EMS

EARN MONEY SLEEPING

SEMON STROBOS

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Old medic joke about 24 hour shifts:

“You know what EMS stands for?”

“emergency medical……something?”

“No: Earn money sleeping

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1

The first full arrest I ran—full cardiac arrest—was at 2 AM in the morning, after 18 hours of running calls. We were “getting hammered,” as EMTs call it. We work 24/48: 24 hours on, 48 off, seven days a week, 365 days a year, excluding our two week vacation. Among many superstitions—anything serious that can’t be controlled breeds superstitions—medics believe they are either white clouds or shit magnets. When my new partner, Trish, the EMT Basic who assists me (the paramedic), asked me which I was, I didn’t know what to say. I didn’t endorse the superstition, but in all honesty I hadn’t been visited with many ugly calls, which is why I took the busier post where she worked. Sitting around waiting for something awful to happen isn’t nearly as much fun as immersion. Waiting is scarier.

“White sheep, I guess,” I’d allowed.

Trish was pleased. The longer your tenure, the less shit you’re in the mood for. Though the big ones still get your attention.

So when the tones went off for the 10th time, she awoke and said, “White sheep, my ass. You’re fired.” Trish used to be a long haul trucker so she drives like a bat on PCP. I had to ask her to slow down, owing to being in fear of my life, screaming a two lane country road “riding the governor” which caps the rig at 92 mph so it won’t burn out its engine.

The tones, and the radio “traffic” in general, I consider to be among the most romantic aspects of an obviously romantic profession. We live with the radio. It’s never out of earshot. Awake or asleep, a medic hears his unit number called. The radio tells all of us, all on the same channel, where to go, what to expect, and we use it to call for rescue, get information, let Dispatch know where we are and what we’re doing at all times. We call “in route,” “on scene,” “transporting,” “destination” and “clear” on every call. It sends us out on calls or posts us to other locations, asks us our status, admonishes us to call in patient information. We ask it which hospitals are open, what the sheriff’s officers’ ETA is (even though they never say), ask for directions when it gets us lost.

When I was a kid there was a TV show called Highway Patrol which featured Broderick Crawford, a character actor who looked like a bulldog with a bad hangover. He was forever leaning with noir glamour on his “unit’ calling “ten codes” into his radio, usually “ten four.” 40 years later things haven’t changed a whit, and years after 9/11 we still can’t talk to law enforcement. Homeland Security never issued new radio channels. At that time, age 10, I had no desire to be a fireman or policeman, but I used to be more mature.

The emergency call goes like this. “WeeOweeOweeO….Medic 203 prepare to copy emergency traffic, map grid 714 Fox 3, 714 Fox 3” referring to the square on our map.

We press our button and say “203” or “Go ahead.”

“Medic 203, respond code 3 (lights and sirens, no matter what the chief complaint is: ‘you call, we haul’) to 2214 Smith Road, 2214 Smith Road, map grid 714 Fox 3, 714 Fox 3, for a 36 year old female, cardiac arrest. CPR in progress.”

“Copy. ETA ten or less.”

For a full arrest a backup unit is dispatched unless we cancel it, saying we have a three man crew (a student on board) or a first responder who can help. Transporting a full arrest requires at least three trained responders. So two flaming units cry and moan through the night racing different roads in the sleeping dark. (Siren tones are named “wail,” “yelp" and ”chatter.”) In the long dark night of the soul it’s always three o’clock in the morning. From dark wine and a thousand roses runs the hour rushing into the dream of night. And Scott Fitzgerald and Rilke were merely describing insomnia and love, not life and death.

We pulled up at a rundown little house on a dirt back road behind a flashing fire truck. I would’ve been icy with fear even if Trish had not been flying at ground level.

Wrenched out of uneasy sleep to fight death. Hoping to remember my algorithms, perform my interventions successfully and not make any horrible mistakes. Do no harm. Only my second intubation of a human patient. The first with no backer.

We’ve beaten the volunteer fireman first responders this time. I hop out, haul the cardiac monitor from the side door and trot in behind a fireman. On the filthy carpet in the living room a dark haired slight woman lies on her back straddled by a police officer doing chest compressions. I get the fireman to take over while squeezing the paddles to her chest, left midaxillary, and right under the collarbone. She does not show a shockable rhythm. She’s in asystole, a flat line indicating no electrical activity in her heart at all. The chances of bringing back a person found down in asystole are close to nil. Bringing her back with reasonably intact brain function is even less likely. 36 years old, no medical conditions, found by her husband within a half hour or less of last seen alive. Still, I do not see dependent lividity, the red or magenta or blue stains indicating blood has pooled and coagulated, and can no longer be circulated, so I follow the indicated algorithm, asystole.

