Ready to submit?
Tell us your stories!

Thanks for your interest in Rosehip Medic Collective's upcoming anthology project. We want this project to reflect a variety of viewpoints from a variety of people – not just those who enjoy producing works of writing, or those who love being interviewed. We are accepting written (emailed, snail mail, or hand-delivered to one of our promotional events) stories, as well as setting up phone and in-person interviews. See the last page of this zine for some interview questions to get you thinking.

We will not print anything either written by you or written by us based on an interview with you until we have shown it to you and received your approval. We will not edit your words except in ways that you ask us or ways necessary for length/readability, and we will get your approval for all modifications. We may not be able to print all stories we receive but we will respond to all stories/inquiries in a reasonable amount of time.

Please be mindful of confidentiality, and change names and identifying details before sending us submissions. We can also print submissions anonymously, and receive submissions via snail mail for added anonymity.

Thanks again for your interest in this project! We'd love to hear from you with any questions you have that are not covered here, or just to hear that you've started work on a story and we should look for a submission from you soon. You can set up interviews, ask us questions, send submissions or request a snail mail address by emailing rosehipmedics@gmail.com

Towards resilience and healing,
The Rosehip Medic Collective

ALTERNATIVES TO EMERGENCY MEDICAL SERVICES 2.0

Call for Submissions and Preview

the rosehip medic collective

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.

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.

Interview Questions

Join our project! The back cover has more about the submission process, and here are some questions to get you thinking. If you are submitting a written story, we invite you to consider these questions while writing. If you would like to set up a phone or in-person interview, please let us know how to best contact you and review the questions below beforehand.

These questions are just a guide for your written story, please answer or skip them in the way that will best help you express your thoughts.

- What made you interested in this project?

- What brought you into healthcare?

- Could you tell us about a time when your work in healthcare really reflected your values as a healthcare provider?

- Could you tell us about a time when it was a struggle to overcome barriers to provide care that reflects your ideals?

Please provide 2-5 sentences that would serve to introduce you and/or your story in the anthology.

Please include any requests about whether or how we edit your story should we decide to use it.

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.

Call for Submissions

The Rosehip Medic Collective is embarking on a story gathering project that will culminate in an anthology - a kind of sequel to our "Alternatives to EMS" zine. Two years ago we presented case studies, history and theoretical discussion of both institutional Emergency Medical Services and tried or existing alternatives. We discussed and critiqued what has existed, and dreamed up what could be created. Copies of that first zine can be found at www.rosehipmedics.org

Now we return to our question of what forms EMS can take, but from the perspectives of individual amateur and professional healthcare workers. Once again, we seek input from a spectrum of people - professional and volunteer disaster responders, street medics, nurses, EMT/Paramedics, outreach workers, village healthcare workers, herbalists, doctors, and people of all backgrounds and healing traditions.

This pre-release zine (with a few first stories) is our callout for submissions – for stories of individual and group successes and learning moments in working towards community-directed care. We define community-directed care as that which:

- emphasizes consent and best practice as 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 are also looking 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.
How did you confront dangerous or ineffective top-down management as a healthcare provider? How did you work with co-workers to provide care in unsupportive workplaces? How do you stand up for yourself/your patients/your coworkers against oppression in the healthcare system? Where have you found individuals, systems or communities that successfully provided community-directed care?

Got stories? Get in touch for an interview, or send us some writing! You'll find more information about how at the back of this booklet. Please join us – by sharing our dreams, traumas, trials, failures, successes, & "ah-ha" moments with other healthcare workers and the community at large, we hope to humanize, learn from, strengthen and work with each other.

<+3

The Rosehip Medic Collective
Rosehipmedics@gmail.com
www.rosehipmedics.org

A tale of accidental medic buddies. Two Rosehip Medic Collective members share a bike path and both stop to support a stranger in medical crisis.

Annah and Oliver are members of the Rosehip Medic Collective. They are a medical student and nursing student.

Annah:

As I bike across the Steel Bridge, I see a standing figure beside someone sprawled down on the ground over two cement steps. They do not look like they're in good shape. I stop to check in with the standing person to find out what's going on and if they want any help. He does.

Sprawled haphazardly is a man who does not look good. He is alone, except for the other biker who stopped before me. He is breathing; I can see his chest rising and falling. He does not respond when I hit the ground next to him and announce my presence loudly. I do it again and he responds with a moan. I talk with the other person who stopped, who is social worker with no medical background. We decide in that moment not to call 911. I don't sense any immediate threat to life, and want to wait some more to see if the man lying on the sidewalk will come to. Maybe he's had a seizure? Maybe he's overdosed? I don't know. I tell the man that my name is Annah and that I'm a medic and would like to help him. He appears dazed, still lying there, asking me several times who I am.

At that point, I remember deciding to call Oliver for medic buddy advice, and him not picking up. I'm not sure if I am imagining all that, or if it really happened, but what definitely happened is that two minutes later, Oliver crosses the Steel Bridge on his bike. He pulls over, and we say hi like we've been planning this all along. I fill him in on what's happening so far. I'm now feeling immensely relieved to have a medic buddy I know and trust, and feel ready to at least make certain the man on the ground is not in need of 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 of 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 dozen street medic trainings together. We've walked in the streets of tense protests together. We call each

Rooting for the Underdog

By Brenton Gicker

Brenton Gicker has worked for White Bird Clinic (www.whitebirdclinic.org) for 8 years and CAHOOTS for 5 years. His views do not represent those of White Bird Clinic or CAHOOTS.

