

Riot Medicine: Bridge Guide

First Edition (cdb1d08)

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Disclaimer

This pamphlet is a guide intended for qualified medical professionals. It is not itself a substitute for professional medical training. The legality of protest, practice of medicine, and their intersections varies from region to region, so there will be no attempt to make absolute statements about what is legal or illegal. Statements about the law are meant to guide you in the right direction, however they are not qualified legal advice. It is up to you to research the political and legal climate where you will be operating and make your own decisions.

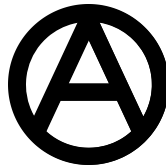


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1 Introduction

You cannot buy the revolution. You cannot make the revolution. You can only be the revolution. It is in your spirit, or it is nowhere.

Ursula K. Le Guin, *The Dispossessed*

As a medical professionalⁱ, you have a wealth of skills and experiences that make you valuable to the social movements that try to bring about a more liberated and egalitarian world. Where there is struggle against the State, capital, and fascists, there are physical confrontations, and where there are physical confrontations there are injuries. Members of these movements provide medical care to tend to those who have been injured. They go by many names: street medics, action medical, riot medics, or often simply “the medics.” They are one of the many forms of self-organized mutual aid that contribute to a movement’s success.

Figure 1: French Medics Hiding from Cops^{1,ii}



When shifting away from a classic medical setting, you may find yourself stationed at a refugee camp, helping the unhoused, or offering consultations at a community health clinic. There are many ways to merge

ⁱIf you’re not a medical professional (and you skipped the warning in the disclaimer), you likely want to read the full *Riot Medicine* text. It’s much longer and assumes you have no prior medical knowledge.

ⁱⁱOn January 11th, 2019, this photo² was taken in Paris showing medics and journalists hiding around the corner from riot cops.

medicine with the fight for a better world. This guide is, however, more narrow in scope. It does not cover how to run a clinic or anything related to long-term care within your community. From its name, *Riot Medicine*, the focus is on medicine in the contexts of protest and insurrection. You, of course, can both change the bandages of the residents of your local tent city and also show up to riots to treat concussions and other trauma. They are not mutually exclusive, but if you are not planning on attending actions, this pamphlet may not be for you.

What this pamphlet will do is help you bridge the gap from working in a clinical setting or classic EMS to working in the sort of non-hierarchical, self-organized, and more chaotic contexts of riot medicine. Perhaps unrest has broken out in your city and you want to join those who have taken to the streets to fight racism, fascism, and other forms of oppression. Perhaps you have no experience working with radicals, and perhaps you've never been to a protest that got rowdy. That's ok. Everyone starts somewhere, and this pamphlet will help you understand what to expect in while organizing with others and while on the street.

This pamphlet is written from an autonomous, anarchist perspective. However, the information and tactics described within will be useful to all participants in the struggle for liberation. State imposed laws and regulations are a reality, and where it is relevant, it is noted where your work may intersect with the legal system to highlight what legal risks there may be. This pamphlet was written in 2021, so as you are reading this, be wary that medical best practices, legal considerations, and all other information may have become out of date.

By reading this, you will be better prepared to take your medical knowledge to the streets and to care for and heal those on the front lines. You may be only one person, but your contributions, however small, help change the world for the better.

2 Responsibilities

Nothing every burns down by itself.
Every fire needs a little bit of help.

Chumbawamba, *Give the Anarchist a Cigarette*

Riot medics make up the autonomous part of the healthcare system that attends actions and interfaces with the organizations and individuals involved in protest and civil unrest. They may seem to exist wholly

outside of the classic healthcare system, but they are organized, trained, and fulfill the same role, albeit at a smaller scale and with far fewer resources. They help educate their community on matters of health and provide emergency medical care. What separates the autonomous system from the classic system is that the former is able to be on the ground, in numbers, continuously, and it can do so where the latter cannot go.

2.1 Basics

The most obvious examples of a riot medic's responsibilities are first aid, evacuation, and transfer of care to Emergency Medical Services (EMS). Their responsibilities can also be as mundane as handing out water on hot days or emergency blankets on cold days. Like classic medicine, they also work to prevent injuries and illness via education about the kinds of things seen during protest or generally while engaged in physical activity. Typically, their tasks at actions include:

- Providing care to injured individuals
- Spreading calm when others may panic
- Evacuating injured persons to safety
- Interfacing with classic EMS
- Setting up makeshift clinics to care for multiple casualties
- Instructing patients on aftercare
- Providing emotional and psychological support for patients experiencing trauma

Your patients are likely to be psychologically traumatized when they are injured. They may have never experienced police brutality before, or they be psychologically strained after months or years of repeated brutalizations. It is more important than anything else to be a beacon of calm amidst panic and chaos. Be kind and gentle. Emotionally care for your patients. Give them assurances that someone is there to help.

Medics may also be involved in jail support to help protesters post-arrest. There may be a mix of legal support, medical support, and others with clean clothes and food who wait outside jails to care for people after they've been booked. Talk to local organizations and see if this is something you can help with.

All services you offer must be free of charge. Do not solicit donations from patients as this may be interpreted as a requirement for an "unofficial" payment. Not everyone can pay, and putting up even this small barrier makes treatment inaccessible to some patients. Most importantly, it breaks down the solidarity we are trying to build with one another.

2.2 Non-Prevention

Part of medicine is preventing injury and illness, and this applies to riot medicine. Medics should educate about risks like dehydration, hypothermia, and tear gas. However, medics should generally not attempt prevent injury by intervening at action.ⁱ The success of an action is very often more important than preventing injury, and intervention is paternalistic. It assumes that the person intervening knows better than the person acting on their own volition what is good or desirable for them. Individuals have the autonomy to make choice on the activities they want to engage in, and your role is about helping minimize unwanted consequences of these choices rather than restricting the set of choices anyone can take. Those who take such preventative actions are often dubbed the Peace Police and shunned at actions.

2.3 Patient Consent

The treatment of every patient must begin with informed consent. Introduce yourself and state your qualifications, often just as simply as “Hello. I’m a doctor/nurse/paramedic. Can I help you?” Ask them about their chief complaint, explain what you plan to do, and reaffirm consent as necessary. Pause to allow the patient to reject treatments, and take care not to push them to accept any treatment.

Due to the more chaotic setting where you will find and treat patients, and due to the limited amount of equipment you will be able to carry, the informed part of informed consent can be abridged because the initial treatments are conservative. You as the provider need to select treatments that are unlikely to not be fully consented to or could be confusing to the patient. Be aware that you may have relative privilege over your patients either due to your race, gender, stature, or more official looking uniform. They may not fully consent but go along with your treatments because they feel intimidated or see you as the only option.

Like how there is implied consent for patients with altered consciousness, protesters who are disoriented or blinded by riot control agents implicitly consent to extraction. Alert them that you’re not a threat. Shout “I’m a medic. Let’s go!” Lack of obvious, immediate dissent should be taken as assent.ⁱⁱ Put an arm around them to offer stability, and guide them to safety.

ⁱExceptions are of course for things that are extremely likely to result in severe injury or certain arrest with little chances of anyone’s goals being achieved. However, if you are new to radical actions, you probably should just watch and learn.

ⁱⁱAs an anecdote, in all my years of medic work, I have literally never had a patient

Patients may often only want a bare minimum of treatment so they can return to a fight. You may feel that a laceration requires sutures, but they may accept the risk of damage and scarring and ask for just wound closure strips and gauze to wrap it. Appropriately warn them, and do what you can to convince them to seek care later, but still give them quick treatment as that is better than nothing.

When a patient consents to care, they are only consenting to the care necessary to heal them or provide lifesaving interventions. They are not consenting to a full medical examination or the collecting of tissue samples. Asking to take samples is likely coercion.

For example, during Yellow Vest actions in France in 2019, there were reports on April 20th and May 1st that street medics were taking blood samples.³ These medics claimed to be doctors who wanted to analyze the blood for hydrogen cyanide from expired CS gas. Consent was given, but not freely, while injured persons were treated on the streets. Photos taken of these events show medics wearing respirators and patients attempting to cover their faces because they were still in danger. The medics chose to treat the patients as lab rats to satisfy their own curiosity instead of getting the patients to safety. Do not do this.

2.4 Patient Confidentiality

Patients have the right to privacy, and it may be illegal to share patient data, even with other healthcare providers without explicit consent. During protests and uprisings, these are not just rights but requirements for patient safety. Police repression can lead to extrajudicial retribution against protests during or after actions. You may be tempted to document your work to avoid lawsuits, but practitioners are generally covered by Good Samaritan laws. Documentation can be confiscated and used in court.

Do not collect any patient data. Do not take photos. Do not ask for names, and if you do ask for a first name only. Phrase such queries as “Is there a name I can call you?” to make it clear that you do not care about their legal name. Do not ask for ID cards or insurance cards. Do not talk to the police, or even around the police, about patients. If they ask, respond with “I legally cannot discuss my patient with you.” If they try to film or observe, push them back and tell them they are violating patient confidentiality.ⁱⁱⁱ

resist this sort of quick extraction, and all have been glad I was able to snatch them away from danger.

ⁱⁱⁱThis works better during actions that are less riotous and in regions where the

2.5 Patient Abandonment

Patient abandonment occurs when there is a negligent termination care on by the caregiver or failure to handover care to another qualified provider. Caregivers may terminate care for valid reasons such as:

- The scene becomes unsafe for the medic
- The patient assaults or harasses the medic
- The medic is incapable of providing the care the patient needs
- Ethical or legal problems would arise as a result of further treatment

Most treatments are short, and patient abandonment does not meaningfully apply. However, even non-life-threatening injuries or illness may require hours of care. It is common for ambulances to be delayed because of barricades, police blockades, or orders to not enter dangerous environments. You may need to spend significant time monitoring and attending to a single patient until EMS arrives. This is often complicated by the fact that there may still be rioting near you. Others may be injured, and people may try to pull you away from your patient to treat their comrade. Unless the new patient is described as having imminent risk of death, do not leave your current patient. Have people bring all new patients to you so you can rotate between them.

If can feel like you're useless when there is rioting happening around and you're waiting with a stable patient, but leaving them to try to extract someone is never as simple as it looks. You can get snatched, leaving your patient alone. Rely on others to bring patients to you.

2.6 EMS, the Police, and Harm Reduction

EMS may voluntarily or compulsorily work with the police. Police may station officers at hospitals with the expectation that persons injured during riots will seek medical care. In general, and in particular at riots, calling EMS may cause the police to arrive.

Always get consent from a patient before calling EMS. They may know the risks better than you, and if they do not, you may need to inform them that police may arrive or visit them at the hospital. If they are not of sound mind, implied consent gives you grounds to call EMS.

Because advanced medical care may not be possible, you may need to provide them the definitive care they need. This may mean irrigating a wound and taping it shut or sometimes just instructing them on how to further debride a wound at home with cuticle scissors. A hospital may

police act more in line with the so-called neutrality that liberal democracy professes.

be the ideal treatment, but they may not be able to go, and the small amount of harm caused by you cleaning a wound or reducing a dislocated finger is still a reduction compared to arrest or no treatment at all.