By this time Trish has brought in the airway bag, pulled out the adult bag valve mask (BVM), put it together, attached it to oxygen and is supervising a fireman holding it to the patient’s nose and mouth, head tipped appropriately, and ventilating at 10 breaths a minute. Nowadays we do 5. Algorithms change. The other fireman is still compressing her chest at a rate of 100 times a minute, compressing a third to half down, deep and even pumps. We check the carotid for a good CPR pulse. After five minutes he will tire and need relief. A bodybuilder by the looks, he could go on longer, but not well. For the time being, the least trained caregiver is doing the most important job.

With my partner’s help, I pull out the intubation kit, select the middle sized curved blade, Mac 3. I slide the blade under the patient’s tongue with my left hand, lift, look for the vocal cords, slide in the endotracheal tube, stiffened by a wire stylette inserted by Trish, using my other hand. Then I pull out the stylette, hold the ET tube in place while she attaches the BVM. She ventilates and I listen over the lungs and stomach to make sure the tube is in the trachea and not the esophagus, watch for chest rise and fall, misting in the tube. Then we tie it down.

You can arrive at the hospital with a mangled patient, you can perpetrate spectacular fuckups and keep your job and license to practice, but arrive with a tube in the wrong hole, you’re looking for another livelihood. Almost as bad, the patient will be dead. And horribly bloated. Probably drenched in vomit.

At this point, the backup crew arrived, bringing with them hot steamy diesel air, dead leaves and, as it transpired, a nasty chaos. The other paramedic was a pompous melodramatic bald shaven dude, who, unfortunately, outranked me. He was a Field Training Officer, me just out of the plastic wrap. By protocol this was my call, as first paramedic on scene, but he could take it over if he felt I was making a mess.

It’s very difficult for a paramedic not to take over anything he possibly can. Marriages, whatever. Works quite well at emergency scenes and fairly miserably almost everywhere else.

Normal life comes to seem slow, boring, inconsequential. Your mind is back on shift. People are taking too long to make decisions. They’re dithering, vain, unfocussed, probably incompetent. Adrenalin and interventions required.

I’ve moved to the patient’s AC, the inner elbow, looking for a vein to cannulate. Jack, the other paramedic, is ordering drugs out, making a huge racket. His plan, which I overhear, is to shoot an ml of 1 to 1000 epinephrine down the ET tube. I know from my paramedic studies—I did very well on the national registry test—that this dosage can be used in infants under some circumstances, but the ET tube should take 2 or 3 ml of 1 to 10.000 epi. Fortunately I have by now got an IV started so we run it wide open and shoot 1 ml of 1 to 10.000 into my catheter instead, so the issue doesn’t arise. The ET tube is no longer used at all for meds, now that access is assured with intraosseus needles drilled into bone, but in those days we would try double doses in the ET tube if we couldn’t get a vein.

CPR is continuous. We put in 4 rounds of epi at five minute intervals. We alternate with two rounds of atropine for slow heart rates (0). We put in an amp of sodium bicarbonate for acidity. We check her blood sugar. Normal, so no dextrose. We check the cardiac rhythm a couple times. Still asystole. The other medic’s partner records every intervention, every test.

Trish, softhearted, is in the next room with the husband by now. He’s sobbing, distraught and irrational. If there could be anything worse than finding your young, you thought healthy, wife dead on the floor, it’s having a gang of firemen storm in and assault her defenseless body with blows and sharp instruments. I pay no attention to anything except my patient and my algorithm.

We pause, having done everything.

“What do you want to do next?” Jack asks. He’s been letting me run the call, which has been flawless so far. It was not a difficult arrest. Access to the patient was simple. She was an easy tube, with no vomit in her airway. She was an easy stick, a healthy young woman with good veins. I had all the trained help I could want.

“Well,” I said, “another round of epi and we call it.”

Trish told me later the firemen and everyone was shocked. Give up on such a young woman? With the husband beside himself?

One half hour of asystole, with every indicated intervention adequately performed, and no cardiac response whatsoever, means the patient is dead. The family can now say goodbye in their own home, without the alarums and excursions of emergency transport, the huge expense, the false hopes, the cold fluorescent hospital.

