKG, I carried it to the houses of cardiac patients. One man gave me 100 one-dollar coins. They sit now in my personal safe, money long replaced by my crisp bank check.

A student must learn to rapidly and accurately read the rhythm on an EKG. The student must know how the medications in a home hint at the medical history of those living there. The student must learn to see the gaps. The absence of medication in our hills may indicate that there is no family doctor. The student must learn to recall medication changes over the years. The patient with new onset seizures who is not taking any medications may be leaving us clues of liver failure, kidney failure, or financial problems.

Our founding document with its antiquated language obscured the names of fourteen students. I read the names of fourteen volunteers--fourteen people willing to rise from a warm bed to help

others. I failed to see how we would band together in a fraternity of scholarship. The synaptic bonds between members connecting us to each other, education, and new opportunities. On that founding declaration sits one name with a small heart atop the letter ‘i’ in Jessica, and her mother’s signature just above.

Jessica, home schooled by her mother, learned to write at the age of fourteen. She started reading at eleven. At eighteen, she had never been in a classroom except lessons offered at church on Sundays. She had never taken a test, received a grade, or faced a teacher sitting in a field of desks. This shunning of modern education spans generations. Together, mother and daughter took the first-level EMS course. Jessica, seized by the classroom and the education, learned that any paying job in EMS required a high-school diploma. At twenty-one, she deftly brought home a diploma from the regional high school 20 miles away. She then enrolled in a Massachusetts community college for an associate’s degree and paramedic certificate, a step that made her the first in her family to ever have attended college. Jessica’s mother follows her, earning her nursing degrees one step at a time.

The experience of achievement permeates the squad. One member, a heavy equipment operator, now works full-time at a professional EMS agency an hour west. One young woman earned her bachelors in nursing. Another member who already had a nursing degree and EMT earned a master’s degree in anesthesia. At present, our tiny service has three paramedics.

Of those founding members, only six are still active. Of those six founders, four are now paramedics, one of whom left the area for employment. During the years, members flow in and out as dictated by personal health, economic factors, and family pressures. Our membership level remains consistently at a dozen. Membership in our squad and funding for education has resulted in new careers for 50% of the members. New income, new education, new influences reflect back into our town.

Each person who volunteers with us finds his or her life changed. We, in turn, influence the community. The journey begins with the commitment to make a small change in another’s life.



For us, that commitment is to measure vital signs, understand medical histories, and treat what we can while waiting for an ambulance to come from two towns away. We treat trauma, cardiac crisis, circulatory crisis, respiratory crisis, neurological crisis, and illness. Yet it is through education and opportunity that our volunteers most give back to our neighbors.

Jessica and all of the others can describe the neurological pathways of hearing and the anatomy of the ear. Each of them can draw a heart; illustrate the flow of blood, the major cardiac vessels, the electrical pathways. Most members, paramedic or not, can perform a quick interpretation of an EKG strip. When we listen to the four corners of a chest with our stethoscopes, we have a robust understanding of the people we serve. Through the veneer of poverty, isolation, and cultural pride we hear the lub-dub of a beating heart that we endeavor to protect.

# Passing, Privilege, & Mutual Aid

by Greg

*Greg is a street medic, herbalist, W-EMT, and street medic trainer based on the east coast. He remains active as a street medic because he believes in supporting people in their struggles to establish their own community agency.*

I am a street medic, herbalist, and new EMT living in rural PA. I moved here in the beginning of September to work on several anti-fracking projects. I would like to share my experience as a new member of the local fire department in a small town. In addition to what I am learning, what I feel I can contribute, I want to expand upon how this exchange is useful to our movements.

“You’re not from around here...” Jeff stated more than asked, “...are you?”

I was on my first call; riding along for a heart attack. The best I could do was stay out of the way. Two fire companies had responded, as well as our ambulance, paramedics in their truck, even life flight got called in. I could barely follow what was going on.

“What gave me away?”

Jeff gave me a head to toe, “Well...just look at you.”

And here I had done my best to fit in.

The collective house I’m living in is a bunch hippies and punks from around the region who are either from here, or moved here to do organizing work in the shale fields. Some of us are from cities. It’s a small enough town that even the locals amongst us stick out somewhat.

I don’t know what Jeff’s impression of me is. We are fairly closeted about what we are doing here. The town doesn’t really understand and, as you can imagine, there are rumors.

One day, our friend’s cousin, the town gossip, came by: “I’ll tell everyone you aren’t a crack house and are even on the fire department....”

I grew up and was born in a small town. Coming from that background, I like the pace of living here. Still, without the riveting night life provided for me down at the fire hall I don't think I would be as happy here. There really aren't many other places to go.

Monday: Once a month; old men mumble the well worn verse of Robert's Rules. I can't understand what the president is saying more than half the time.

Thursdays: In-house trainings; the juniors try to show off how much they know.

"I'll kick all your asses once I've been in the Marines four years!" says one scrawny 19 year old. The conversation digresses to a slew of slurs that I am embarrassed to say I didn't stand up to.

This week we deployed the porta-pond, I'm repeatedly frustrated that we don't ever practice medical skills.

There have only been three other active EMTs in the company since I've been here. The others have been out of commission with injuries. We get a little over a call a day and I'm still not cleared to run on my own yet.

Sam was the head of EMS when I got here and hasn't said a word of encouragement to me yet. We have ridden calls where the only words she's spoken have been direct answers to my questions. She's really warm to kids, but I don't know what it's like to be her. Nor do I know how to work with her...

The other woman Jess is new to town too, also unemployed. She's been the main person to teach me much of anything. I've been really impressed by her bedside manner; she shoots the shit with everyone including the cops...

Driving down the street, a cop went by. I think it was Harry. My boss, chief of the EMS is a cop. Am I supposed to wave? Am I expected to wave at the other cops? At the Fire department Christmas party they wanted to thank all the police on the department. So they gave them donut seeds (Cheerios). Weird... I don't think I get to make cop jokes yet.

For me it's all been a lesson in passing. I have a lot of privilege and am used to being read as white, male, and straight. But I'm queer, Jewish, and an Anarchist. More importantly in this case

I'm an outsider. Sometimes it feels like I have a slightly secret Identity. Running from a house meeting to a call on the ambulance; my double life. I want to fit in, to gain the respectability, local knowledge, and cultural currency that has already proven useful for our campaigns. I want the damn credit on my taxes... even if it means hanging out with the "Good Ol' Boys."

Most importantly though, I'm volunteering for the experience. The concrete medical skills so that I can contribute to the community and ultimately help people. Also I am learning the nuances of local culture, how folks relate, what they struggle with.

"If it wasn't for the gas points," the Chief said, "I probably wouldn't be able to keep driving my truck." A good portion of the company, many of who have lived here and been part of the community their whole lives are either unemployed or work at the factory. Multiple people work third shift.

As Earth Firsters and Radicals in general we are often faced with the dilemma of when no-compromise politics meets more diverse, non-Anarchist communities. How and what do we let slide without totally selling out? Being vegan while people talk about hunting? A feminist where men and women are demeaning women? Queer in a place where that might be just a swear word?

All of this exists in a context where I want the people I am working with to respect me and teach me the lifesaving skills they volunteer to help their community.

Learning where change is possible, where to push and where not to...

Justifying these compromises; promising myself that once I earn respect I will challenge people in ways that are effective. Is that what it feels like to work within the system?

On the scene of an accident the patient's blood pressure jumps 10 points as the State Trooper comes in to get a statement.