2.7 Risk

Confronting the State and fascism is an inherently risky endeavor, and there is some amount of risk you need to accept by joining a social movement. Some people chose to take on the role of medic instead of “just” being a protester because they believe in its relative safety.^{iv} Some do this out of fear, and others do it for a bit of the thrill. They want to get close to action and have stories to tell without as much risk of being arrested.

Ask yourself honestly why you are becoming a medic. If you are doing it for the thrill, you can endanger and kill patients. If committed medics see you, they may move elsewhere with the expectation that you will provide care and not turn away when things get violent. If you are treating a patient, and a police officer tells you to stop, stopping can kill the patient. You should be willing to face arrest to continue treating seriously injured patients.

For example, during Unite the Right in Charlottesville, Virginia on August 12th, 2017, a neo-nazi drove a car into antifascist protesters injuring, among others, Heather Heyer. Street medics assisted Heyer and performed CPR when she went into cardiac arrest. A State Trooper forcibly removed an EMT from assisting, threatened others who lined up to help, and attempted to stop a street medic (a nurse) from performing CPR.^{4,5} Heyer died as a result of her injuries. This is not the only documented case, but it is one of the most prominent.

Generally, you should know what laws you are willing to break in the course of your work. This may mean simply remaining with a protest that is declared an unlawful assembly, or it may mean working closely with insurrectionaries during fighting in the streets. You should figure out what actions you are or are not willing to take or what laws you are willing to break before you are confronted with the decision. This allows you to have a sense of risk beforehand so you don’t make irrational snap decisions you may later regret.

^{iv}In some regions, medics in uniform may experience less violence from the police. In some regions, they experience more.

2.8 Self-Preservation

As a medic, you need to first and foremost care for yourself. If you become a casualty, you and your team will no longer be able to provide medical support, and another team will have to care for you. Medics are limited, and your one injury can take a total of four medics out of action for hours.

Activists, including riot medics, may develop unhealthy complexes that push them into engaging in unnecessarily risky behavior. Some people develop martyr complexes where they feel they aren't really contributing toward a cause unless they are suffering. This may come from external drivers like the need to "prove" to others that they are truly dedicated to a cause or the need to demonstrate credibility by getting injured or arrested. The best way to demonstrate your dedication to a cause is by repeatedly showing up to actions and efficiently rendering care.

2.9 Neutrality

Many people who enter the medical field, and especially those with the kinds of sympathies that would cause them to become a riot medic, do so because they believe in helping others and that all deserve medicine. When you become a riot medic, your primary group you are responsible for care for are protesters and bystanders, not their opposition or the police. Police have their own medics and most have basic first aid training. They often have much better armor than protesters, and they are able to receive care that may be inaccessible to protesters.

Treating police or fascists can be dangerous. Medics get attacked by police and fascists while treating them.^v Fascists will attack medics unprovoked and may see them as the enemy.

You may feel you have an obligation to help anyone who is injured, but remember that any time spent helping police or fascists is time not spent helping protesters. There are often not enough medics for the volume and severity of injuries at large mobilizations. What you consider neutrality is actually be picking a side.

2.10 Summary

The main responsibilities of a riot medic are treating patients and evacuation to advanced medical care. Major differences are they ambulances

^vIn 2020 during the George Floyd uprising, street medic Sierra Boyne and her buddy attempted to treat a right-wing casualty.⁶ She was pushed off by both the victim's affiliates and the police when they arrived.

may be delayed or blocked, and that you may be stuck with one patient for hours. Your roll is not about preventing actions, but dealing with consequences; let people take radical actions. Consent may need to be abridged, and treatments may need to be minimal. Protect patients by not collecting information. Protect yourself by not being excessively risky, but don't be so careful that you never actually help anyone. Do not abandon your patient to go in search of others.

Above all else, be the beacon of calm that allows people to feel safe and secure.

3 Organizing

I will not rule. I will not be ruled.

Anarchist aphorism

Riot medics are often organized into collectives or loose affiliations of individuals within a region. Some groups may have a high number of members who are physicians, nurses, and the whole range of paramedics. Others may be predominantly, or even exclusively, individuals with only first aid training. Using the what knowledge and resources they have, they provide assistance to protesters at demonstrations and riots.

Figure 2: Training Together⁷



3.1 Groups and Collectives

Liberatory social movements aim to remove hierarchies and to create a world based on cooperation and mutual aid. These movements are often prefigurative: they try to live and organize in a way that reflects the desired future state they are striving for. Ergo, they reject existing hierarchies and ways of thinking even if one could argue such things are more effective.¹ The kinds of decision making processes and chains of command you may be used to in life, and in particular in your workplace, will not exist. You may need to learn how to participate in collective decision making and how to reach consensus. You may need to learn how to operate autonomously while also leaving space for the autonomous actions of others.

Hierarchy in this sense refers (loosely) to ranked social relationships where some have the authority to give orders to others and punish those who disobey. A simple example is that of the employer-employee relationship where employee who disobeys their employer can be fired. Another example is a union or club that has a president or councilors that can set group policy and revoke membership of those who didn't follow it. Non-hierarchical organizing does away with these sorts of coercive relationships, and it exists based on voluntary association. Individuals participate because they choose to, and no one in the group has power over anyone else.

Some groups use a stronger consensus model where they attempt to get (close to) 100% agreement before making a decision. Some groups use a weaker model where a decision is made when everyone can live with the decision even if they're not happy. Some groups have loose affiliations and no consensus is reached, and they only come together to share information and coordinate knowing that some will take action that others completely disagree with. Note that consensus is not simply majority rule where 51% of members can trample the other 49%. Care is taken for everyone's desire and autonomy, and when care is not taken or if a member vehemently disagrees, they are free to leave.

Note that this non-hierarchical approach to organizing does not disregard the expertise within medicine. A physician likely has more knowledge of human physiology than a paramedic, and an acknowledgement of these differing qualifications during treatment is still expected. Likewise, a medic with no certifications likely knows more about how to move and act during a protest than medical professionals new to riot medicine.

¹I say "could argue," but in reality centralized, top-down organizations are not actually more effective than decentralized, bottom-up organizations.

There is a long tradition of this within radical thought. For example Mikhail Bakunin wrote of the following on expertise in 1871⁸:

In the matter of boots, I refer to the authority of the bootmaker; concerning houses, canals, or railroads, I consult that of the architect or engineer. For such or such special knowledge I apply to such or such a savant. But I allow neither the bootmaker nor the architect nor the savant to impose his authority upon me.

For you, this means that your experiences as a paramedic or your knowledge as a doctor will be deferred to when necessary, but your experiences, knowledge, age, or other traditional markers for seniority do not grant you the right to make demands of others. You may be the only person in a collective who has any formal medical training, but this does not make you either a *de jure* or a *de facto* leader.

You may be treated like an “outsider” as you are a new face and do not come from a radical background, and it may be uncomfortable. Because of this, you may be tempted to take to the streets on your own, but it is highly recommended that you try to work with established collectives with significant experience. They have skills from being on the ground that you likely do not, and they know what danger exists at protests and how to avoid it. High level medical knowledge is not sufficient to make someone a riot medic. An experienced protester with only knowledge of first aid is near universally a better medic than a physician who does not know how to handle themselves at a protest.

3.2 The Buddy Pair

The buddy pair is the fundamental organizational unit for medics. If you work in an ambulance, you are likely very familiar with this concept. You and your buddy are responsible for looking after each other’s well-being (both physical and mental) before, during, and after an action. A medic does not separate from their buddy during an action with the exception of multiple patients in close proximity requiring care. You cannot take care of your buddy, and they cannot watch out for you when you are not together. Separating endangers both parties.

Some common responsibilities you and your buddy have toward each other include:

- Being a second set of eyes while scanning for patients or danger
- Providing a second perspective or opinion for a situation (medical or otherwise)

Figure 3: Buddies⁷

- Being the devil’s advocate or voice of caution
- Dividing equipment and carrying redundant equipment
- Double checking equipment
- Reminding the other to eat and drink
- Being alert while the other rests
- Controlling a crowd while the other assists a patient
- Preventing people from taking photos or videos of a patient
- Being a secondary for two-person CPR
- Assisting with moving or carrying a patient
- Communicating with EMS, other medics, or other groups while the other is helping a patient
- Debriefing each other at the end of the day
- Supporting each other’s mental health in the long-term

Ideally, your buddy would be another medic, but if that is not possible, a friend or comrade is a suitable alternative. They can still hand you supplies and be watchful eyes while you attend to a patient. If they have protest experience, they can be your guide and keep you out of unnecessary danger.

3.3 Contingency Planning

Even if protest is legal and rather safe in your region, the risk of arrest or serious injury is never zero. Far-right “lone wolves” may violently attack

your protest, or police may decide they just don't like your attitude and arrest you, possibly landing you in jail. Even as a medic, where these risks may be lower than the average protester, you still face some risk of imprisonment or serious injury. If you're unlucky, police will heavily-handedly target medics with greater ferocity than other protesters.ⁱⁱ Because of these risks, you should make and share with comrades your contingency plans for what to do if you are injured, are arrested, or have your house raided by the police.

Consider talking to a lawyer who specializes in social movements and putting them on retainer. If you cannot afford this, consider finding a lawyer who may take on many clients from the same collective for a group fee. There may be non-profit legal assistance for people arrested during protests in your area.

If you have pets, give a friend a key to your home, and tell them how to care for your pets. If your pets have special diets or medication, make sure your comrade knows about this, and leave a note somewhere obvious.

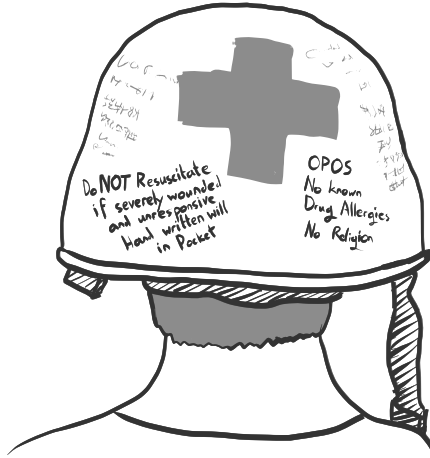
You may want to come up with a media plan for what to do if you are injured, arrested, or killed. Do you want your situation politicized or not? Some people may want their lives to stay more anonymous, and others may trust their comrades to turn their misfortune into propaganda to advance the movement's goals.

3.4 Summary

You should expect to organize in a non-hierarchical, autonomous way with formal collectives or loose affiliations. Be wary of trying to apply old organizational patterns to your activism. Avoid giving orders, and do not feel obligated to obey any you receive. Work with a buddy for your own and your patients' safety. Make preparations in case you get arrested or injured.

ⁱⁱMedics in the US are specifically targeted by the police for violence and arrest.

ⁱⁱⁱOn October 1st, 2019, a photo surfaced of a medic wearing this helmet.⁹ While this is not a legally recognizable DNR (Do Not Resuscitate), it shows the fear and desperation medics face during unrest and repression.

Figure 4: Contingency Directives^{1,iii}

4 Police and the State

Anarchists know that a long period of education must precede any great fundamental change in society, hence they do not believe in vote-begging, nor political campaigns, but rather in the development of self-thinking individuals.

