The Principles of Action Medical Patient Care

By Brian Dominick

Improving the quality of care action medics provide to our comrades is already a primary objective of the action medical community. Lots of refreshing and vital discussions with regard to analysis and betterment of our care standards, especially treatment protocols, is surfacing in action medical circles.

This document is an opinion, written by one street medic, with the intention of providing some elementary insight into the broader standards we use to evaluate the quality of action medical health care provision and organizing. This is not intended as a directive of any kind, nor does it necessarily reflect the collective stance of any particular group. I present it for discussion, ridicule, and adaptation*, and invite comments or critiques from action medics everywhere.

First, Do No Harm

In the end, there is nothing more important to the action medical community than our reputation. Our ability to do good when we are most needed is tied to our never having done harm. Confidence in us as an integral part of social movements is vital to our participation in those movements. So from the beginning, we must emphasize clear understandings of our own limitations as health care providers, and a distinct ability to operate within those limitations during instances of patient care.

Sometimes, compliance with this principle will seem impossible. The feeling of helplessness or "impotence" in the face of dire need may be overwhelming. For this reason, we need to always remember that our mere presence is an invaluable contribution in medical emergencies. We are always, and sometimes uniquely, capable of (1) obtaining advanced care for a sick or injured person, (2) securing a scene and preventing further injury or mistreatment by others without the skill to properly care for a given patient, and (3) providing a reassuring presence to help calm and stabilize our patient — not to mention the patient's friends or other onlookers. We are never without the ability to do something, provided we do no harm.

Treating Anyone In Need

Easily the most controversial principle upheld by street medics and street clinicians is the standard of treating any person who is sick or injured, including those we might consider adversaries. For affinity group medics, this is a standard to be discussed within one's own collective, since their primary obligation is to their organization.

For street medics and clinicians, our first obligation is to one another. The overwhelming ethical opinion on this issue, at least among medics fulfilling those two roles, is presently in favor of treating anyone in need, regardless of who they are. Therefore, if we are working in teams or collectives where that's the opinion, those who disagree with it need to make an ethical choice (privately if necessary) and stick by it. That choice is to abide by the principle of treating anyone in need, or to leave the collective. Medics should never disrespect or scorn those who make the latter choice, itself a demonstration of that medic's respect for other medics.

The most common complication with this principle comes into play when we consider situations where medics might be called on to treat police officers (or other armed agents of the state) or extremist Right Wing "counter-demonstrators." Our various perspectives on these issues need to be respected, but our conclusion vis-à-vis how we, as medics, will function in the streets and clinics must be collective and consistent.

Some may find comfort in a couple of caveats regarding this principle. The first is that a medic is only responsible for providing patient care when doing so will not place the medic at risk of injury or arrest. Clearly, most treatment of injured police or other violent extremists will compromise the medic's safety. But in cases where the medic's safety is convincingly guaranteed, the principle is in effect, and the ethical dilemma stays at home.

Additionally, the principle of First, Do No Harm is also in effect, and it may override the principle of Treating Anyone in Need. In cases where (1) the injury in question is very obviously not severe, (2) the injured person presents a clear history and intent of causing immediate, physical harm to others ("Treat my eyes so I can go kick some more hippies' asses!"), and (3) restraint of the patient is illegal and/or impractical, treatment may constitute a violation of others' health and safety.

The strongest argument behind the principle of treating anyone in need is the action medical community's image as non-threatening to those who might otherwise choose to target us. This image must have substance if it is to stand any chance of holding up under analysis by the adversaries of the broader social movement.

This principle will no doubt remain under scrutiny among action medical practitioners. If the philosophical and ethical foundations of it are at some time swayed, or if its perceived value with regard to our ability to present action medical as "neutral" vis-à-vis treatment standards is eroded, this principle may change. An open, on-going and democratic dialog is imperative to our understanding of and confidence in this principle.

Treating Patients as Comrades

In nearly all cases, those we are called on to treat are not just "patients." They are, in fact, our comrades – indeed, our heroes. In some cases an air of social professionalism is necessary for the mental comfort of our patient. In most cases, the patient's understanding that we aren't just first aiders, but that we are activists and comrades, is overwhelmingly important. Let us not forget why we are present, and let us make it evident to others that we are not politically neutral, and that we are struggling along side those engaged in more explicit protest.