Even while learning to do the medical skills better and faster, I can return to what we value as Street Medics: compassionate care, communicating with our patients, explaining what we are doing as we do it...

Riding with a patient from a different accident to the hos-

pital; the woman is distraught about her dog. As far as folks who stayed on the scene could tell, her dog was never in the car with her. As Harry and the assisting paramedic go through the motions, I wonder how many drunk drivers I can calm and comfort before I start caring less.

Obviously there is a long way to go in dismantling Patriarchy, Capitalism, and Racism within EMS--as well as in separating the emergency medical systems from criminal punishment systems. But from my perspective, it is clear that the community is better served by first responders who provide care, while demonstrating awareness of and actively divesting from systems of oppression.

As Anarchists we talk about Mutual Aid as a principle and core value: We help other communities because we believe in a natural reciprocity, where all of our struggles are intertwined...

To my knowledge, the only place within dominant culture that the concept even exists is in every local firehouse. As an almost daily occurrence, neighboring towns help each other out.

I still haven't broached the topic of fracking or activism at the Firehall. But as I continue to live here I look forward to exploring the parallels and (subversive) intersections between EMS and the radical environmental movement. Politics aside, emergency responders are a group with the potential to be greatly affected by increased infrastructure and extraction.

## Medicking Isolation

by Taiga

*Taiga is a member of the Rosehip Medics who volunteers as an EMT in rural New England.*

When my pager screeched on the icy winter's afternoon, I recognized the address. It was a nondescript call: 70 year old male feeling ill; no specifics. I first heard about this address over a year ago, when I joined the rural volunteer ambulance in this tiny northern New England town. The old man who lived there was known as a "frequent flyer," one who regularly called 911 for minor to non-existent ailments. Of all the regular patients in this economically depressed, elderly community, Rick had a reputation for calling us out of loneliness or boredom. I'd been warned that I'd end up at his place sooner or later.

Our ambulance service is a one-truck operation covering two rural towns in one of New England's poorest counties. It is unstaffed and volunteer-run, with crew members carrying pagers and responding to calls whenever they are able. In the time I lived there, the crew had nine members who responded regularly – a handful of others responding every once in a while and showing up to our firehouse meetings to grumble and debate the service's operations. We are far enough from definitive care, along bad enough dirt roads, that staff at the nearest hospital call our town, "where cardiac patients go to die."

This is a part of New England where self-sufficiency is prized, where many families have lived for generations, and where people only call 911 for critical emergencies. As I was warned when I joined the crew, we don't get small calls. So Rick was the exception: the old man who regularly calls us for what seems like nothing. As I pulled on boots, jumped in the car and edged down the icy road, I hoped we weren't all heading out in this weather to a false alarm.

Katherine, an experienced crew member, radioed the fire

station that we were responding, and I headed straight to the scene while she picked up the ambulance. Mary, another new EMT on the crew, met me on scene, outside a dilapidated farmhouse. Paint peeled from the clapboards, and the torn screen door was patched with plastic and plywood. Inside, a small, gray-haired man sat in a worn brown armchair. The living room was faded and mostly empty, with dirty patches of carpet scattered across a sagging floor, but Rick grinned at us from his enveloping seat as we introduced ourselves.

“Hi Rick, I’m Mary, remember me from last time? Now what’s going on today?” Mary asked, as I set jump kit and oxygen tank on the floor.

“Well, I got up to go in the other room, and I didn’t feel good, and I sat back down here...” was the vague reply.

“You didn’t feel good? Can you tell me more about that?” Mary questioned.

“I just didn’t feel good. I don’t know. I can’t describe it.”

“And it happened when you stood up?”

“Well yeah, I got up to go in there, but I felt sick, so I sat back down.”

“Are you having any trouble breathing? Did you feel short of breath at all?”

“No, none of that...”

“Did you feel dizzy? Or nauseous?”

“No, no, nothing like that.”

“Did you lose your balance? Or have any chest pain?”

“No...”

“But you didn’t feel good.”

“Yeah, I felt funny.”

Mary sighed at the ambiguous answer.

“Okay, is it alright with you if I take your vitals?” I asked, lifting my blood pressure cuff and pulse oximeter.

“Sure...” He extended his arm willingly, from many instances of practice. When his vitals were normal and a patient history yielded no clues, Mary and I looked at each other in confusion. We asked more questions, but Rick appeared alert and oriented, showed

good perfusion, and denied recent trauma and any alarming symptoms.

“So you felt funny, but not dizzy? Can you describe for us how you felt?” Mary persisted, trying for more clarity.

“Well...” Rick said, a sly smile spreading across his face, “well maybe I didn’t feel sick. Maybe...maybe I just wanted to see some pretty girls.” His face broke into a grin, and he looked at us as though letting us in on a great inside joke. As this admission sank in, I thought of Katherine, guiding the large, unwieldy ambulance over five miles of twisty, icy roads to reach us. Mary and I exchanged a quick glance.

“You didn’t feel sick? Are you sure?”

“No...” Just lonely was the unstated answer.

I stepped outside, relaying the nature of the call to Katherine over the ambulance radio, hoping she would take it easy on the winter roads. She pulled up a few minutes later, in time to re-check Rick’s vitals, question him a while, and conclude that he was not in need of emergency medical care. After a few minutes of small talk, the house emptied as we said goodbyes and encouraged Rick to call us if he started to feel ill.

At the ambulance crew meeting the next week, we relayed the story to the rest of the crew, all of us sharing a moment of frustration – aimed at the nature of the call, Rick’s comments, and, on a deeper, unspoken level, our inability to improve his situation.

“It’s frustrating, but we always respond—right?” the chief broke in. “Even when it’s the third time this week to his house for nothing, we always respond. Because the next time he could be having a heart attack.” I looked around the table as everyone nodded – of course, it wasn’t even a question.

Yes, the next time it could be a medical emergency, and that’s part of the reason the crew continues to respond – I still get alerts for that address every few weeks, even though I’ve moved away – but it’s not the only reason. In a town with no place to spend money but the post office, there is no central meeting place – no café, no general store, not even a library. With a predominantly elderly population, many with limited mobility, it becomes even more dif-



difficult for people to interact. While it isn't always spoken aloud in the tough, bravado-filled culture of EMS response, there is a very real acknowledgement among the crew that daily isolation can be as much of a health risk as acute emergencies. This only grows truer as the population ages.

When the chief is home and a call comes in for Rick's house, she puts the rest of the crew on standby and drives in her own car the short distance to his house to check on him. If an initial assessment reveals only no medical emergency, she cancels the ambulance and sits with him a while, catching him up on town gossip and breaking through the isolation a little. Afterwards, she makes her way home, maybe only to respond again to his house later the same day. Though that kind of treatment doesn't get documented in reports, it plays as much of a role in this town's system of care, sense of cohesion, and community resilience as any medical care could. In this type of rural EMS infrastructure, I see possibilities for community-directed models of care that do not separate medical and mental health, that value diverse types of care, and that approach community resilience as both holistic and collaborative.

## Treat 'em Like Family

an edited interview with Charles

**TAIGA:** *You said in your email that this Anthology corresponds with some work you're doing. But what are you doing?*

CHARLES: I'm attending Paramedic school. And for almost 9 years I've been on the local fire department as an on-call and then part-time volunteer. I guess part of going to paramedic school has forced me to reevaluate all the steps, all the medical and legal issues, the way we're supposed to present ourselves and talk and the kind of information we need to give them. And it's also forced me to reflect on the behavior of my coworkers while we're on the truck.