Lucy Parsons, *The Principles of Anarchism*

Police brutality is a public health crisis; they beat civilians at will, they torture those they arrest, and they use crushing violence against protesters. Moreover, police do not protect civilians; they protect the interests of the State and capital. While it may be possible to de-radicalize individual police officers, as a unit, they are the primary opposition to protesters and those who fight for civil rights and liberation. This has been made exceptionally clear in recent years where the Blue Lives Matter ideology, a reactionary mockery of the Black Lives Matter movement, has spread to police forces around the world, often accompanied by other symbology for police supremacy.

Depending on the privileges you have and how you are perceived

by society, in particular your skin color and gender, you may have never experienced police harassment. You may have never even had an encounter with the police. If you have, it may have been simple or easily diffused. Maybe your last run in was 15 years ago, but police have changed a great deal since then.

The way police treat protesters, even supposedly neutral persons, those protected by the Geneva Conventions like medics, can be a world of difference from how they act day to day. Liberal democracy claims the police are a necessary tool to keep crime at bay, but in reality this means oppressing minorities and stopping dissent. Your past experiences with the police may not accurately predict how they will interact with you when you take to the streets.

4.1 Hear Nothing, See Nothing, Say Nothing

Aside from the standard armored riot cops, or even the high visibility walls of cops with batons, are police intelligence officers. Some may be plainclothes and mill about. Some may wear specially colored vests with titles like “Police Liaison Officer,” and regardless of what their claimed role is, they are there to learn about a protest’s goals and key individuals. This can be used to build cases against people or preemptively constrain a protest. Do not talk to friendly cops, and better yet, do not talk about specifics with anyone unless you fully trust them and can avoid being overheard.

As mentioned when discussing patient confidentiality, you should avoid asking for names or other information that can be used to identify individuals. Further, you should avoid asking questions that lead to answers where a patient can admit to a breaking laws. This may be overheard, or you may be interrogated later. You can’t say what you don’t know, so carefully phrase questions and cut off patients if they start spilling incriminating details. For example, if a patient is holding their head, don’t say “What happened?” because what happened is irrelevant. The question “Did you get hit in the head?” is preferred because it tells you the mechanism of injury without revealing if they were involved in fighting the police. Better yet, preface questions with phrases like “without going in to detail” or “without telling me exactly how.”

Much of your time spent as a medic will be searching for people to help and finding places to be where you expect help will be needed. You may see many things, and people around you may be engaged in illegal activity, but that is of no concern to you. Don’t watch. Don’t film. If there’s no incoming cops, walk away so that if the act is filmed, you won’t

be in the shot and called as a witness.

Generally, you should never speak to the police. If police speak to you, find out if you are being detained or are required to stay. If not, leave immediately. If you are detained, do not speak until you have legal counsel. Nothing you say will benefit you and you may get yourself into greater legal trouble. The key phrases and exact steps you need to memorize to legally get yourself away from the police vary by region, so you will need to learn these on your own.

4.2 Professional Courtesy

While the safest advice is to never speak to the police, under any circumstances, without a lawyer present, often while on the streets, you may need to cross police lines or get access to injured persons. Acting with the sort of professionalism you use in your hospital or praxis can help you talk your way in to being able to assist. When doing this, you must be exceptionally careful to not say anything incriminating about yourself or others and to not reveal information about actions. This is something you should practice with your buddy before deploying it on the streets.

If you have a uniform that is sufficiently professional, talking your way across police lines is significantly easier. Attire is discussed more in Section 6 (“Tactics”). In some regions, physicians have special identification cards that can be used to allow them to provide treatment during police operations. Carrying identification with your legal name presents its own risks, as does showing it to police who have been known to collect photos of protesters and their IDs on their personal phones. Talk to local medics and radicals, and investigate the degree to which police in your region violate civil liberties and people’s privacy before attempting this. You may consider it worthwhile if it helps you reach protesters more easily.

While this tactic may work, it may also raise suspicion among protesters about how and why you were able to cross police lines. Is it because you’re secretly a cop? This can cause them to distrust you and even harass you later in the day or at another action.

4.3 Summary

The police are not your friends, and they actively oppose everything social movements stand for. Do not talk to them without a lawyer present. If you must in order to cross their lines or reach patients, be very cautious about what you say. You can’t reveal what you don’t know, so intentionally being ignorant of crimes or patients’ identities can protect both you and them.

5 Equipment

The fulfillment of the revolutionary project is ultimately an inescapable ethical obligation that each of us have to the dead and the exploited.

Idris Robinson, *How It Might Should Be Done*

Your equipment will be limited compared to what you have in your clinic or ambulance. You will be limited to what you can carry on your back, and much of that volume and weight will be for the things you need to survive an action such as food, water, and personal protective equipment.

The three fundamental questions to ask yourself when selecting equipment are:

1. What do I actually know how to use?
2. What am I realistically going to need?
3. What amount of weight can I actually carry?

If you can't run, you can't stay with an action. If you're slow, you may get arrested or attacked. While you're new, less equipment and a lighter load is suggested.

Professional healthcare workers often feel unprepared when they don't have the full array of equipment they're used to, but you will need to learn to deal with this. In particular, physicians often want for their intubation kit complete with laryngoscope. Such equipment is large, heavy, expensive, and rarely used. Consider cheaper and lighter alternatives even if they provide inferior care.

5.1 Clothing

In Section 6 (“Tactics”), attire style and appearance is discussed a bit more as it can change how police interact with you. Generally, your clothing should be chosen so you can do physical activities in it.¹ You should be able to run and move freely in it. Avoid obvious or unique logos as these can be used by police or fascists to identify you.

¹For example, very tight jeans or a dress might not allow you freedom of movement and can get caught on things when climbing. Of course, you know yourself best, so pick what you find comfortable being active in, but keep in mind that you might have to run to safety in it. Select accordingly.

Dress in layers so you can add or remove clothing as necessary. Riot control agents bind to cotton, wool, and other natural textiles, but synthetic material such as nylon can melt to your skin as a result of coming in contact with explosives, other pyrotechnics, or burning tear gas cannisters. Layering allows you to wear both a heat resistant layer and a riot control agent resistant layer.

Close-toed shoes are mandatory. Hiking boots are recommended because of their grip and protection for your ankles. Large punk boots are less recommended as they are harder to run in. Running shoes are also a good choice, though they offer less ankle and puncture protection.

A utility vest is a good addition to your attire as its many pockets make it easy to store frequently used items like gloves, gauze pads, and hand sanitizer. Pants or shorts with large pockets can also fulfill this role.

Something like a gaiter or keffiyeh is a good choice to protect your neck from riot control agents. They can also be used to conceal your identity if necessary.

5.2 Personal Protective Equipment

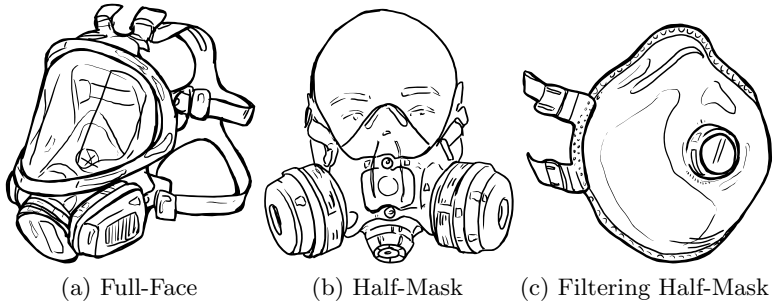
You need to protect yourself to be an effective medic. If a baton round fractures your skull or you are blinded by tear gas, you cannot do your job. You want to protect your head, eyes, ears, lungs, and everything else (in that order), and you want to do so in a way that isn't so conspicuous as to make you stand out in the crowd and draw police attention. The rule of thumb is if others have PPE, you should too, and if they don't, neither should you. Also, it may not even be legal to wear any PPE as it can be classified as a "passive weapon" as it makes you more resistant to police violence. Look up local laws and norms among protesters. A complete discussion of all the personal protective equipment (PPE) you might want and their trade-offs would be as long as this entire guide, so the following is a reasonable selection for getting started on a budget.ⁱⁱ

For your head, ideally you would get a ballistic helmet. If this is not possible, an EMS-style rescue helmet, a bike helmet (specifically BMX), or climbing helmet are fine choices. Avoid helmets without a chinstrap. Find one that fits snugly on your head and can accommodate a respirator and goggles. If you cannot wear a helmet, consider getting bump cap (baseball hat with a hard plastic lining).

ⁱⁱCrimethInc's *A Demonstrators Guide to X* series¹⁰⁻¹³ and the Indigenous Anarchist Federation's *Skills for Revolutionary Survival* series^{14,15} are great guides on PPE.

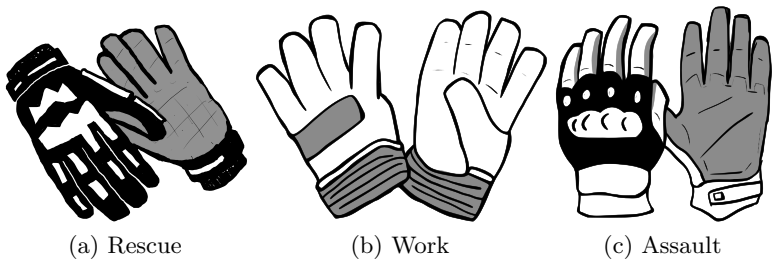
For your eyes, you can use a full-face respirator, or pair it with a half-mask respirator and goggles. A common combination is to have two pairs of goggles. Swim goggles as the first pair protect against riot control agents. Ballistic goggles that have the lens laminated with a clear, durable tape seems to be able to stop many types of munitions. A simpler options is to use safety glasses or goggles, though this only is effective against shrapnel and glass, not munitions. All eyewear should be clear as even light tint significantly impairs vision at night.

Figure 5: Types of Respirators



For masks, a P100 or FFP3 filtering half-mask is the simplest and cheapest. A half-mask can be paired with better ballistic eye protection, and a full face can be used as a combination protection for eyes and your lungs. Half-mask respirators are useful as you will not have to replace their visor if they're damaged.

Figure 6: Gloves¹



For your ears, use earplugs with a Noise Reduction Rating (NRR) of

-30dB. For your knees, plastic skate pads or soft handball pads are useful if you trip or have to kneel over a patient. For your hands, rescue gloves, assault gloves, or work gloves suffice.

5.3 Medical Equipment

For your bag, it is recommended to use an EMS style bag that opens like a clamshell. You can find cheap, small EMS bags; you do not need to get a professional bag. If your bag does not come with modular pouches, you should acquire those as they significantly help with organizing your equipment.

Figure 7: EMS Backpack⁷



The items in the following tables are suggested for a starting medical kit that covers both the most common injuries and the sort of severe injuries you are qualified to handle. Optional items have their quantity written in *italics*. In addition, pack the PPE you need plus food and drinking water. Keep any medications you might need if arrested on your person (not in your bag).