Jack overruled me. Which meant we had to put a cervical collar on our corpse so that the neck would not flex and dislodge my tube in route. We had to log roll her onto a backboard and tape blocks beside her head. We had to pick the board up and secure it to a stretcher. We had to load the stretcher onto an ambulance. We had to speed lights and sirens to a distant emergency room. We had to pretend we were doing adequate chest compressions during all this movement. We had to call the facility and tell them we were en route with a full arrest, CPR in progress. One medic drove, three in back continued to 1) ventilate the patient with the bag valve mask, 2) hang from the swaying monkey bar with one hand and try to do chest compressions with the other, and 3) keep shooting more epinephrine into my IV. The fact that none of this works very well compared to the relative order of the living room before Jack got there didn’t really matter since the patient was unsalvageable by now anyway.

Do do this at home, by the way. No special training required. No excuses. “I didn’t know CPR.” If you don’t particularly care for French kissing dead people, just leave out the part where you tip his head back and breathe two breaths into his mouth, while pinching his nose, after every 30 compressions. Just straddle the body, put the heel of your hand in the middle of his chest with the other hand on top and pump fluidly 100 times a minute, compressing the chest a third to half way. If you’re not into the female superior position, you can kneel beside the patient, but it will strain your lower back.

Jack really enjoyed this part. We rolled the stretcher into the ER with him standing on the footrail, pumping chest. After the MD had pronounced—who expected anything else?—Jack put both his hands up in the air. Some kind of benediction, I think.

“Stop!” the doc had said to his staff, thrashing in a feeding frenzy, freezing them dead in full flagrante delecti. “Look at the monitor. Does anyone see any kind of rhythm? (Pause) This patient is DEAD.” My sentiments exactly.

I’m probably as compassionate as the next guy, and my bedside manner really isn’t that bad, but I can easily imagine and rehearse reproaches about my icy heart. “Woo, that’s cold, man.” Plenty of people are nicer than I am, more helpful, more tactful, more sympathetic,

I’m motivated by professionalism. I want to do the job not just right but perfectly, and faster than anyone else can do it. 25 full arrests. 6 saves.

When I imagine someone reproaching me for lack of sympathy, my response to this imaginary inquisitor—it’s never happened in real life—is, “and how many lives have you saved?”

“Well, how many have you?”

“I don’t really know. About one a week for five years, depending on how you define it.”

Unfortunately I find a lot of this stuff funny. I spend a lot of time laughing with my partners. Maybe it’s what keeps us sane, but I think it’s the exhilaration. We like our work. We feel good about it.

I remember the doc who met our truck at Wilford Hall Medical Center when we were running in another full arrest.

“Stop,” he said as we were wheeling the stretcher into the door. We stopped. We looked at him. He mounted the side of the stretcher and began pumping chest. “Go,” he said. We did. “I saw them doing this on ER,” he confided. “It looked really cool.”

2 You Call, We Haul

Probably 85 % of 911 callers do not need emergency transport to a hospital. They don't have a car, the ankle they sprained or broke during the day is keeping them awake and they don't want to wake up a neighbor or relative, they don't have a doctor, they think ambulance transport will shoot them to the top of the line at the ER, whatever. You call, we haul. They don't call us for lethal chest pain, they do call for flu.

We already have universal health care. Anyone can call 911, get an ambulance ride to the hospital of their choice, and be seen by a physician. It may take all day, with no follow up or preventive care, but that just means more calls and more visits.

So we have our frequent flyers. There was Donny Brook, an alcoholic who lived in a rundown farm house, stranded by suburban sprawl, down the street from a porn mega emporium. Donny was good for a call a month. He had some serious medical problems, as alcoholics do, and was a poor historian, so you never knew what you would get when you got there. You never do anyway. There was always the chance he could be bleeding out from burst varices, vomiting blood into his lungs, or breathing agonally from a cranial bleed--both common in alcoholics--but usually it would be one of his psych problems. Unfortunately, medics tend to want patience with psych calls. Psych calls don't fit the blue collar mindset or the macho image: another life saved. Though we see as many as some psychiatrists. A major part of our practice. When I moved from Basic to Paramedic, one of my few regrets was that my Basic partner now took all the psych calls, which I found pretty interesting, and often challenging. My boast is I can get along with anyone for 15 minutes. After that she was the ER's problem. My technique mostly is stay in front of them, keep some but not intrusive eye contact, and let them talk. Everyone wants to explain, to anyone who will listen, exactly and in detail what's bothering them. Few people and fewer psych patients get the full attention they desire.