Five years ago I worked as non-emergency transport. Grandma fell down at the nursing home, and 9-1-1 ambulance brought her into the hospital, but then they would call us to bring her back home. Or Uncle Phil got a dialysis appointment, but he's got no legs--his diabetes has taken his legs in addition to his kidney. So we pick him up, take him to his appointment, and after his appointment, they call us and we take him home.

Between these two settings, 9-1-1 and a non-emergency company, I interact with a lot of different patients in a lot of different ways. I work in a small town where people never see beyond the horizon. People don't really understand radical politics, and radical thinking, and I find myself on more than one occasion wanting to, you know, you just take this herb or that herb, soap... 'That cut's pretty bad, but you don't need stitches; you soak it in a strong tea of oregon grape leaves and calendula flower. It'll close up, it won't hurt, it won't scar, it'll heal up real good.' But I can't say that, I have to go through all the motions.

But every once in a while my professionalism flips. One case that I'll probably never forget was a 14 year old girl who had been fighting with her mother. And over the course of a 45 minute trip where I picked her up at one hospital and took her to the children's hospital in Cleveland, I gave her information that no one's

ever given her. ‘Why am I going to a children’s hospital?’ No one ever bothered to explained that to her. ‘What is this diagnosis that’s laid on me?’ No one’s ever bothered to explain that to her. ‘Is magic real? Can I trust my intuition? Is there a bigger world out there that I can’t see? I feel these things going on inside my mind and I’m really angry about them, but I don’t necessarily feel that they’re really me.’

And I would find myself saying, ‘I really shouldn’t be talking to you about this cause I could get in a lot of trouble. I’m not supposed to talk about magic. We’re not supposed to talk about feelings.’

‘No no--no one’s ever told me this stuff. I always thought it was a put-down that they sent me to a children’s hospital. No one ever told me I’m not done growing yet. Explained to me what it means to be a child biologically.’

I can still see her face when I picked her up; walked into the isolation room there in the hospital, there in the psych room where there’s no cabinets, there’s no chairs; there’s just a bed. She was sitting there, curled up in a ball with her dyed red and black hair hanging in her eyes, and she looked at me like ‘oh god--it’s another one.’ And by the time I dropped her off 45 minutes later, she was beaming; she was radiant. Because here’s this random-ass guy who got it. I didn’t treat her like a child; I treated her like family. I talked to her in the way that I wanted someone to talk to me when I was 14 and I didn’t have a clue what was going on in the world around me, and why these things were happening and why people were reacting to me the way they were reacting to me, and why my parents acted the way they were acting. I wanted someone to sit down with me, and say, ‘it’s okay. It’s really confusing right now, but it will get better.’

Bringing street medics and radical thought to patient advocacy and actually explaining [care] to patients, has had on more than one occasion a really positive impact working with drug addicts and the chronically poor, the geriatric patients and the psych patients. I always end up with the psych patients, the crazy people and the old people. They’re always like, ‘oh give those to Charles; he seems to handle them better.’ Or homeless people- ‘he seems to handle them

better'--cause I treat them like human beings and they don't know how to do that anymore. They're all burned out on it. I treat them all like they're my family.

You know, I picked this one guy up at the rest stop one time. He was a traveler he had left one gathering and he was on his way up to California. He wasn't homeless, he was just without a home. You understand that there's a difference. They couldn't grasp the notion of someone not having a home. They didn't know what that means. As soon as I saw the guy I was like 'this guy's not homeless; he just doesn't live here. He doesn't have a house; he's a traveler, yeah I've got that.' They were like, 'we don't know what to do with him.' The security guard up at the hospital gave him a jacket and I gave him 20 bucks. We found him a place to stay at a halfway house shelter for the night. And the next day I happened to be in town, and saw him out on the highway and he was catching out. There was nothing wrong with him. He was just moving through the world in his own way and somebody got worried. Wanted to make this big thing out of it. This semi-policing is the way EMS in general is set up right now.

***TAIGA: I'm interested in a couple things you said. Just now you used the term 'policing' of people's lives and identities through EMS. That's a great use of that word. I wonder if you could talk more about that word, how you see that working...***

CHARLES: Well, on the one hand the way the city is set up right now, and the way EMS in general is set up. The police come when things are really ugly and really angry. They break things, they break people, they break doors, whatever. And then they call us to come and pick up the pieces. Especially when they're confused. They always say 'you need to either come with us or go with the squad.' On only one occasion has anyone ever said they'll go with the police. Every other time they go with us. It's because the cops don't want to deal with them. My department, the full time staff in my department are union. The police are also union. These guys are all friends. So often as not, the firemen act a lot like the police.

They understand what they understand: heterosexual, normalized, mainstream, thought process. This is what's right. Anything that doesn't fit inside of that, they don't get. You're weird, you're a freak, whatever. We don't have a lot of transgender people living here or really a lot of GLBT people in general. We have a couple of gay guys and a couple of lesbians in town, but not many. We're a very small town. We had a woman who was working on the squad who was openly lesbian; she didn't last very long. I actually ran into her today and she's getting along extremely well but it's really sad. She basically got kicked out of the department.

What it is, is they want things to be simple. And if it's not simple it's too complicated. And that makes them upset. We have a lot of military veterans in the department. They don't like having their buttons pushed, and if someone gets in their face, they respond the way the police do. I don't know. I don't know if I'm answering your question. A lot of it upsets me. The way I see these guys treat people.

***TAIGA: I'm curious if you have things that you would say to other people working on ambulances in relatively small towns or working within EMS and feeling frustrated.***

CHARLES: Yeah I have a big one. Something that has haunted me nine years. Every person I pick up is a member of my family--every single person I pick up. I don't care if they're a junkie. I don't care if the others are saying, it's her again...we're so sick of picking her up. This is the 15<sup>th</sup> time. They're my family. I love them in a way that isn't possible for a lot of these guys because they can't get past the judgmental stage.

We picked up this guy the other night with an overdose. He was an IV drug user and he got a hold of some morphine pills and overdosed on them. The performance of the paramedics on duty was lackluster at best. Their attitude was as apathetic as I have ever seen. And he died because it wasn't a top quality performance on their part. They weren't fighting for this guy in a significant way.

I've seen a lot of people die. I never ever imagined that my life would be filled with death in that way that it has become, and every single one of them sticks with me. I remember asking the question seven or eight years ago: what do you do with the stress and the grief and the sadness of watching somebody die? Where do you put it? And I'm asking this question of nurses and doctors and paramedics, some of them have been doing it longer than I've been alive. And I haven't found any here (and very few anywhere else) who have told me any different than their standard answer which is: oh, it doesn't involve me; I don't feel anything; I don't have any emotion when it comes to this stuff. It's just part of the job; just part of what I do. And for a long time I lived with that. I went with that. And it didn't work so well. It haunted me.

I evaluated a lot of really negative, personally destructive behaviors on my part. And I was talking to a [street medic friend] about it, 'cause I had a series of really bad calls. I asked, 'How do you deal with it? These guys say it doesn't affect them.' And she said, "the minute it doesn't affect you, you need to get out of this business; the minute that they're no longer human and you think that they've become meat bags, you're doing it for the wrong reasons."