Moreover, we should be constantly assessing our role in the building of social movements, thus developing collective understandings of what action medical is and means. We differ from traditional emergency medical services not only in our education process, equipment availability and treatment protocols. We are, indeed, a movement group, and unless we self-define as such, we will lose a good deal of our relevance, and perhaps our own understanding of our roles in the process of social change, as a collective and as individuals.

Prioritizing Care-giving According to Need (Triage)

We owe it to patients to give the best possible care to those in need. That much is obvious. What isn't always clear is how we go about prioritizing that care in the field, or in the clinic. Simply stated, triage should be performed by prioritizing treatment according to the severity of injury, modified in some cases by our ability to provide the necessary care.

Proper triage relies on a complete assessment of the scene of a multiple casualty incident – a survey initially carried out before treatment of any patients begins. Our natural response in multiple injury situations is to treat the victim closest to us, as soon as possible. Unfortunately, we have to recondition our responses to incorporate the likelihood of more serious injuries in the vicinity.

For those medics who lack the ability to evaluate the efficacy and necessity of certain treatments, the same principle applies. For instance, in cases where a spinal injury is suspected, but almost certainly not present, the default practice is to engage in C-spine immobilization protocol, without interruption or hesitation, regardless of other injuries which may be more certain, but not as severe, as the potential spinal injury.

In the most unfortunate (and rare) cases of critical injury, those of us without the ability to differentiate between patients with a chance of survival and those who are dead (or have sustained irreversibly fatal injuries), the assumption should always be that we treat the most severe injuries until advanced care arrives.

There is one caveat to this triage protocol: regardless of the number or quality of injuries presented, any debilitating injury to a fellow medic (partner or teammate) takes priority over any other injury present. Proper care of severe injuries requires skilled assistance and oversight, and the best treatment of multiple victims requires multiple medics. This modified standard has the added benefit of providing us with confidence in our own safety and security at the hands of our teammates.

Documentation, Debriefing, and Analysis

As with the recognized "medical professions," action medical strives to improve patient care by modifying treatment protocols to reflect field or clinical discoveries with regard to their safety and efficacy. All medics are able to contribute to this endeavor in an integral way. We inform those who help develop protocol standards by documenting the treatments we perform while on duty, especially in cases where new techniques are tried, where injuries treated are unusual or special in any way, or where treatment results were unexpected or somehow extraordinary. We commit to reporting even cases where we made mistakes or mistreated a patient, so that others might learn from our mistakes, and they can thus be prevented in the future.

Part of the documentation process is collective debriefing. We have a responsibility to share our experiences, our observations, and even our emotions with fellow medics. This builds trust, confidence, accountability and security among our movement.

Finally, those with the ability to analyze, evaluate and propose modifications to treatment protocols should involve themselves in doing so. The majority of action medics depend not just on our own experience in using accepted protocols, but also on the specialized knowledge and experience of those who can critique and develop those protocols given the information at hand.

Honest Evaluation of Ourselves and Fellow Medics

If it is true that improvement of our methods can only come about as a result of analysis, so too must it be the case that evaluation is essential to improvement of ourselves as medics. Peer evaluation should be considered a shared process, and all medics should be considered peers. The greenest of medics-in-training might have something invaluable to offer the most seasoned medics around, and this truism should be recognized, respected, embraced and fostered.

Debriefings, periods between actions, trainings, and even moments of calm in the field should all be considered appropriate times for asking questions, raising concerns, or offering advice. As long as these discussions are raised in a respectful and non-authoritarian manner, there is no reason any medic should take offense at them – instead, we should welcome them as opportunities to either clarify a misunderstanding, or learn something that might improve our abilities or increase our knowledge.

Constantly Striving to Improve Our Skills

A medic's skills, wisdom and abilities will never stagnate as long as we exercise and challenge them in clinical education and street application. Medics have two obligations, perhaps not as distinct from one another as they may seem presented here. First, we should always seek to expand and refresh our knowledge through a variety of trainings in various settings, including non-action medical first aid/health care and non-traditional healing. Second, we need to teach what we know, within our abilities; when we are confident in our knowledge, we have to begin sharing it.

Our collective growth as action medical is intertwined with our ability to grow as individuals, so the contribution is always bilateral. And in times of such overwhelming, violent adversity, the growth of social change movements is intimately wed to that of action medical.