Table 1: Packing List — First Aid

Qty.	Item
1	Trauma shears
3-5	Emergency blanket
2-4	Instant cold compress
1	Vomit bag
10	Dextrose & salt drink mix packet
5	Single-use saline vials
1	500 mL pneumatic eyewash bottle
1	Tweezers
1	Splint
1	Cervical collar
1	Can refrigerant spray
5	Paracetamol tablets
5	Ibuprofen tablets
5	Aspirin tablets
5	Anti-histamine tablets
1	Salbutamol inhaler w/ spacer
1	Epinephrine autoinjector
1	Narcan spray bottle

Table 2: Packing List — Wound Care

Qty.	Item
20	Individual package gauze (10×10 cm)
10	Gauze roll 10 cm
2	Non-adhesive dressing (10×10 cm)
1-2	Roll 2 cm medical tape
1	Roll 5 cm medical tape
2	Elastic net dressing
3	Self-adhering bandage (2 cm)
2	Self-adhering bandage (5 cm)
2	Elastic bandage
1-2	Combat dressing
1	Chest seal (pair)
1	Package hemostatic gauze
5	Package wound closure strips
20	Adhesive bandages (assorted size)
1-2	Triangle bandage
1	Tourniquet
1	Burn dressing (10×10 cm) or burn gel (50 mL)
100 mL	Antiseptic spray
50 mL	Antibacterial creme
400 mL	Antiseptic irrigation solution
2	Irrigation syringe (30 mL)

Table 3: Packing List — Infection Control

Qty.	Item
10-15	Pair Examination gloves
100 mL	Hand sanitizer
2-4	Surgical mask

Table 4: Packing List — Basic Life Support

Qty.	Item
1	Keychain CPR mask or pocket CPR mask or BVM
5	Oropharyngeal and/or nasopharyngeal airway (sized large child to adult)
2	Disposable razor
1	Tension pneumothroax access kit

Table 5: Packing List — Diagnostic Equipment

Qty.	Item
1	Pulse oximeter
1	Penlight
1	Stethoscope
1	Blood pressure cuff
1	Blood glucose meter (with lancets and test strips)
1	Thermometer (with disposable covers)

Table 6: Packing List — Misc.

Qty.	Item
2	Package tissues
5	Tampon (assorted sizes)
2	Plastic trash bag
10	Pair earplugs
10	Safety pins

6 Tactics

As for politics, I'm an anarchist. I hate governments and rules and fetters. Can't stand caged animals. People must be free.

Charlie Chaplin, *Charlie Chaplin: Interviews*

Medics are more akin to lifeguards than they are paramedics. They are part of the crowd, and they have to actively seek out situations where violence may occur so they can quickly render care. Tactics vary greatly with geography and time. The best teachers are experienced medics in your region, and experience itself.

6.1 Unfriendly Medics

During popular uprisings, such as the Yellow Vest, there may be medics with right-wing views. Not all medics have a liberatory outlook. Be aware of this as you look for groups to work with or while on the street. Right-wing medics are exceptionally rare, even at right-wing events, so this is mostly just a word of warning against blindly trusting all medics.

Further, not all medics who claim to have left-wing views are allies. Snitches and infiltrators exist, and yes, they even take on the role of medic to camouflage themselves. A notable example is the case of “Anna the medic.” Starting in 2004, she worked as an infiltrator leading to the 2006 arrest of green anarchist Eric McDavid and two others.^{16,17} Anna used her position as a street medic as an in to groups, and when called upon utterly failed to provide aid leading to at least one hospitalization.

6.2 Attire

How you select attire and equipment will depend on what sort of tactics your opposition employs, and to what extent medics are protected by the laws of liberal democracy. In some regions, most notably the US, medics are explicitly targeted for violence and arrest. In others, they are free to move relatively unimpeded.

In Figure 8, the three broad classes of medic are pictured. For the purposes of discussion, they are named from left to right: uniformed medic, classic medic, and black medic. Generally speaking, more professional uniforms and more ostensibly neutral behavior can mean less restriction of movement and more options for treatment, if the police act with

Figure 8: Medic Attire¹

restraint toward medics. If this restraint does not exist, the uniform does nothing.

Uniformed medics are the rarest as they require very high levels of legal protection or at least a norm of medics being treated as neutral. Their attire is close to the official EMS uniforms of their region. They generally must act with neutrality to do their work and refrain from overt displays of politics.

Classic medics are fairly well marked and are quite common, especially during mass unrest. They are marked clearly enough to be considered medics by bystanders, but generally their main protection from police violence and arrest is the police not perceiving them to be a threat. Their role is medic, but they are active protesters, though not the main aggressor at an action.

Black medics may be only minimally marked and are generally dressed in ways that obscure their identity to help them avoid repression. They often move as part of the Black Bloc, and there is no self-imposed restriction on actions. This class has the disadvantage that their minimal markings make it hard for others to find them, so they need to be more alert and actively seek patients.

None of these classes is “better” or “worse.” In some regions, some classes are more common because they are more effective. Talk to locals about what regional norms are for medics, but in all likelihood the classic medic attire and disposition is where you will start.

6.3 At Actions

For actions, coming up with a plan of how you think the day will play out lets you and your team make informed decisions on how to dress, what to bring, and where to position yourself. Read up on the event and look at social media posts if they exist. Print out a map of the expected areas where the actions will take place, and give a copy to everyone on the team.

It is exceedingly difficult to make statements about how any single medic or collective should act at an action. Many of the factors one must consider are region specific. However, the following three things are a reasonable baseline:

1. Be safe, be alert.
2. Move towards where you expect violence.
3. Don't let a surging crowd pull you away from your duties.

Other general advice is:

- Be present at the starting and ending points of the action.
- Be near to blockades.
- If you are uniformed or obvious, be wary of drawing attention to people carrying out covert activities.
- If there are obvious radicals, be near them as they are often targeted for violence.
- When people break through a police line, hold back and look for casualties.
- When police charge, avoid over-retreating and leaving casualties behind.
- If a patient is being attended by a qualified provider and they do not need your help, don't stay. Go find another patient.
- Walk, don't run. Running medics spooks people.
- Hold the straps of your buddy's bag when moving through a crowd to avoid getting separated.

6.4 Summary

Experience is the best teacher, and there is no substitute for attending actions if you want to learn tactics. Be alert, stick with your team, and actively seek out tension so you can provide aid. With time, you will develop a sense for this and it will become natural.

7 Patient Assessment

Revolutionary action is not a form of self-sacrifice, a grim dedication to doing whatever it takes to achieve a future world of freedom. It is the defiant insistence on acting as if one is already free.

David Graeber, *Possibilities*

Patient assessment does not need to be followed by rote, and the contents of this section are comprehensive to cover all cases. Most injuries you will see are easily identifiable trauma, and clarifying questions are just to check for the possibility of head injury. For everything else, the following mnemonics and steps will help you quickly make a diagnosis or at least provide a starting point for treatment.

7.1 Pre-Contact

Before you reach your patient, size up the scene. Check if it is safe for you to approach. Is anything burning? Are police charging? Has a vehicle driven into a crowd, and is it disabled? Do not become a casualty yourself.

The scene size-up will give you an idea of the mechanism of injury (MOI). Is there a collapsed tripod?ⁱ Is there an ongoing street fight between two armed groups? Consider if the current scenario or environment could have caused an injury or illness.

7.2 Primary Assessment

Introduce yourself, and get consent before beginning treatment. The primary assessment uses the mnemonic ABCDE to remind the medic of the main steps of the process: airway, breathing, circulation, disability, and expose/examine injuries. This assessment is for immediate threats to life, not about measuring quality or the nature of any vital signs.

If the patient is unconscious, check their airway and if they are breathing. If not, begin CPR.ⁱⁱ Check for “disabilities” such as a broken neck and blood glucose levels. Finally, check for hemorrhages by exposing or examining injuries. While exposing and examining injuries, spend a

ⁱA tripod is a three legged structure that activists suspend themselves from to block roads or access to buildings. Police must expend significant time to get them down safely.

A Airway
B Breathing
C Circulation
D Disability
E Expose/examine injuries

M Massive hemorrhage
A Airway
R Respiration
C Circulation
H Hypothermia

few seconds to search the patient’s entire body as the first injury you see may not be the most critical, especially in the case of gunfire.

In combat scenarios, ranging from knife fights to use of live ammunition, the mnemonics MARCH is often used to address greatest threats to life first. MARCH stands for massive hemorrhage, airway, respiration, circulation, and hypothermia. Hemorrhages need to be controlled and the airway needs to be cleared before beginning CPR. Patients may cool rapidly even in warm weather and need to be kept warm, hence the “H.”

7.3 Secondary Assessment

Check the patient’s heart rate, respiratory rate, blood pressure, peripheral blood oxygen saturation, blood sugar, and temperature. For manual measurement of heart or respiratory rates, measure for at least 15 seconds and multiply by 4 to get an accurate measurement. Axillary temperature is sufficiently accurate for measuring core temperature. If possible, write all measurements in a notebook along with the current time. This can help check for improving or worsening conditions, and it may be relevant to the next healthcare provider.

If the patient has no immediately life threatening conditions, perform a head-to-toe examination. Start at the head and palpate their body while looking for deformities or tenderness.

If the MOI suggests significant trauma, do a rapid trauma assessment to look for things like CSF leaks or internal bleeding. Use DCAP-BTLS

ⁱⁱSome texts recommend not check for a pulse as it may be weak or difficult to find in a chaotic setting. Respiratory arrest is followed promptly by cardiac arrest, so there is a bias to beginning CPR rather than checking for a pulse. If you are confident in your abilities, you may choose to check for a pulse during respiratory arrest and use its presence/absence for guiding basic life support.

mnemonic during your quick, 60-90 second assessment. If you find nothing, go on to a more thorough secondary assessment.

D	Deformities
C	Contusions
A	Abrasions
P	Penetrations
B	Burns
T	Tenderness
L	Lacerations
S	Swelling

Check the overall quality of the patient’s skin using the mnemonic SCTM. Human skin naturally has great degrees of variation in color and even among patients with apparently similar skin color, there are different undertones (e.g., a person with “white” skin may have red or olive undertones). When you are examining skin color, you are not taking an absolute measurement, especially when looking for paleness (pallor) or redness (erythema). You need to compare their current color against the their baseline color. If this is difficult to asses, you may choose to hold up a small mirror so the patient can see their face and ask “Is this your normal skin color?”

SC	Skin Color
T	Temperature
M	Moisture

In unconscious patients, prior to beginning diagnosis, you would have attempted to wake them with verbal or painful stimuli. This would give you their partial GCS. Fully asses their GCS during the secondary assessment. Check for orientation by asking them if they know their name, the date, the approximate time, and the events the lead to their injury illness. Asking their name may be dangerous, so you can phrase the question as “Don’t say it aloud, but do you know your name?” To check for anterograde amnesia, ask them to remember a simple word like “avocado,” and ask them to repeat it later.

C	Circulation
S	Sensation
M	Motion

When checking the extremities, check for damage to nerves and blood vessels using CSM. Check for the normal capillary refill time of under 2 seconds by squeezing a fingernail or toenail for 3 seconds and releasing. Check for parathesia (numbness, itching, or tingling) in their fingers and toes. Check for motion and strength in their hands and feet by having them push and pull against your hands. When checking for motion, avoid commenting on a lack of movement as this may distress the patient.

You may need to get the patient’s recent medical history, in which case use the SAMPLE mnemonic. When investigating their chief complaint, OPQRST can help you quickly converge in on the problem. These are relatively self-explanatory.