And that made it better. I started to realize that most of the guys who said, 'oh this doesn't bother me', had fasting blood sugars of 400-500; they weighed 350 lbs; they drank too much; they were on their fourth marriage; they smoked too much. They had all the classic symptoms of repressed grief. They just didn't admit it or accept it. They mistakenly assumed that the natural coping mechanism of grief is compartmentalizing.

I get it, because I can do that with the best of them. Rolling up on six dead bodies in a van on the highway and then stopping to get a cup of coffee on the way home afterward. That's all fine and good. But it was only when I looked back with clear eyes: it wasn't eight hours later, me and two guys that were on the truck that night were at each other's throats screaming at each other. Because we had witnessed a horrendous thing. Six people were dead.

Things were said. "They were immigrants from another country, they were computer programmers, they weren't from here,

they were passing through town, it was a freak accident, now they're all dead, let's just go on with our day." And I was like, wait a minute, it is okay, and it has to be okay to stop and recognize that we witness horrible things. We are the keepers of our town's secrets. We need to recognize that we are the ones who know these deep dark secrets, honor those secrets I guess, and honor the passing.

There was a little old lady. We barely got to the door, got her on the cot, got her down to the truck, and then she died. Then she stopped breathing. And I can't tell you how many times they die once we get them on the cot, or once we get them in an ambulance.

Talking with [the same friend] about this, because she's one of the few people I can connect with in this way, I realized that our job is sometimes not to save life. Because like [another friend] told me once when I ran up on a guy full of bullet holes: "sometimes when they fall, if they were to fall backwards on the best surgical sheet surrounded by the best surgeons in the world, they're still gonna die." So we can't save them all, we can't even save most of them. The ones who are gonna die are gonna die. Our job is bearing witness. And we have to be okay with that. We have to accept the fact that we're not gonna save them all but at the same time give it everything we've got every single time. We can't be thinking, 'oh yeah, he's just an IV drug user - who cares?' or 'we have to try harder for this one 'cause they're a kid.' Everyone is somebody's child. Everyone is family and we have to treat them like family.

And sometimes I do this. Sometimes I remember this and I act accordingly. Other days I can't. On my best days I do, but it's constant work.

Every life is sacred. I don't care if they're an IV drug user, or a 98 year old grandmother, or a four-year old child, or the 54 year old nurse. Every single one of them is a unique opportunity, a unique expression of life. We have to recognize that specialness, honor that uniqueness. You have to be okay with that. Give it everything you've got, but accept that sometimes there's just not enough to give. Because sometimes they're going to die.

One woman, her heart had completely died I guess; I don't know what happened, but she stopped breathing on her cot. Her

heart stopped beating. We had just been talking to her and she died right in front of us. And we were doing such successful compressions and airway ventilation that she was having purposeful motion 45 minutes after her heart stopped. She's looking around while the machine was analyzing her heart, she flatlined. She could see the letters painted on that freight train that was coming for her. And when I finally called it, I knelt down next to her bed not to pray for her, but just to tell her: "you know, I'm sorry, we tried the best we could. We tried." And I'm talking to them when I'm doing CPR or when I'm bagging somebody who's in arrest. I talk to 'em like they're fully conscious, I always talk to my patients. I talk to dead bodies, and I talk to people that are unconscious. I treat them all like they can hear every word I say.

Just treat everybody like that; don't ignore them. Don't talk about the fucking football game over a patient. You get in the back of a squad with a patient, and the person in the front is asking if you heard who got elected to city council last night? It doesn't matter. This person doesn't want to hear this conversation. They didn't call the ambulance or 9-1-1 because they were interested in this conversation. Remember why we're here. The person on the cot is why we're here. Talking about the facts of the call. People want us to be nice to them. They don't want us to be judgmental of them. And when they die we've got to carry that on too. We've got to honor their life, even if it was a really screwed up life with a really bad socioeconomic situation and some really poor decision making that led them down the path they went down. I remember we all get one chance in this body. Sometimes you might get an extension.

I tell people in street medic trainings, in the section on interacting with 9-1-1, 'you've got to remember that when the squad shows up they're tired. They're really tired.' They're tired of the chair in the truck. They're tired of that asshole in the other seat. They're tired of their boss. They didn't sleep well.

'Cause I don't sleep much when I'm working. I've never had a decent night's sleep at the fire station. I'm tired of the pain in my back. I'm tired of your mouth. I'm tired of all of it. As street medics, you can't interact with that fatigue or you lose. We teach that patient



advocacy is everything and we have to remember that. We have to be a better patient advocate. I need that to inform what I do on the truck, it's what it's all about. It's not about the bottom line or the billing. It's not about getting to the next call and it's not about good trauma. It's just about our patients. And remembering that it's about our patients. Whether that's at a protest or at a bottom line bar or a 4<sup>th</sup> of July festival or a nursing home, they all deserve our full attention.

Anybody that makes a transition from Street Medic to emergency or public safety should know that it's a hard crossover. I'm the strangest person most of these people have ever met. Which is weird because I'm not the strangest person I've ever met. If they were to go to a protest, a big summit and work at one of the clinics and had to work with some of the community, they'd run out of there screaming. They don't know how to even begin to interact with those people. It took me a little while at the G20 as a street medic to get back into remembering to be particular about pronouns and not making assumptions about anything. It's a different world.

***TAIGA: Do you have anything else you'd like to talk about or suggest that we think about?***

CHARLES: Don't let the bastards grind you down. I know that's a really overused phrase. I know what I know, I think what I think, I feel what I feel. Being surrounded by people who don't, it's just so hard sometimes to remember who I am when I'm submerged in that climate.

Don't be afraid to stand up to the Assistant Warden at the prison. Tell him he's not in charge. Tell him, "I'm not a prisoner and I'm not your employee, you can't talk to me like that." Don't be afraid to tell the family "I'm sorry but you can't let Grandpa go on like this. He's gonna fall and you're not going to be there, and you're going to have a dead grandpa." I don't care how mad they get. It's the patient I'm most concerned with. It's not the bystander or the family's feelings when they don't want to hear what I have to say.



## Section Two: Working Outside the System

In the first section of this zine we presented stories of care workers attempting to act in accordance with their radical roots and in line with their commitment to care for and validate each patient. Through resiliency, creativity, and communication, they manage to build networks of support or temporary spaces for alternative approaches to care.

The authors of the following stories express similar motivations, and employ different means and roles; in particular the roles of patient and medic are not always so distinct. Patients provide support to other patients, and medical providers in need turn to one other for help in dealing with the stress and grief of witnessing illness and death. When emergencies become commonplace, apathy, isolation, and chronic illness all in turn become emergencies.

We are all responsible for bearing witness. Some of us reabsorb the trauma and ignore its effects on the body and mind—including burnout, chronic illness, PTSD, and anxiety. There are also models for processing trauma as a form of resistance. Connecting with others and letting people know they are seen and that they matter is strong medicine in and of itself. Can we validate each other's present truth while holding onto our boundaries and letting go of other people's baggage? Holding space cannot overshadow the place of urgent medical needs and care, yet it can and should exist alongside it in larger ways than it typically does.

The stories that follow are about aiding others simply because care is warranted. These approaches, anchored in respect for individual autonomy and mutuality, are revolutionary in that they affirm self worth and restore hope. Through what Aurora Levins Morales calls 'brief ties of mutual care' we can build longer bridges and create supports flexible enough to hold us together. Our stories of reaching out to give and receive help offers us glimpses of successful communities of care.