"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 ones who "choose" to be homeless (or, more accurately, have resigned themselves to it); the drunks and aggressive panhandlers; the ones you find passed out on the lawn or fighting in the alley; the ones who spend their SSI checks on liquor when they haven't eaten in days.

Working on CAHOOTS, we know these people well. Difficult 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

"It's frustrating, but we always respond—right?" The chief broke in. "Even when it's the third time this week to his house, 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 heart attack, 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 so small there is nowhere to spend money, 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 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 poverty and daily isolation are health risks as big as acute medical conditions. Rick's loneliness is not the sort of emergency we picture when we imagine EMS work, but one look around his home tells you it is a condition every bit as serious.

When the chief is at 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 check on him. If an initial assessment reveals no medical problems, 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. It is so far from being enough – these occasional visits, occurring when someone feels desperate enough to call 911 for company. *But still, 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, that recognize the need for human interaction as much as the need for physical wellbeing, and that approach community resilience as both holistic and collaborative.*

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 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 put him in rescue position, and another passerby stopped to help but 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 but 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 words: "Keep off me! Who the fuck are you?" We gave him even more space, but slowly he calmed 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'd 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, because 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 awareness 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, and 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, and I don't remember who, said that if we see someone on the street that needs help, we stop.

I 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 – he would show up first thing in the morning 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, accepted a Rose City Resource Guide with some numbers written on the front if he wanted to check into detox at 7am in the morning. He said he wouldn't go, but thanks anyway.

For the next two weeks I would see him on the waterfront on my way to school, I'd wave, stop and say hi, wish him well on his travels south.

Two friends bump into each other commuting home from nursing school and medical school respectively. But everything we did was from our street medic training, not our professional lives. We didn't diagnose or fix or make much progress, but we made sure someone knew that he mattered to us.

"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."

"Do 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 broke in.

"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, and denied 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 wide grin, and he looked at us as though letting us in on an inside joke. As this admission sank in, I thought of Katherine, guiding the large, unwieldy ambulance over five miles of twisty, icy roads. Mary and I exchanged glances.

"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. 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 immediate need of medical care. We stood around a while, making small talk, and then 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 and mild amusement.

Rural Emergencies

Taiga is a member of the Rosehip Medic Collective who gained EMT experience volunteering on an ambulance in rural Vermont.

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 my tiny Vermont town. The old man who lived there was a "frequent flyer," one who regularly called 911 for minor to nonexistent ailments. 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, unstaffed and volunteer-run. Crew members carry pagers and respond to calls whenever they are able. In the time I lived there, the crew had nine members who responded regularly, with a handful of others responding every once in a while and showing up to our firehouse meetings to 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 county is one of the poorest in the country, with an aging population so isolated from one another by distance, bad roads and bad weather that daily care is a challenge. This is a place 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 one 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 in as responding, and I headed straight to the scene while she picked up the ambulance. Mary, another new EMT on the crew, met me outside the dilapidated farmhouse. Paint peeled from the clapboards and the torn screen door was patched with plastic sheeting. Inside a dim, faded, mostly empty livingroom, a small, gray-haired man sat in a worn brown armchair. As we entered, he grinned at us, the chair seeming to swallow his small frame.

"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.

3 a.m. House Visits – An Anonymized Interview

Jason is a street medic, WFR, martial artist, & community medical provider in his late 20s; he asked that both his name & certain details be omitted or changed, including people and place names.

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

When he returned to his hometown in his 20's things had changed, 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 dealing 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 says he 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. Jason says that after the immediate shock, he went to work cleaning and stitching up his friend's 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 later, he called his friend back agreeing with the condition that "you only tell people who you trust."

Since then (at the time of the interview), Jason says he has received 7-8 such calls, "lots of knife wounds—to the shoulder, arm, foot—& blunt trauma. No gun wounds thankfully, though I'd like to learn to treat them."

He says that over the first few calls, a kind of system emerged. Not knowing many of his late night/early A.M. callers, Jason asks only: (1) who told them and (2) where they are. With those questions answered, he says "I have no further phone conversation." Jason adds that 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, & its scary—I feel threatened." Sometimes he says 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 & 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 that it is these women he has found most ready to participate in patient care. After inviting the patient's companion to heat water for oatstraw and lemon balm tea, he gathers the narrative of what transpired from both. He then explains that he is unlicensed to provide the care he will provide and that he needs a full-on agreement before providing care – from the patient and "more importantly" from their companion ("because they will likely get drunk or drugged up").

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

- "take it easy"
- avoid substance use (unless that means going through withdrawal, in which case they are to minimize use). "Both are bad for recovery," he says.
- carry out his after-care instructions (Jason brings "a shit-ton of gear" on these calls, including two handout kits – one for the patient & another for the companion.)
- 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. Another 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 added.

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." Jason says that 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 states having has background caring for undocumented people and people on probation or with warrants.

After his initial treatment, says Jason, "I arrange follow-up visit 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 sometimes the 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." He goes on, "I don't like these people because they're destroying the community: that's what a drug dealer does." However, he believes strongly that they 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."

Jason adds that he 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."

Apart from his patients and the interviewer, Jason has told no one: "I have to keep this secret and it sucks." When asked why he agreed to 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 track 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."