S	Signs and symptoms
A	Allergies
M	Medications
P	Past medical history
L	Last oral intake
E	Events leading to incident

O	Onset
P	Provokes/palliates
Q	Quality
R	Region/radiation
S	Severity
T	Time

If the patient has a suspected spinal injury, you may be able to clear them yourself during the secondary assessment. The criteria for clearing a patient using the focused spine assessment are as follows:

1. The patient is reliable.
 - (a) They have a GCS of 15.
 - (b) They are unintoxicated.
 - (c) They are not distracted either by preoccupation, onlookers, or rioting happening around them.
 - (d) They are not distracted by another injury such as a broken arm or leg.
2. The patient has normal CSM in all four extremities.

- (a) Their skin is warm and pink, and they have radial/pedal pulses.
 - (b) They have normal sensation and no tingling or numbness.
 - (c) They can move their hands/feet and have strength unless a lack thereof can be explained by another injury.
3. Their entire spine is free of pain and tenderness when palpated.

To palpate the spine, you need to have direct access to the spine from the base of the skull to the bottom of the back. With at least two other medics assisting, roll the patient on to their side while stabilizing their cervical spine. Palpate the spine starting from the base of the skull and working towards the pelvis. This cannot be performed over bulky clothing. Each vertebra should be individually palpated. If the palpation is painful, the patient may have a broken vertebra. Stop the examination and roll the patient on to their back. Evacuate the patient to advanced medical care.

7.4 Triage

True mass casualty incidents (MCI) are generally rare at riots, so here we look a more narrow scope of an MCI: anything that overwhelms you and your team. Often this is a police charge, use of riot control agents, or multiple concussions because of opposition throwing bottles and stones. While normal triage principles apply, be aware of a few things:

1. Even small head wounds bleed a lot making blood a potentially poor indicator of severity of injury.
2. Experienced protesters are accustomed to violence and may calm while severely injured.
3. Inexperienced protesters are not accustomed to violence and may panicked after taking a baton to the thigh or being lightly tear gassed.

If you have multiple patients, their subjective assessments and insistent friends may be inaccurate measures of the severity of their injuries. Pause to assess things yourself and make a decision on who to treat after very quick (10-15 second) assessment. Delegating someone to tend to the panicked can reduce load.

7.5 Calling EMS and Handover

Calling EMS or working directly with them may be part of your common duties. If not, the following are useful for quickly and efficiently communicating information to EMS.

- In one short sentence, state the reason why you are calling EMS. This may be as simple as “I have an unconscious patient with head trauma.”
- Give your exact location. This may be a cross street, address, or position relative to a landmark.
- Give the dispatcher your mobile phone number so that they may call you back if the call is disconnected.
- State your qualifications. They may be able to guide you through treatment.
- Give relevant details on the patients and their injuries that may allow the dispatcher to send the appropriate resources or to prioritize your patients against other incidents.
- Do not hang up until directed to do so. The dispatcher may instruct you to stay on the call until an ambulance arrives in order to help guide them to you.
- Expect delays. EMS response may be with 5 minutes normally, but due to blockades, it could be hours, if at all.
- Expect police. They may arrive with EMS.

Handover to EMS generally goes smoothly, especially if one medic on the team works in healthcare. State your qualifications, and quickly give them your notes. If your buddy does not work in healthcare and they are the ones who meet EMS to lead them to you, have them state your qualifications so they will treat you as a peer when they arrive.

7.6 Summary

Patient assessment is done in two steps. First, check for life threatening conditions using ABCDE or MARCH. Attend to these, or if they're not present, move on to a secondary assessment. Take vitals signs like heart rate, respiratory rate, blood pressure, GCS, blood sugar, oxygen saturation, and temperature. Mark these down for reference later.

8 Psychological Care

If trauma results from perceiving a threat to one's existence or the existence of another living being whom one cares about, then a necessary step in healing from trauma is securing a sense of safety from existential threats to oneself or others.

Jane Adams Collective, *Mutual Aid, Trauma, & Resiliency*

Many injuries and illnesses you see at actions will be relatively minor, but the long-lasting effects of psychological trauma from police brutality or surprise fascist attacks can be far more damaging. This section covers the framework known as Psychological First Aid (PFA). When effectively applied, PFA can reduce the chances and severity of PTSD.

If you've worked in disaster relief, you may have encountered another framework known as Psychological Debriefing (PD). PD is not effective in reducing PTSD and may cause harm, and thus it is not recommended.^{18,19}

As a note, I have adapted PFA's steps and how they are applied as they were intended for use by centralized organizations like NGOs and the military for dealing with civilians following MCIs such as natural disasters or terrorist attacks. In riot contexts, things go a bit differently, so even if you're already familiar with PFA, I would recommend you read this section regardless.

8.1 PFA Basics

Psychological first aid is a framework for providing supportive, emotional care to individuals who have experienced traumatic events. It is not some exact set of steps, and you should adapt it to the cultural and social norms of your region. Like how medical first aid is the initial step into managing a wound, PFA is the initial step in the process of recovery from trauma. The major goals of PFA include:

- Helping individuals feel safe
- Avoiding retraumatizing or additionally traumatizing individuals
- Connecting individuals to other individuals and groups who can provide further aid
- Restoring a sense of autonomy

8.2 PFA Steps

PFA uses some combination of the following steps.

Ensure your own safety. Like with other first aid, you need to ensure your own safety. If police are still actively terrorizing individuals, you may not be able to intervene and begin care. If fascists have made an incursion into your action and there is street fighting, you may not be able to help until the violence has died down.

Identify who needs care. Identify who needs care and quickly triage them. Individuals with moderate and severe physical injuries should take priority over individuals who have been traumatized. The basics of PFA is kindness and calmness which is something most people can provide, but you as a medic may be one of a small number of people who can offer medical care. Individuals who have been on the receiving end of violence may not always be the ones who need care as they may have expected said violence and used proactive coping measures to prepare for it. Look for individuals who seem frozen, dazed, or panicked. They are the ones more likely to need PFA.

Introduce yourself and obtain consent. Like with first aid, identify yourself and obtain consent to treat the individual. State your qualifications, what you are able to offer, and ask if you can assist them.

Remove the patient from the source of trauma. If the patient is still in a chaotic environment or near where a traumatic incident took place, you may not be able to care for them or help calm them. Consider moving them somewhere that is calmer and has a greater sense of security than their current location. This may not be possible, or you may need to stay close to the area where the traumatic event occurred so that others may be able to find you for medical care.

Separate the calm from the panicked. If you have multiple patients, you may need to separate the calm-but-traumatized from the panicked patients. The patients who are panicked and highly animated may erode the small amount of calmness in other patients.

Keep nosy busybodies away from patients. Bystanders may be curious about what happened and ask invasive questions to the patients. This may further traumatize them as it may force them to speak about the traumatic event, and it can interfere with their ability to feel calm and safe. Journalists may try to take photos or ask questions to get a scoop. Keep busybodies and journalists away from patients.

Help the patient feel safe, comfortable, and calm. Help the patient feel safe. Moving them to a safe location is a good first step. Telling them that you are here to help and that others are there for

support can be helpful. Offer them something to drink or a snack. If they are crying, offer them tissues. While quite simple, this is a powerful gesture that symbolizes both care and a return to normalcy. Speak to them in a calm and reassuring voice, both in tone and content.

Keep the focus on the patient. Ask the patient about how they feel, and avoid making your interaction about how you feel. Keep your judgement about the event and your appraisal of their response out your treatment. It does not matter if you think their reaction to the traumatic event is appropriate or not. Don't tell them they're overreacting. All feelings are valid. You are there to provide care and support regardless of your interpretation of the event.

Do not lie or misrepresent the situation. While you attempt to calm and reassure the patient, do not lie about resources available or the current situation. If there are unknowns, you may state so, and you may choose to omit some details if they are not relevant or helpful. However, do not make statements like "everyone is fine" or "nothing bad is going to happen to you now" unless you know with certainty that such statements are true.

Be mindful of how you communicate. Communication isn't just words alone but tone, facial expressions, and posture. Try to see yourself from the patient's eyes considering your relation to them both culturally as well as through your relative privileges. Maintain a pleasant disposition. Face your body towards them, and keep your focus on them. If they are sitting, either sit or squat so you do not loom above them. When they talk, nod your head so they can see that you are actively listening.

Consider offering physical contact. Some patients may find physical contact to be helpful and calming. This may mean a hand on their shoulder, holding their hands, or a hug. Ask for content before touching a patient, and be explicit about what kind of physical contact you are going to offer. For example, clearly say, "would you like a hug?"

Prompt the patient to speak. Ask the patient if they would like to speak about what happened. Do not force them to discuss anything as this may retraumatize them. Allow for long pauses as they collect their thoughts. Repeatedly asking them questions can add to the stress of the situation and interrupt their train of thought. One exception to this is if there is still an active threat and they were one of a small number of witnesses. If there is still danger (like an armed assailant), you may need to get them to answer basic details to help protect others.

Use grounding techniques. The patient may be panicked or

disassociated from the current situation. Encourage them to breathe slowly. Help them identify 5 things they are feeling (physically) and 5 things they can see or hear that are calming. Ask them what they see in the clouds, what the weather is like, or if they can hear any birds. Have them put their feet firmly on the floor or their hands in the lap, and ask them to describe the feeling.

Enable self sufficiency. Once you have attended to the patient's immediate needs like safety and minor material comforts, ask them what they need. Do they need to get home? Do they have friends at the action who can help them? Are they worried about someone else at the action, and can you help them find this person? Do they want to be connected with more qualified providers of psychological care? Facilitate their own autonomy.

Create a plan. Help the patient come up with a short-term plan they can immediately enact. For example, make a plan to get them home. Discuss this with them, and then act on it.

Connect them to support. Help connect the patient to support in their life such as friends, family, or other organizations that work with activists. Ask them what they have done to cope in the past, and suggest they try using these measures again. If you know of support networks for activists or traumatized individuals, provide them with business cards or a means of contacting this additional care. Even something as simple as a left-leaning community kitchen where they can meet others may have some benefit.

Suggest and encourage positive coping. Your care may be brief, but the patient may need ongoing care. Some of this care can be done on their own, and you can encourage healthy coping strategies such as:

- Getting enough sleep
- Remembering to eat and drink enough water
- Staying connected with and talking to friends, family, and comrades
- Finding someone with whom they can talk about their trauma
- Spending time with their pets
- Continuing to engage in fun and relaxing activities like game night, reading, or seeing live music
- Exercising and spending time outdoors, even if it's as simple as walking around their neighborhood

Discharging your patient. You do not want your patient to feel abandoned. You may have to care for others, and if you need to leave

your patient temporarily, tell them so, and tell them you will be back. If you need to end care because they are leaving or you need to leave, ensure they have been connected to someone or another group that can continue to care for them. This connection should not be vague and abstract, but concrete. Introduce them to someone, and ensure that the next provider is aware that you are transferring care. Of course, no such provider may be available, and you do not have unlimited time to spend with each patient. You may not be able to give a proper hand-off, and you may have to attend to your own needs. Do what you can to make the termination of care not feel abrupt.

8.3 Summary

As it has been repeated, one of the ways a medic can help heal patients is by being a beacon of calm amidst chaos and panic. This calm can be used for organizing other medics and guiding treatment. Furthermore, it is a critical component of psychological first aid. Remember that calmness and composure do not mean that a medic needs to be stoic and lacking in outward compassion. PFA involves making the patient feel safe and calm, attending to their basic needs, avoiding retraumatizing them, and connecting them to additional means of care. Help the patient come up with a short-term plan they can act on to help them restore their autonomy.