## A Tale of Accidental Medic Buddies

by Annah and Oliver

*Annah and Oliver are members of the Rosehip Medic Collective in the Bridge City.*

ANNAH: AS I biked across the Steel Bridge, I saw a standing figure beside someone sprawled down on the ground over two cement steps. They did not look in good shape. I stopped to check in with the bystander to find out what was going on and if he wanted any help. He did.

Collapsed haphazardly on shallow steps was a person I presumed houseless, his belongings in a backpack 5 feet away, not aware of the two strangers around him. He was alone except for the other biker who stopped before me. He was breathing. I could see his chest rising and falling. He did not respond when I hit the ground next to him with my palm and announced my presence loudly. I did it again and he responded with a moan. I spoke with the other person who stopped, a social worker with no medical background. We decided in that moment not to call 911. With my brief assessment I didn't sense any immediate threat to life, and wanted to wait a bit more to see if the man lying on the sidewalk would come to. Maybe he had a seizure? Maybe he was high? I didn't know. I told the man my name and that I was a medic and would like to help him. He appeared dazed, still lying there, and replied by moaning, and almost incoherently asking me several times who I was.

At that point I called Oliver's phone for medic buddy advice and he did not pick up. Serendipitously, two minutes later Oliver appeared, crossing the Steel Bridge on his bike. He pulled over, and we said hi like we were planning this all along. I filled him in on what had happened so far. I was immensely relieved to have a medic buddy I knew and trusted, and felt ready to continue assessing the man on the ground who may or may not need emergency care.

OLIVER: I could see the situation from halfway across the Steel Bridge- someone is on the ground, people are with them, but something is wrong. I biked carefully, my heart going faster, thinking about how I will approach this scene. I slowed down, telling myself to focus on the bridge and not crash my bike trying to see ahead. I pulled up and immediately saw Annah and relaxed. Annah and I have sat through a hundred meetings and half a dozen street medic trainings together. We've walked in the streets of tense protests together. We call each other for medical advice, each of us with a different set of clinical skills. We are occasional medic buddies, friends, and we can work together under any stressful circumstances. I knew whatever intervention had already happened was good; there was a plan. Instead of rolling up to a crisis I had rolled into a trusted friend's plan to help a stranger in need. What more could a street medic want?

The patient was not talking, but he had been. Annah had helped him into rescue position, another passerby stopped to help; it was just a waiting and watching game. No one had called 911 or wanted to. We settled in and waited, watching the patient breathe through his many layers of clothes, bundled up against a cold dry day. We would check his level of responsiveness every few minutes and we kept our distance. We stayed calm, smiled at each other, and didn't need to say, "I'm so glad you're here." The other bystander gathered that we knew each other and knew some first aid. Our instant team expanded to include him, and our ease with each other and the situation kept him calm.

Slowly the person on the ground responded to our words with grunts, then slurred words: "Keep off me! Who the fuck are you?" We gave him even more space, and slowly he calmed down and we came closer to chat. We exchanged names and explained why we were there.

We learned that this was not his first seizure.

He had just shot up with friends.

Where are the friends?

The friends had run off.

“Well fuck them.”

“Who the fuck are you again?”

Something unintelligible.

“Did you call the cops?”

We made very little progress and he started to nod off again, drifting in and out. Our plan had to change. This was not just the aftermath of a seizure. What was he on? Was this an emergency?

Our plan, for lack of a better one, was basically to bother him to stay awake. “Hey friend! Stay with us!” Sorry for ruining your high, but we’re worried and we’re involved now. We care and we’re stuck together until you’re well enough to walk away.

During a moment of lucidness he handed us dog tags that read, “In case of Emergency” and listed a phone number. We called and it was Mom. We talked with her, then he talked with her, not entirely coherent for most of it. She said, “Yes, take him to the hospital if he’ll go, he needs rehab.” No, she was not around, no she would not get involved, not this time.

He didn’t want to go to the hospital, no ambulance, no cops, no detox center. But if we could take him somewhere he would stay. After he talked to his mom he decided he liked us. “Who the fuck are you” turned into “why the fuck do you care?” One of us replied, “If we see someone on the street that needs help, we stop.” Oliver made a dozen phone calls trying to find somewhere reasonable for him to go. He didn’t want to go to an emergency department. Didn’t want to go in an ambulance. He wanted to go somewhere that was unavailable at 5:24 pm on a Wednesday. Maybe he was interested in showing up first thing in the morning somewhere to see if there was a bed.

He thanked us for stopping and staying with him when he didn’t feel well. For lending him a cell phone to talk to his mom. For not stealing his bag or calling the cops. He felt well enough to go find his friends. He accepted a Rose City Resource Guide with contact information on the front for a detox center at 7am the next morning if he wanted to go. He said he wouldn’t go, but thanks anyway.

We were just two friends bumping into each other commuting home from nursing school and medical school, stopping to help someone who needed it. Yet everything we did was from our street medic training, not our professional lives. We didn't diagnose or fix or make much progress, still though we made sure he knew that he mattered to us. We don't think we dramatically altered the course of anyone's life through this moment of convergence. The act of stopping and making connection with each other, our patient, and the third bystander was fundamental to our commitment as medics, affirming the fundamental importance of taking the time to prioritize caring for one another.

## Rooting for the Underdog

by Brenton Gicker

*Brenton Gicker has worked for White Bird Clinic ([www.whitebirdclinic.org](http://www.whitebirdclinic.org)) for 8 years and CAHOOTS for 5 years. His views do not represent those of White Bird Clinic or CAHOOTS. He can be reached at [beg977@yahoo.com](mailto:beg977@yahoo.com).*

***“Men make their own history, but they do not make it as they please; they do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted from the past.” — Karl Marx***

Working for CAHOOTS (Crisis Assistance Helping Out On The Streets, a program of White Bird Clinic) people often ask how we are able to tolerate the bad behavior of some of our clients and still provide them with respect, patience, and compassion. They are usually referring to homeless alcoholics and other addicts we serve, not necessarily the many other people we assist with their medical and emotional needs.

They are referring to our “problem clients”; homeless people who are chronically intoxicated and belligerent. These aren’t necessarily people who are temporarily homeless while they work through bad circumstances, such as a foreclosure, a disabling accident, bankruptcy from hospital bills, etc (though many homeless do fall under that category). These aren’t necessarily people who are homeless as a result of mental illness (though many homeless fall under that category too).

These “problem clients” are the ones who “give the homeless a bad name”; the one’s who “choose” to be homeless (or, more accurately, have resigned themselves to it); the drunks and aggressive panhandlers; the one’s you find passed out on the lawn or fighting in the alley; the one’s who spend their SSI checks on liquor when they haven’t eaten in days.

Working on CAHOOTS, we know these people well. Diffi-



cult as it may be at times, we try to treat them all with unconditional positive regard. We are paid, to some extent, to root for the underdog. We take our role seriously: everyone needs an advocate.

***“We are all in the gutter, but some of us are looking at the stars.”***  
— *Oscar Wilde*

We all have low-points in our lives. Many of us have had periods of extreme depression or excessive drinking due to whatever crisis we were in (a breakup, the death of a loved one, financial woes, etc). Most of us can tap into our personal and social resources to get through it and move on. But not everybody does: some people enter a vicious cycle of crippling self-loathing and self-destruction that doesn't end for a long time, if it ends at all. Some people seemingly had no chance to begin with.