9 Minor Ailments

The government is not giving anything, and even with the protests pressuring them, they have yet to come up with anything in terms of any kind of program to prevent further atrocities against Black people.

Lorenzo Kom'boa Ervin²⁰

Many of the injuries and illness you encounter are trivial to care for and are covered by basic first aid. Some of the less trivial injuries and illness are covered here.

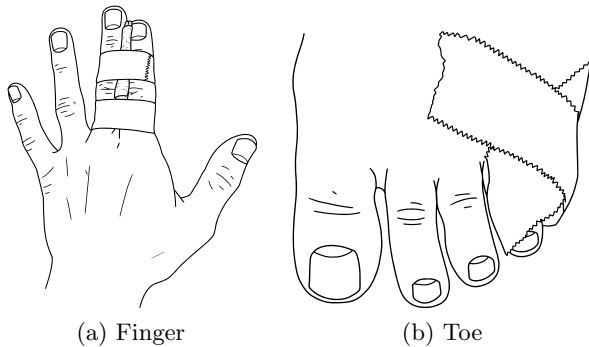
9.1 Fractures and Dislocations

Treatment for fractures is to splint the joints above and below the fracture. Treatment for dislocations is to splint the bones above and below the joint.

Fingers. Fingers can be splinted individually using commercial or improvised splints. Another technique is buddy taping where the injured finger is taped to an adjacent finger for support (Figure 9a). When buddy taping, place gauze between the fingers to prevent chaffing and maceration.

Toes. Toes are buddy taped in much the same way fingers are (Figure 9b). Additionally, use a long strip to tape the toes to the top of the foot to provide support. This is especially important if the pinky toe is injured. Because the toes are small, you may need to cut your strips of tape in half lengthwise.

Figure 9: Buddy Taping⁷



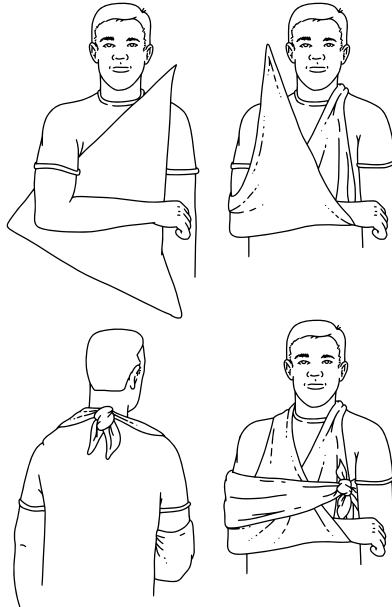
Hand. Injuries to the hand that are not limited to the fingers require splinting the wrist. Splint the hand in the position of function. This is slightly open as when the hand hangs freely when at one's side.

Arm and shoulder. Slings and swathing is used to immobilize the arm and shoulder (Figure 10). This is particularly useful for clavicle fractures.

Sling. A sling can be made using a triangle bandage. Hold the triangle bandage up to their chest so that the longest side is vertical and opposite the side with the fracture. Have the patient place their hand on their breast. Pull the top corner around the back of their neck and tie it to the bottom corner. The third corner should be approximately at their elbow with enough extra material to make a flap. This flap will cup their elbow and prevent their arm from sliding out of the sling. Fold this flap around their elbow and use safety pins to secure the flap. Alternatively, use a long strip of duct tape to secure the flap.

Swathe. Use a second triangle bandage, strips of cloth, or webbing to secure the arm to the patient's torso. Injuries to the elbow may make it impossible to sling and swathe, so you may need to improvise immobilization.

Figure 10: Sling and Swathe⁷



9.2 Strains and Sprains

Strains, sprains, and tendinitis are damage to muscle, ligaments, and tendons from trauma or overuse. Soft tissue may become inflamed, stretched, or torn. Field treatment for athletic injuries is to immobilize, facilitate healing, avoid further injury, and manage the pain. Patients should be sent home even for minor injuries as they can become dangerous if the situation escalates.

Consider wrapping and splinting. If you cannot differentiate an athletic injury from a fracture or dislocation, assume the worst and immobilize it. Sprains that lead to an unstable joint, strains that lead to significant loss of function, or injuries with severe pain likely require advanced medical care.

Body parts can be wrapped to provide stability during evacuation

and to protect them from further injury. Wrapping can also help with tendinitis. For example, wrapping a wrist can help minimize forearm tendinitis.

Consider use of NSAIDs. Use of NSAIDs can help reduce pain and swelling.

Use the PRICE method. For the first 24 to 48 hours after injury, use the PRICE method to minimize pain and swelling.

Table 7: PRICE Method

P	Protection
R	Rest
I	Ice
C	Compression
E	Elevation

Protection. The injured joint or muscle needs to be immobilized or padded to prevent from further injury.

Rest. The patient needs to rest which means leaving the action. For aftercare, a rule of thumb is that a patient should rest the injured body part until they can do simple activities without pain.

Ice. Ice helps minimize swelling. Ice can be applied for a maximum of 20 minutes per hour, allowing the injury to warm naturally between applications. A towel or bandages should be placed between the ice and the skin.

Compression. Use of an elastic bandage for compression helps reduce edema and provides some immobilization.

Elevation. Elevating an injured limb above the heart helps reduce edema and associated pain.

Use the No HARM method. For the first 72 hours, us the No HARM method to avoid further injury.

Table 8: No HARM Method

H	Heat
A	Alcohol
R	Re-injury
M	Massage

No heat. Application of hot packs or submersion in a hot bath should be avoided.

No alcohol. Consuming alcohol can increase blood flow leading to increased swelling. More importantly, it can decrease sensitivity to the injury leading to aggravation of the injury.

No re-injury. Related to resting, engaging in activities that could re-injure the body part should be avoided.

No massage. Avoid massages as they may cause additional tissue damage.

Consider evacuation. Resting and avoiding re-injury may mean that patients need to leave the action. Their injuries may prevent them from running from danger or fighting to protect themselves.

Recommend light exercise. After the first 24 to 48 hours, light exercise helps promote healing. Ideally, the patient should seek physiotherapy, but in the absence of that, a general rule is to do light exercises that promote strength in affected body part. Recommend this to the patient.

Wrapping Techniques

A wrap should be snug (but not tight), provide support, and somewhat immobilize the joint. All wraps should be done with an elastic bandage or self-adhering bandage.

Wrapping an Ankle. When wrapping an ankle (Figure 11a), the foot should be at a 90 degree angle to the leg. Start the wrap on the bridge of the foot, then make figure 8's around the ankle. Finish the wrap by wrapping around the Achilles tendon.

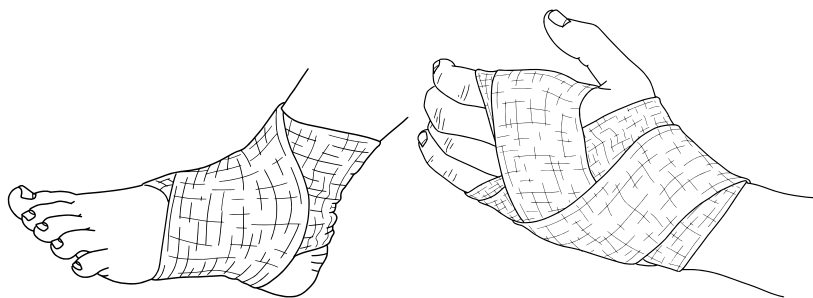
Wrapping a Wrist. When wrapping a wrist (Figure 11b), the hand should be open, the fingers spread, and the wrist in line with the forearm. Start the wrap on the forearm, then make diagonal wraps up the hand. One wrap should fully wrap the palm of the hand to serve as an anchor. Make additional diagonal wraps back toward the wrist. Finish by securing the wrap on the wrist.

Wrapping a Knee. When wrapping a knee (Figure 11c), all wraps should be as close to the joint as possible. Because of the tapered shape of the quadriceps and calf muscles, wraps that are too far from the joint will slide back toward the joint and become loose. Start the wrap above the knee making two circles to act as an anchor. Make a diagonal wrap, crossing between the upper and lower leg on the back of the knee.

9.3 Protester's Malaise

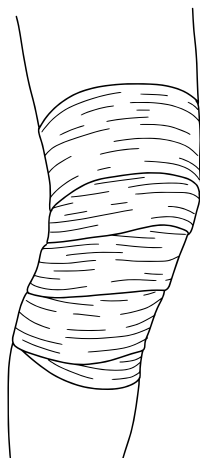
A common illness you may see is something I've dubbed "protester's malaise." It's a non-specific set of symptoms that result from dehydration,

Figure 11: Wrapping Joints⁷



(a) Ankle Wrap

(b) Wrist Wrap



(c) Knee Wrap

mild intoxication, and under-eating (hypoglycemia). It's often exacerbated by heat, especially during the first hot protests of spring or summer. This malaise tends to affect younger people, generally under 25, and is the result of simply not taking care of one's self. Hours of marching or rioting without refueling leads to symptoms including: a general feeling of unwellness, lethargy, disorientation, nausea, and vomiting.

Treatment for this sort of generalize malaise is to move the person somewhere warm (on cold days) or cool (on hot days), give them a small amount of water, and dextrose tablets. If you have a BG monitor, check their BG and diabetic status before giving them dextrose. Have them drink slowly so they don't vomit. Suggest they eat a sugary meal and drink more water after you leave, or suggest they just go home for the day.

10 Wounds

Without a doubt, patriotism and militarism constitute the foundation upon which the imperialism practiced by the great powers of the present day rests.

Shūsui Kōtoku and Uchimura Kanzō,
Imperialism

Basic wound management is to clean, irrigate, and dress the wound. This is hard to do wrong, so this section only covers slightly more complex wounds that may go beyond your normal experiences.

10.1 Controlling Bleeding

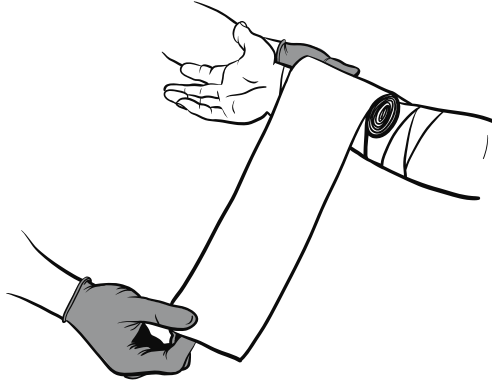
Direct pressure is the primary method of controlling bleeding. Large wounds may need to be packed with gauze before applying pressure. Abdominal wounds or wounds with obvious arterial bleeding should be packed with hemostatic gauze.¹

For wounds to extremities, create a pressure dressing (Figure 12) by placing a bulky dressing (a thick gauze pad or a rolled up gauze roll) directly over the wound. Use a gauze roll or folded triangle bandage wrapped around the extremity to secure the bulky dressing in place. Ensure that when wrapping the extremity, the bulky dressing is fully

¹Hemostatic granules are harder to use.

covered so it cannot slip out. Tie a knot directly over the wound. Check the patient's CSM to ensure adequate perfusion.