Imagine, for instance, that as a child, your parents passed you around to provide sexual favors to their “friends” in exchange for money or drugs. Imagine if you grew up living in motel rooms watching your prostitute mother have sex with strange men; or going on drug-fueled crime sprees with your father instead of going to school. Imagine if, as a child, your punishment for mistakes was being burned with cigarettes.

Hopefully, you can imagine how enduring such experiences might lead somebody to having little confidence in or allegiance to a society that maybe they never really understood or fit in with; and how those experiences might cause somebody to mask their emotional scars with substance abuse and antisocial behavior. You can also, I hope, imagine how carrying those experiences around with you might seriously interfere with your ability to be a functional person by societal standards.

***“If you're going through hell, keep going.”*** — *Winston Churchill*

There's only so much that any person can endure. Each of us has a breaking point. I believe the horrors some of the people I've described have suffered could cause any of us to end up in similar

circumstances. Many people fall apart from much less.

It is easier to be compassionate to people when you know what hell they've been through, even when they are behaving poorly and may even be heaping abuse upon you as you try to help them.

I've seen people spend years, maybe even decades, digging themselves into a deep, dark pit of addiction and homelessness and criminality and sickness, decide they want something better for themselves and finally change; seemingly moving on without looking back.

There's people nobody believed were capable of changing who proved everyone wrong by not letting the tragedies of their past taint and define their present and future. These people inspire me to continue rooting for the underdog.

# Guerrilla Psych

by Aurora Levins Morales

*Aurora Levins Morales is a writer, visual artist, historian and activist. She is the author, among other titles, of Medicine Stories, and Kindling: Writings On the Body. She can be reached at auroralevinsmorales.com.*

June, 2002. I was in the depths of a very bad breakup and I wasn't eating or sleeping much. Two months earlier, my partner of six years had left without saying goodbye, committing a series of betrayals on his way out that devastated my trust in others and in my own judgment. I felt desperate to escape my overwhelming emotional pain. I'd just returned from a major academic conference, where I'd had two seizures in a single night, each time waking to ask where he was, my missing husband. One nurse said doubtfully that I had no ring and no tan line. In the two sunny months since his departure, it had faded.

Now I was back home and it was late at night and I couldn't feel my feet. I didn't know what was happening to me, didn't know my shallow breathing had deprived my extremities of oxygen, so I went to the ER, thinking about my numbed arches and toes, not my broken heart. I don't really remember the full sequence of events. I was exhausted, it was one in the morning, and they had only one option on offer. Either I got in an ambulance and went to a suburban psych ward, or I went home to the same hyperventilation that had made my legs vanish out from under me, back to single parenting through alternating bloody anguish and black despair. I wanted something, anything to change, and I was too tired to think, so I let them put me in the ambulance. When I got to the facility, they said I had to take a massive dose of Remeron or go back home. I slept for three days, the heavy hand of the medication forcing my eyelids back down each time I struggled toward alertness.

But on Day 4, I woke up and started talking to my neighbors, and because I'm an organizer and a healer, I listened to their stories and I organized, doing what I do with all my struggles, trying to find

ways to collectivize them in a world of privatized pain. What I saw all around me were emergencies that never needed to have gone this far. We were all of us imprisoned for lack of community.

There was the young, white, devoutly evangelical Christian woman who had become pregnant while at college, whose lover was East Indian, and whose mother, also devout, had forced her to have an abortion, which they both believed was a mortal sin. She was brought home to live with her parents and forbidden to ever mention the pregnancy or the abortion again. Her mother's racism and fear of scandal in their congregation had taken precedence over what she'd always been told was God's irrevocable law. Imposed silence and the spiritual abyss that opened up inside of her sent her reeling into a so-called psychotic break. When I met her, she was loaded to the gills with lithium, and unable to cry. She needed help to integrate the immense moral contradictions, grieve her lost child, and build a sense of sovereignty from the ruins of what felt like the ultimate violation.

There was the young Latino man, a first generation child of immigrant parents who worked themselves ragged to build a business he could inherit, their whole lives pinned on making him a successful small businessman or even a professional. But he was an artist, and the weight of their expectation, their complete incomprehension of his passion for applying inks to paper, and his inability to disappoint them and tell them his truth, felt like such a tiny, no-exit room to him that he'd attempted suicide five times. The staff was jittery around him, eyeing him sideways, and he liked to yank their chains with offhand comments about sudden death.

And lastly, the new mother, bedridden with post-partum depression, made deeper and more complex by her husband's affair while she was pregnant. On top of which, on September 10<sup>th</sup> he'd been on a business trip to New York, and they had stayed up half the night talking on the phone, trying to mend, so he overslept and missed his flight, which ended up hijacked and crashed in a field in Pennsylvania. In the face of massive death, personal betrayals had seemed suddenly small, but still, she couldn't get out from under her heavy heart.

All of us were there because our most intimate relationships had been damaged, and there was nowhere else to take the intensity of our pain. And the new mother and I were also there because we needed someone else to take care of our children while we caught our breath, and an emergency was the only way to get access to respite parenting.

All of us needed for there to be thickly planted networks of neighborhood healing houses, places of crisis care, with an abundance of peer support, soothing teas, people to listen, and help finding ways to change and mend our relationships or let them go. We needed acknowledgement of the depth and importance of our losses. A friend of mine whose husband had also disappeared said, if they had died, people would bring us casseroles, and not expect us to function, but heartbreak gets no respect.

The first rule of this place we were in was take your meds. The second rule was no physical contact with other patients. It was forbidden to hold a hand or offer a hug. That was my starting point. Part sabotage, part guerrilla theater, I sidled up to my new friends and with exaggeratedly furtive whispers out of the side of my mouth, asked two of them to stand guard because I was going to hug the third. Throughout the day, I got them to join my conspiracy of contact, and it started to knit us into a band.

Rule number three was food may not be brought back from the cafeteria. New Mama couldn't drag herself out of bed to go to meals. The only thing she could stomach, anyway, was chocolate milk, but the rules required her to go sit among the noisy crowds to get it. I started smuggling pints to her room in my pockets, and got some of the others to help. Each small carton was a declaration of kinship, proof that she was not alone, that we were on her side. Her wan smiles grew wider.

Although I still spent a lot of time sleeping off my exhaustion, and they made us go to silly, busywork activity groups, where we had to circle the stick figure faces that matched our emotional states, I sought out the people I'd connected with and kept trading stories. I validated the Christian girl's sense of betrayal, said anyone would be upset. You don't need lithium, I told her, you need

respect and room to mourn. Her parents wanted her to live with them when she was released, and the thought made her spiral down toward a desire to die. I told her she didn't have to go home. She was over 21. She could defy them. She started talking with another inmate who was due to get out around the same time about getting an apartment together.

The Latino artist was the one I talked with longest. He liked to muse out loud about his next suicide attempt, partly defiant attempt to shock, partly his way of shouting pain without betraying vulnerability. Next time, he said, he was going to try an electric hair dryer in the bathtub. Most people reacted with tension, so I joked. In a relaxed and interested tone of voice I'd ask him how he would kill himself with different assortments of objects—an apple, a paper clip and a rubber band? A toothbrush and an envelope? He started seeking me out. When he frightened the art therapist with his comments about scissors, we laughed together. One time he called me aside and showed me a broken plastic knife. He said the staff wouldn't let him have a dull butter knife, but loaded him up with plastic, which, when broken, had a razor sharp edge.