Figure 12: Pressure Dressing²¹

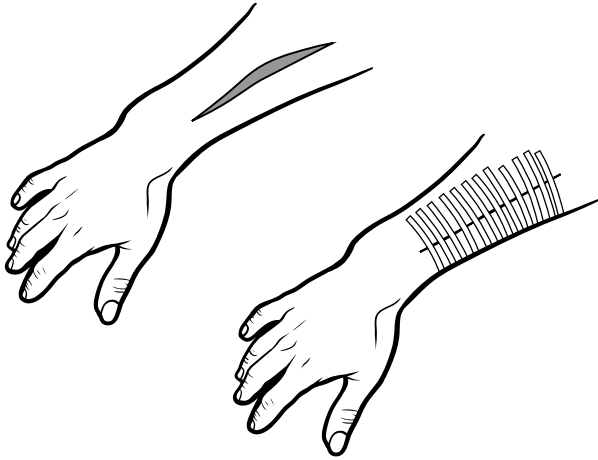


If pressure dressings are insufficient, use of a tourniquet is recommended. Early use of tourniquets is associated with improved survival rates with minimal risk.²²⁻²⁴ These should still be used as a last resort as once they are applied, they should remain in place until the patient reaches definitive care due to risk of rhabdomyolysis and renal failure. Applying a tourniquet may force a patient to go to the hospital, and if there is significant repression, this can lead to them getting imprisoned or disappeared.

10.2 Wound Closure

Patients may not be able to go to a hospital either on financial grounds or due to repression. Carrying wound closure strips allows you to close wounds in the field that would otherwise be left open.

To apply wound closure strips, first clean and dry the area surrounding the wound. Remove one strip from the package and press it on to the skin on one half of the wound. Using your other hand, pinch the wound together to close it, then press the remaining half of the strip against the skin on the other side of the wound. Every 3 mm, repeat this process to fully close the wound. Optionally, after closing the wound, place additional strips parallel to the wound to reduce tension. If possible, cover with Tegaderm or similar transparent film dressing; this will help secure the wound closure strips in place, while still allowing visual inspection of the wound.

Figure 13: Wound Closure Strip Application²¹

10.3 Open Abdominal Wounds

Treatment is to first control the bleeding. Do not remove objects protruding from the wound or organs. Do not remove clothing that is stuck to the organs. Cut the rest of the clothing away leaving the clothing in contact with the organ in place. Use plain or hemostatic gauze to stop any bleeding.

Once bleeding is controlled, do not attempt to put the organs back into the body. If you must handle the organs, do so very gently. Cover the organs with gauze moistened with saline or water.

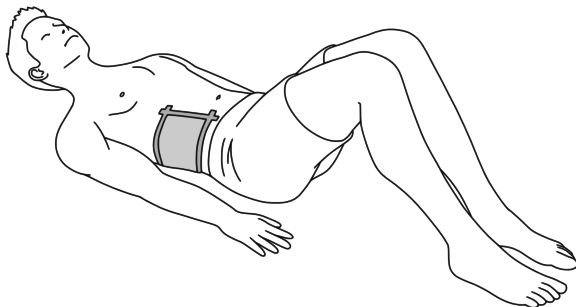
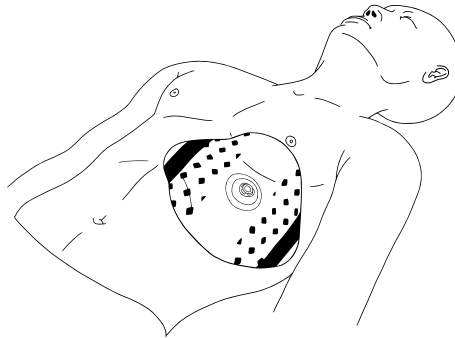
Figure 14: Open Abdominal Wound⁷

Figure 15: Application of a Vented Chest Seal⁷



To reduce tension on the abdomen, place the patient's feet towards their pelvis so their knees are elevated (Figure 14). Treat for shock. Evacuate the patient to advanced medical care.

10.4 Chest Wounds

Chest wounds can cause pneumothoraces. Application of a vented chest seal can prevent air from entering while allowing air to exit. This can help prevent a tension pneumothorax. Note that a vented chest seal is specified. A non-vented chest seal can trap air in the pleural space either causing or exacerbating a tension pneumothorax.

Commercial vented chest seal. Commercial chest seals use extremely sticky adhesive that adheres to wet skin. Be cautious of letting the seal come in contact with itself or your gloves.

Use trauma shears to cut away the patient's clothing. Attempt to use gauze to dry to the skin around the wound to maximize adhesion between the skin and the chest seal. Remove the seal from its packaging. Place the vent directly over the wound (Figure 15). If there is both an entrance and exit wound, place the vented seal on the anterior wound to allow it to vent. The posterior wound may use a non-vented chest seal so long as a vented seal was used on the anterior wound. Press the seal tight against the skin to ensure an airtight seal.

Improvised occlusive dressing. An occlusive dressing can be improvised. Use a square piece of a plastic bag to cover the wound. Tape down three of the four sides to allow air to escape.

10.5 Dog Bites

Police may have canine detachments with attack dogs that are used to intimidate protesters and subdue individuals for arrest. Dogs are often trained to bite once and hold, but individuals may have multiple bites. Dog bites can lead to puncture wounds, lacerations, crushed bones, and damaged muscles, tendons, and nerves. The bacteria in a dog's mouth can lead to infection including MRSA.

Treatment for dog bites similar to that of other lacerations or puncture wounds. Wounds should be cleaned with water and a mild antibacterial soap then thoroughly irrigated. A difference to other wounds is that not all bite wounds should not be initially closed.²⁵ Bites that are appropriate to close are lacerations on the face and scalp, wounds that do not extend into subcutaneous tissue, wounds with simple characteristics, wounds without underlying fracture.²⁶ Additionally, wounds should not be closed in immunocompromised patients.

10.6 Handcuff Injuries

Handcuff neuropathy is neuropathy of the hand caused by compression of the superficial branch of the radial nerve. This is the most commonly affected nerve, but other nerves of the wrist may be affected.²⁷ Handcuffs may become over tightened during struggle or as a means of control. Metal handcuffs come with a double-locking mechanism to prevent additional tightening after they have been locked, but police may forget or “forget” to do this. Plastic handcuffs are often used for mass arrest. Some models lack double-locking mechanisms which allow additional tightening.

Signs and Symptoms. Signs and symptoms of handcuff neuropathy include tingling or numbness (parathesia) and weakness.

Treatment. Remove watches, jewelry, or anything else that may constrict the patient's wrist. It is unclear if edema contributes to handcuff neuropathy or if it is caused by compression alone,²⁸ and as such NSAIDs are commonly prescribed. Consider administering NSAIDs. Apply cold compresses to reduce pain and swelling. The patient may need follow up from a physician, and symptoms may persist for months regardless.

11 Riot Control Agents

May we meet one day in a world
without tear gas, in which skin color is
not a weapon.

CrimethInc., *What They Mean When
They Say Peace*

In layperson's terms, riot control agents (RCA) are tear gas and pepper spray. Because of how widely deployed they are, and the frustration at dealing with them, there are endless myths about these weapons from their mechanism of action to how to deal with contamination. This section covers the basics of riot control agents, their treatments, and the urban legends themselves. Protection against RCAs is covered in Section 5 ("Equipment").

11.1 Basics

RCAs are lachrymators: they are agents that cause tear production in the eyes and otherwise irritate mucous membranes. Generally, when someone says tear gas, they mean an RCA that is aerosolized into a cloud and deployed over a large area. When they say pepper spray, they mean an RCA that is sprayed in a liquid form over a relatively short distance. Most often, tear gas is CS gas and pepper spray is either oleoresin capsicum (OC) or PAVA suspended in a solvent. There are some cases of DM gas being used which is an emetic agent (something that causes vomiting), and police or fascists may deploy other chemicals such as HC smoke (hexachloroethane) or pesticides outside their intended use as a means to cause discomfort and illness in protesters.

Table 9: Common RCAs

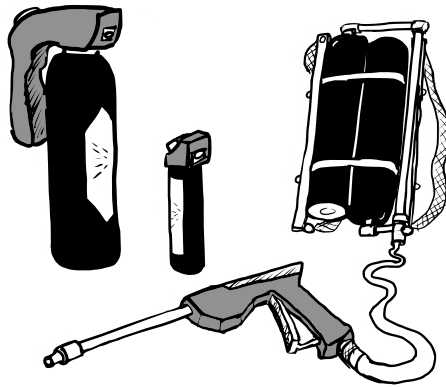
OC	oleoresin capsicum
PAVA	pelargonic acid vanillylamide
CS	2-chlorobenzalmalonitrile
CN	phenacyl chloride, chloroacetophenone
CR	dibenzoxazepine
DM	diphenylaminechlorarsine

Tear gas is not a gas, and in some regions it is more aptly named tear smoke. RCAs are deployed by aerosolizing the compounds. This can be

done by creating a micro-powder, dissolving it in a solvent, or simply burning it.

Tear gas is often deployed via a 40 mm launcher that typically releases multiple projectiles or via grenades that explode or burn and release the agent. Pepper spray is often deployed at close range using handheld devices. Police may also use large backpacks to soak protesters with large amounts of RCA. Water cannons may mix RCAs in their streams to allow even larger scale deployment.

Figure 16: Pepper Spray Delivery Devices¹



11.2 Signs and Symptoms

Symptoms of exposure to all tear gasses (CS, CR, CN) are generally similar. Under low concentrations, tear gas causes a burning sensation in mucous membranes, especially the eyes. Other effects are tearing of the eyes, increased nasal mucus production, and coughing. Moderate concentrations and longer exposure lead to profuse coughing, blepharospasm (involuntary closing of the eyelid), increased salivation, difficulty breathing (dyspnea), prostration (doubling over), burning and stinging sensations on the skin, disorientation, dizziness, syncope (fainting), headache, tachycardia, and vomiting. Heavy concentrations, especially in enclosed spaces, can lead to death by asphyxiation or pulmonary edema. Patients with preexisting respiratory disorders such as asthma are more sensitive to tear gas and exposure to even small quantities can be life-threatening.

Effects of pepper spray (OC, PAVA) are a burning like pain on the skin with severe pain in mucous membranes of the eyes, nose, throat, and lungs as well as increased nasal mucus production. Even a small

amount of pepper spray in the eyes causes blepharospasm. Inhalation of pepper spray or residual vapors from contaminant on the face can cause coughing leading to prostration. The most painful and severe effects of pepper spray typically abate in 15 to 30 minutes without treatment, though lingering eye watering and a sensation of burning of the skin may remain for 24 hours. Like with tear gas, patients with preexisting respiratory disorders may have life-threatening closing of their airway.

It should also be noted that handheld devices do not necessarily contain OC or PAVA. Either may be blended with other RCAs like CS, or the handheld device may only be CS. Because of this, some of the debilitating effects associated with these chemicals such as dizziness and disorientation may be present. Anecdotal evidence from patients suggests that they believe these debilitating effects are because of the “strength” and “spiciness” of the OC spray and the not addition of other RCAs.

11.3 Treatment

Treatment for all RCA contamination is generally similar and involves flushing the affected body parts with large amounts of water or saline to remove the agent. During decontamination, prevent runoff from spreading the RCA to other parts of the patient’s body or your body, especially mucous membranes or open wounds as this runoff can cause additional irritation.