His parents were due to visit in a few days, and he became increasingly anxious and seemed more serious about self-harm. I told him that being an artist was really important, one of the most important things he could choose to do with his life. I told him his parents had worked that hard so that he would have a choice. I said he needed to tell them that he was an artist, that that was what he wanted to do with his life, not run the family business, and trying to please them was killing him. That they might not support him right away, but they would come around, that they loved him and wanted him to live and be happy.

Then I got him to promise he wouldn't try to kill or injure himself for the next 48 hours, that he could come to me to talk at any time during that period, but he couldn't hurt himself. I said it mattered to me that he be OK, and that he live the life he wanted. He tested the seriousness of my intention a little, but saw that I meant it, and I think he was shaking when he agreed. He kept his deal, and I think being asked to make that promise by a stranger

who was only invested in his happiness, was a kind of talisman to him. I was sent home before the visit, so I don't know how it went with his parents, but I told him he could keep talking to me in his mind, that I'd be his guardian angel, and any time he wanted to hurt himself, he should tell his imaginary me about it instead.

It was all so simple, what I offered. Contact, respect, and kindness. And in the offering, I found some equilibrium for myself. It's funny, I was in such agony, but what I remember most from those eleven days is the people I reached out to. They remain vivid to me while the pain has long since faded. Because the reaching itself was an act of healing, an act of self-worth and hope. All of us were wounded in the place of bonding, of knowing our wellbeing mattered to those we loved. I left that sterile place, full of sledgehammer drugs, rigid authoritarianism and cheerful disrespect, much stronger than when I came, because I found a way to build a tiny island of what we all needed, however temporary: brief ties of mutual care, that overused, tattered, and resilient word, community.

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# Trigger Up: Stop Locking Up My Friends

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*Hey reader! I know that lots of folks have experienced trauma at the hands of the mental “health” industrial complex (i.e. abusive therapy, involuntary incarceration, etc), and this piece addresses some of those topics. Please read with care and take breaks as needed.*

*love and light, RD*

I wish I had the resources to do solidarity for incarcerated folks earlier in life, and/or learned how earlier. I remember the myriad times my friends were locked up, the stories they would return with—not just from psych wards, but from facilities we knew as juvie, rehab, or (ugh) “camp.”

Here is what I know about how to practice solidarity for my friends when they get locked up involuntarily in the psych ward:

1. Get their legal name, especially if they’re a trans person. Birthdate can be helpful, too. Depending upon where they are incarcerated, the medical staff may refuse to call them by their preferred name, and so you will need to use their legal name with those people.
2. Get the name/phone # of the facility where they are incarcerated. If you can, find out what block they’re locked up in. Some facilities are really big, and it’s easy for them to “lose” a person if you don’t have specifics.
3. Call and ask to speak to that person.
4. Call again. You don’t usually get thru the 1st-3rd times. Sometimes you can leave a message. In your message, tell them (assuming you’re going to) that you will call back, and when.
5. If you’re able to reach your friend, ask if there’s anything they need. Do they want you to get in touch with someone? What do they want you to tell that person? Can you feed their cat, pay



their phone bill, or complete some other time sensitive task for them? Sometimes it can be simple as letting their sweetie know where they are.

6. Ask (don't insist!) if they'd like to be visited. If they don't feel like being visited, accept their "no." If it's a soft no, let them know that it's okay to change their mind later (like: cool, but if you change your mind, I'd still make time to visit you!).
7. If they'd like to be visited, ask if there's anything you can bring them to make them more comfortable. Food, a particular blanket or stuffed animal, art supplies, whatever.
8. Call the day of your visit, and give them a time frame to expect you in, and set a limit for how long you will stay (this is healthy, and part of taking care of yourself!). Confirm you will try to bring the things they have requested if that's part of your agreement.
9. During your visit/over the phone: if your friend feels comfortable discussing it with you, you can ask if they are getting their needs met. Ask if the doctor(s)/orderlies are listening to them and their experiences with their own body. Sometimes the medical "professionals" will ignore what the "patient" is saying about their prior experiences with certain meds, and the results can be disastrously fucked.
10. As a person on the outside, you have the power to advocate for people on the inside. You can call the facility where they are incarcerated and ask them to contact that person's prior healthcare providers, probation officer, etc, and/or to advocate for them to be supplied with whatever they need to survive. It doesn't mean it will work, but you can try. It's better than leaving your friends to rot, yaknow?
11. Of particular note around meds and not getting one's needs met: oftentimes trans people are denied their hormones while incarcerated, which can exacerbate any existing instability and be really really fucking upsetting.
12. Keep your friend's incarceration confidential, unless you are given permission to do otherwise! There's a lot of stigma around mental "illness" diagnoses/incarceration, so make sure you don't

jeopardize their safety by disclosing this information to others without permission.

13. Provide support for them (if they want it) when they get out, if possible. that can look like: making them cookies, letting them crash in your spare room, whatever you want it to look like.
14. Set and maintain boundaries. This helps keep you healthy.

When talking with your friend, use your active listening skills. Don't give them a fuck ton of advice unless they ask for it. While there are some mental health facilities that offer notfuckedup care, if your friend was incarcerated without their consent I can almost guarantee you that they are dealing with some level of trauma, so don't make it worse by being a jerk! You don't have to validate everything they say, but you can listen. Sometimes this is one of the most healing things of all.

### 3 a.m. House Visits

an anonymous interview

*Jason is a street medic, Wilderness First Responder, martial artist, & community medical provider in his late 20s; he asked that both his name & certain details be omitted or changed, including the names of people and places.*

Jason says he grew up dealing drugs and was friends with dealers. In high school, he was known as a troublemaker. “I did a shit ton of drugs too,” he adds.

Things had changed by the time he returned to his hometown in his 20s, but he liked to stay in contact with old friends. Among them, said Jason, “one of my friends from high school moved into being a big player [in drug trafficking networks].”

“One night, at 3 am my old friend calls me up & tells me he needs help; he tells me he’s just been stabbed.” Jason packed a bag and went immediately to see his friend. Arriving, he found his friend had indeed been stabbed, a clean but nasty wound—the friend had been applying pressure. After the immediate shock, Jason went to work cleaning and stitching up wounds. After finishing, he instructed his friend to “stop drinking,” to change the bandages frequently, and prescribed him some herbal infusions that might help speed the healing process. He proceeded to check on the friend every other night for a couple weeks. Jason says his friend was grateful “when he got injured, healed, & didn’t have to go to the hospital.”

Two weeks later, when this friend called Jason and asked to refer other injured friends to him, Jason said he’d “think on it.” A few days after that, he called his friend back agreeing with the condition that “you only tell people who you trust.”

Since then, Jason has received 7-8 such calls, “lots of knife wounds—to the shoulder, arm, foot—and blunt trauma. No gun wounds thankfully, though I’d like to learn to treat them.”

Over the first few calls, a kind of system emerged. Not knowing many of his late night/early A.M. callers, Jason asked only:

(1) who told them and (2) where they are. With those questions answered, he says “I have no further phone conversation.” Jason adds he does not use a pseudonym or anonymize his phone number.

Most of the time, responding to these calls, Jason relates that he feels uncomfortable – “it sucks to be woken up by these calls, and it’s scary—I feel threatened.” Sometimes the injured person is surrounded by fellow gang members and “scary” people; once when attending to an injured leader he was confronted with 6-8 angry gang members “chest-pumping and showing similar energy,” getting ready to repay the attack. “I have to psych myself up for it,” he says; “You’ve got to put on your game face.”

Jason begins care by setting boundaries: “I show up in medic mode...I am not your friend, I am not your customer.” He has observed that his patients have all been men and that there’s “almost always a woman” present—and it is these women who are most ready to participate in patient care. After inviting the patient’s companion to heat water for oatstraw and lemon balm tea, he gathers a narrative of what transpired from both. He then explains that he is unlicensed to provide the care he will be administering and that he needs a full agreement before proceeding – from both the patient and “more importantly” from their companion, “because they [the patient] will likely get drunk or drugged up.”

Jason’s agreement/instructions include that his patients are to:

1. “Take it easy”
2. Avoid substance use (unless that means going through withdrawal, in which case they are to minimize use). “Both are bad for recovery,” he says.
3. Carry out his after-care instructions (Jason brings “a shit-ton of gear” on these calls, including 2 handout kits – one for the patient & another for the companion.)
4. Go to the ER if certain conditions present themselves.

Jason says he has threatened his patients—not with violence, but with consequences—if they don’t follow these instructions. One of these patients refused to go to the ER, he says, and two days later was forced to by illness. That patient was deported afterwards. An-

other man he treated was brutally beaten, with bruises all over his body (including the fragile abdomen). After assessing him, Jason says he was “pretty sure” the man was not bleeding internally, but he shared what kind of ‘red flags’ would indicate more serious internal injury (localized swelling/pain increase, change in Level of Responsiveness) and emphasized this would mean a NON-NEGOTIABLE trip to the ER. “I try to scare the shit out of people,” he adds.

Jason owns that he has never received formal training in most of the care he provides. As a Wilderness First Responder, with “lots of personal backcountry experience, in the bush,” he has learned to improvise his supplies—for instance giving himself and others sutures with fishing line or dental floss. He adds that a familiarity with yoga, body movement, martial arts and chronic usability issues has given him “a sense of what will become a severe chronic issue – the difference between internal bleeding, injured organs, and soreness.” He also learned a great deal working as a veterinary technician and as a disaster relief volunteer, where he “watched people who were really competent [in providing medical care] do it over and over for months.” He also refers to having a background caring for undocumented people and people on probation or with warrants.

After his initial treatment, says Jason, “I arrange follow-up visits every few days, then every few weeks.” Other than these visits and preexisting friendships, he keeps his distance: “I treat a lot of bad people...most of the people I treat are bad people, but they’re nice to you.” He doesn’t request monetary donation from his patients, beyond the occasional cost of materials and gas—though he says most offer him more. Jason says he accepts this extra money and gives it to community groups he cares about, saying “the shit that they give me is blood; I don’t want it. I don’t like these people because they’re destroying the community: That’s what a drug dealer does.” He believes strongly, however, that they still deserve care: “It sucks to be beaten up, robbed at gunpoint, have their house broken into.”

When asked what most drives Jason to keep on taking these nighttime calls, he responds, “Mostly I see it as really good practice; I am personally trying to prepare for collapse, to gain experience

treating violent injuries and working with people outside of our [radical/liberatory] communities. In the event of a social upheaval, these will be really good people to know (well-armed, organized, and with access to lots of resources). They're frightening allies who have been neglected by my community. Also it allows me to do this work because I don't want to work in the ER." He also values being able to 'siphon' the money offered to him back to other groups and that "it's engaging to be part of an underworld."

Jason says that apart from his patients and the interviewer he has told no one about this part of his life. "I have to keep this secret and it sucks." When asked why he agreed to give an interview about his nighttime calls, Jason says, "because I want people to understand how I got into this – because other people can do it." He reflects, "I fell into it – I didn't plan for it; it just kind of happened because my friend needed help. But people could plan it out without too much work. I think we could do something similar from an above-ground place too, with trac phones possibly." He also sees his care for these gang members as falling within the context of providing accessible health care: "I'm a medic for my community. People call me all the time for all kinds of things. This is definitely not isolated."



# Closing Thoughts

As we gathered these stories we were impressed by the diversity of voices and experiences we heard, but we also saw common themes emerge from them. In a field where many of us face isolation, those shared experiences seem worth highlighting. Here are our thoughts on a few of the many common threads throughout these stories – we hope you will add your own thoughts to them.

A common thread that weaves through the section on working within the system is positive experiences with rural EMS. These stories emphasize the familiarity that comes in small communities, where patients stand out as more than anonymous names or record numbers. Writers comment on the possibility for community-level EMS systems to give back to their responders through education, training and skill-building, and to recognize chronic emergencies – isolation, poverty, and lack of access to care – as the serious and present threats they are. We are curious about translating lessons learned from rural EMS into the smaller urban communities where many of us work as street medics. Though they are located within larger cities, many of the specific circles where we work are no larger in population than a small town. How can we bring these effective, individual-scale emergency response systems to the people we know and support in our own communities?

Another theme in this collection is the role of EMS as a safety net – sometimes functional, sometimes very dysfunctional – for individuals abandoned by society. One contributor writes that first responders “deal with the consequences of broken communities... our job is to pick up the pieces.” In doing that work, we see first hand how the systemic injustices in our society are connected to one another – malnutrition to poverty, poverty to health, health to environmental destruction...the list goes on. Repeatedly witnessing these struggles and the ways they are linked is a difficult role, but also one filled with possibility. The healers in our communities are uniquely placed to recognize these systemic oppressions, and their very concrete consequences. And also to build small, community-level solutions that can begin to fight them.



Trauma and burnout in care providers is another theme that surfaces in several of the contributions we received. As Charles says, first responders and healthcare workers are “The keepers of our town’s secrets,” charged with the extremely difficult job of bearing witness. As we worked on this zine, one contributor added a fantastic resource to our constantly evolving conversation about self care and mental health of healthcare workers. The Code Green Campaign ([codegreencampaign.org](http://codegreencampaign.org)) works to raise awareness and support of first responders facing mental illness, including recognizing suicides of first responders across the country. One look at the barrage of stories on their website shows the necessity of changing the way we think of self care and support for our care providers. We hope our contributors’ words serve as a call to rally behind one another and to care for ourselves and our fellow healers in addition to caring for our patients.

In the first Alternatives to EMS zine, we recognized the importance of supporting the healers in our communities as they further their education and training. We drew conclusions about the need to keep those people close to and involved in our communities as they go through the rigors of intense schooling, so that we do not lose our amateur healthcare workers as they drift away from us and into the world of healthcare professionals.

The stories in this zine have shown us another side of that same conclusion – the need to maintain ties with and between community-directed care providers so that we can continue to share and learn from each other’s experiences. While it is easy to feel that we are alone in a broken system, reinventing the wheel each time we attempt to provide truly patient oriented care, these stories show us that we are far from alone and we can learn much from each other. We hope this zine acts as a reminder to seek out and maintain connections to one another, and to share lessons learned and moments of success and inspiration.

Finally, we are inspired by the creativity and ingenuity in the diverse stories we received. From unexpected sources of care in small-town EMS, to unplanned medic collaborations on city bridges, to patients banding together to support each other within bro-

ken treatment programs, the people in these stories remind us of the effect that each person working within, outside, or against our healthcare system can have. In these pages, we read of actions and choices and solutions we would never have dreamed of by ourselves. Let's keep working, and keep sharing our stories with each other. Providers, healers, patients, witnesses – together, we are so much stronger, more resilient, and more resourceful than we even know.

In Solidarity,

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