Both syncope and vomiting are symptoms of exposure to tear gas. Together these can lead to pulmonary aspiration followed by death via asphyxiation. You should be on the lookout for patients who appear to be unresponsive when tear gas is deployed.

Remove the patient from the RCA. If tear gas is used, the air may be noxious for many minutes. Attempt to move the patient upwind from clouds of tear gas. Tear gas is heavier than air, so if possible, move your patient to higher ground.

Prevent the patient from touching the affected area. A patient’s instinct will be to rub the affected body part, especially the eyes and face, while contaminated and after decontamination. This can make the contamination worse and spread it to other body parts. When RCAs are deployed, no one should touch their eyes at all except to remove contact lenses.

Remove contact lenses. If the patient has RCA on their face or eyes, they should remove their contact lenses. Flushing the eyes can push contact lenses up into the eye socket. Ask your patient if they are wearing contact lenses, and if so, direct the patient to remove them

before treatment. If the patient cannot open their eyes or is incapable of removing the contacts, you may need to flush their eyes until they can open them to remove the contacts.

Clean contact lenses. Some patients will attempt to save their contact lenses and reinsert them after you have decontaminated their eyes. You should suggest they dispose of them immediately. They may put the contacts due to impairment or other reasons, and your job is to help minimize recontamination and associated pain. After treatment, assist the patient with cleaning their lenses. Have them wash their hands using the solution from your bottle. Then, have them rub their contacts together between their finger and thumb as your slowly stream water onto the lenses for at least 30 seconds. After they put their lenses back in their eyes, you may need to help them gently flush out residual RCA.

Remove contaminated clothing. For heavy contamination, they may need to remove their clothes to prevent continued irritation. Masks and bandanas need to be removed before decontaminating the face, but other clothing can be removed after.

Decontaminate the body part. Flush the body part with large amounts of water. Specifics techniques for decontaminating the eyes are covered later in this section. Because pepper spray is oily, it may be useful to gently dab or wipe the affected area with gauze to remove the bulk of the pepper spray. Vigorously rubbing and scrubbing will exacerbate the pain.

Rinse the patient's mouth. Patients should rinse their mouth with water or saline to remove the RCA. Even in the absence of burning or irritating sensations in the mouth, a mouth rinse is encouraged as it helps remove the taste and it helps them feel cleansed.

Allow coughing and sneezing. If your patient is coughing or sneezing, allow them to continue as this is the body's natural response and it will help remove the RCA. Give your patient tissue or gauze, and have them blow their nose.

Consider use of an inhaler. If your patient is asthmatic, remind them to use their inhaler. You may want to carry a salbutamol inhaler in your kit in the event patients have lost or forgotten theirs.

Consider treating for hypothermia. Patients may remove contaminated clothing, and clothing may be wet from treatment. On cool or breezy days, this can contribute to hypothermia. Consider wrapping the patient in an emergency blanket so they do not have to put back on their contaminated clothes.

Consider other complications. Patients may develop delayed

respiratory distress or hyperventilation, or they may go into shock as their adrenaline wears off. Consider treating them for respiratory distress.

Instruct the patient on how to decontaminate at home. When you discharge the patient, direct them on how to safely decontaminate when they get home.

Clothing should be removed before entering their home. Tear gas residue, especially CR, should be vacuumed off clothing and the body before entering the home. The patient should throw out the vacuum bag after use to prevent spreading tear gas.

Clothing should be washed separately from other items, twice, and with a harsh detergent. If clothing cannot be immediately washed, direct them to put it into a sealed plastic bag until they can wash it.

The patient should shower in a well ventilated room using the coldest water possible for at least 20 minutes. Warm water opens pores and may cause additional burning sensations, so patients should shower with the coldest water they can tolerate until the feeling of burning stops. Likewise, scrubbing affected areas should be avoided until burning stops.

11.4 Eyewash Techniques

For flushing the eyes, use a pneumatic eyewash bottle, contact solution bottle, or water bottle filled with water or saline.¹ The patient should tilt their head forward to prevent pepper spray from running into an uncontaminated eye, the nose or mouth, or down their torso. Whatever bottle you use, it should be held 2 to 3 cm from the patient's eye.

The main difficulty with flushing the eyes is keeping them open either due to blepharospasm or the reaction to having water sprayed in them. Always manually open their eyes with your fingers (Figure 17a), though some may know to do this themselves.

When flushing the patient's eyes, have the patient tilt their head forward (Figure 18). Spray water or saline directly into their eyes one at a time. Spray directly into their eye while directing the stream over the entire eye in small sweeping motions. Each spray should only last 1 to 2 seconds. Repeat as necessary.

¹Use of spray bottles, the type used for cleaning windows or misting plants, is not recommended. In general, they do not allow the medic to spray a sufficiently high volume of water. They are relatively ineffective on the mist setting, and the stream setting will usually startle the patient into closing their eyes. Controlling the pressure of a stream from a spray bottle is difficult, and excessive spray pressure can damage the eye.

Figure 17: Opening a Patient's Eye⁷

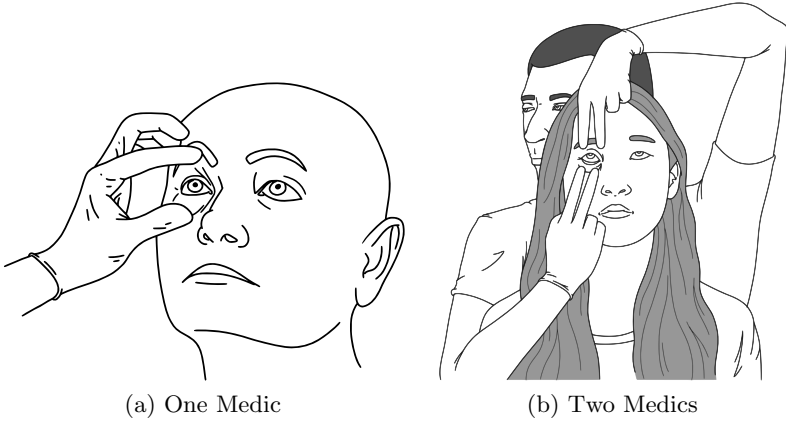


Figure 18: Decontamination with a Pneumatic Bottle⁷



11.5 Multiple Patients and BSI

A difficult aspect of treating patients who have been contaminated with RCA is that RCA contaminations, especially with tear gas, are short lived mass casualty incidents (MCI). You may be rapidly overwhelmed with patients, and you will need to triage patients. Patients who initially seem fine may degrade into respiratory distress or shock if they suffer an allergic reaction or their adrenaline wears off.

When treating multiple patients, as in all MCI situations, you need to direct all patients to come to you so you can monitor the status of all your patients simultaneously. Find somewhere relatively safe to treat everyone where patients will not be trampled by a crowd or police charge. This may simply be backing against the wall of a building or sitting patients on a planter.

If you are working with multiple medics, split responsibilities so that some medics treat RCA contaminations and some treat traumatic injuries. To speed up treatment and prevent yourself from exhausting your supply of gloves, BSI best practices can be somewhat relaxed. If patients are not bleeding and your gloves have not come into contact with their saliva or nasal mucus, you may reuse gloves between patients.

When treating multiple patients with RCA contamination, you may want to consider partially treating all patients first before making a second pass and doing a full decontamination. Doing this allows you to triage patients and assess whether anyone needs additional interventions. It is also beneficial to start with patients who have RCA in their eyes before moving to patients with RCA on their torso and extremities.

Doing an initial treatment on everyone before doing full decontaminations also reduces the total amount of panic in the group. A partial rinse of the eyes may not stop the immediate feeling of burning, but it will reduce their pain levels, allow them to open their eyes some, and allow natural tear production to help flush out RCA. Most importantly, partial treatment is comforting by showing that someone is there to care for them.

When you move to treat a new patient, make sure you clearly communicate that you are moving to the next patient and will be back. This is especially true in panicked or blinded patients. You do not want them to feel abandoned.

11.6 Urban Legends

Of all the topics within riot medicine, treatment for RCAs seems to be the most rife with misinformation and urban legends. While commonly used

as remedies for RCA contamination, none of the following should be used: liquid antacid and water (LAW), cow's milk, oil, citrus (lemon or lime), vinegar,ⁱⁱ lidocaine, hydrogen peroxide, baking soda paste, toothpaste, and onion. None of these show any efficacy for reducing pain, and in particular use of LAW can be dangerous. Liquid antacid is not a liquid but a suspension of powdered antacid, and this grit can damage the patient's corneas. Only use water or saline.

11.7 Secondary Injuries

Shooting munitions at crowds and throwing burning or exploding grenades leads to secondary injuries. Munitions can break bones, and if they're shot at head level, they can kill protesters. Exploding tear gas cannisters can cause acoustic trauma and bits of shrapnel can cause other trauma. Burning cannisters can cause full-thickness burns if they lodge in loose clothing. The pressure from point-blank use of pepper spray can cause trauma to the eye. Panicked crowds may run and trample each other. Be aware of secondary injuries when RCAs are deployed.

11.8 Summary

Treatment of RCAs is simple: flush the affected area with water or saline until the burning has mostly subsided. Be wary of hypothermia after decontamination or respiratory complications from the RCAs themselves.

12 Afterword

Attach yourself to what you feel to be true. Begin there.

The Invisible Committee, *The Coming Insurrection*

Hopefully by reading this you feel more prepared to move out of a clinical setting and into protests to apply the skills you've developed as a medical professional. If you want more information on the topics of organizing, the specifics of medicine at riots, and tactics, you may want to read the full *Riot Medicine* book. For a quick reference with just the most relevant signs, symptoms, and treatments, the *Riot Medicine: Field Guide* has information on kinds of conditions you might not see in your day to day work. Other street medic resources exist online and as zines in radical

ⁱⁱProtesters and medics favor apple cider vinegar in particular. It is equally as useless as all other vinegars.

bookshops, and these can be helpful for tactics or understanding the ideas of street medicine, but unfortunately many of them recommend pseudoscientific and outdated treatments. Use caution.

Riot Medicine itself was significantly influenced by *NOLS Wilderness Medicine* by Tom Schimelpfenig, and I still highly recommend it. Useful and accessible resources for understanding psychological care are *A Clinical Guide to the Treatment of the Human Stress Response* by George S. Everly Jr. and Jeffrey M. Lating, *Mutual Aid, Trauma, & Resiliency* by the Jane Addams Collective, and *Trauma and Recovery* by Judith Herman. The specifics of injuries from firearms and riot control weapons are covered respectively in *Clinical Update: Gunshot Wound Ballistics* by Craig S. Bartlett and *'Non-Lethal' Weapons* by Neil Davison.

If any of the anti-authoritarian messages in this text spoke to you, or if you're merely curious about these topics, you can read more about modern anarchism theory and praxis in *Anarchy Works* by Peter Genderloos. Maybe you want the quick and dirty to just answer a few questions, in which case browsing through *An Anarchist FAQ* hosted on The Anarchist Library might be more up your alley. That said, anarchism and revolution are not about merely having the "right" ideas; they are very much about living the ideals of liberation and autonomy. Take to the streets, and talk to others. Have an open mind, and learn by doing. Become the revolution.

We'll see you on the barricades.

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