Distraction is good too. How many kids do you have? You do not want to feed their delusions, though. Not up to you to diagnose, or document their delusional system. "The little green men want you to be quiet and cooperative" is not a good strategy. Better to admit you don't see them and change the subject.

On occasion, a police officer and five strapping firemen plus three medics will be required to hold someone down while I shoot in a cocktail of Haldol and Versed, preferably into a vein. In five minutes my rabid WWF wrestler turns into a pussycat. Snoring pussycat.

The first time they put Haldol into my pharmacopeia I fell in love. No more tying down struggling loons. No more trying to keep psychotic body builders with 'roid rage from hurting themselves or us. It takes one stronger person to subdue someone. Though not me if I can avoid it. But it takes 4 to 6 fireman and officers to do so without hurting anyone. Damn, I thought, seeing the Haldol take effect, I need to give this to the receiving nurse, my partner, my boss.

Once we had to chase Donny across a plowed field, after his mom reported he was delusional and suicidal. This was not as much fun as it might have looked. On the one hand, we did have some employer-sanctioned sport chasing Donny like a cimarron kid over the furrowed black dirt--actually grey or brown in the sun--cutting off his routes of escape. True, we were exempted for a while from responding to mangled vehicles seeping oil and blood, rectal bleeds with blood pressures in their socks, while we dealt with Donny. On the other hand, it was midsummer in Texas. Even standing motionless under a pecan tree will soak your uniform within minutes. Cutting and roping on foot made even our belts and boots slimy and greasy in short order. With no near prospect of a shower or change. Fortunately Donny had no endurance. Footspeed also unexceptional.

This time, though, Donny's mom answered the door. It's always good when people aren't out on the curb waving at you, hyperventilating, when you have to ring doorbells to get their attention. Unless there's no answer, and the caller may be alone inside. Then you have to contemplate breaking and entering, preferably with a police officer in charge, hoping to find a false alarm, rather than a collapsed aortic aneurism or pulmonary embolism. Though I’ve never once responded to a medic alert to find an actual patient in distress. Their dog or kid hit the alarm button, they don’t know what happened, or they’re nowhere to be found.

I do remember arriving as second unit at one dropped call. The caller had been talking to our dispatcher about chest pain when the line went dead. The first medic on scene was just standing there on the porch. A really bad neighborhood, where even the cops went in twos. Where even the birds sing bass. Plus at least 50% of households in Texas feature a fire arm, possibly in the grip of a gang member with outstanding warrants, a paranoid schizophrenic, or a deaf and demented German rancher. The medic said there was supposed to be a dog inside, though where did she hear that? No barking. I found an unlocked window and slid in over a table. I held a chair in front of me for a shield. “Nice doggy,” I said in a high placating voice. “Don’t shoot, EMS,” I said in a deep calm voice. “Nice doggy. Don’t shoot, EMS. Nice doggy….”

I got to the living room where I found, right by the front door on a ratty couch, a fat middle aged woman, still holding the phone to her ear, stone cold dead and blue. I opened the door, pulled her to the floor onto her back and attached the monitor my partner brought in. Asystole. We checked for dependent lividity, initiated CPR. I opened her mouth, dislodging a set of false teeth, to find a virtual lake of vomit. She had aspirated to death, like so many of our full arrests, like Jimi Hendrix and Janis Joplin. Our portable suction really does not work well enough, but I got as much out as I could, and attempted to intubate around the ventilations provided by the BVM and the compressions. Couldn’t get the tube. Too fat, no neck. Ventilation via BVM was adequate, though, so we ran the code on her floor, IV epi, everything, and pronounced after half an hour.

Finally Donny’s door opened. His mom looked at us, nonplussed.

“What’s up?”

“What?”

“Did you call 911?”

“Nooo.” She sounded like she wasn’t quite sure. I believed her though.

“Well, did Donny call? Where is he?”

“He’s in the back, asleep. I think.”

We trooped through the house, kicking aside Burger King bags where necessary. In the back bedroom we found Donny supine, mouth agape, snoring raggedly. An unedifying sight. Color, muscle tone, chest rise normal.

“Donny! Hey, Donny! Wake up, man. Come on, buddy.” We shook him reasonably gently.

“Whuh,” he allowed.

“No, man, you gotta wake up. Talk to me.”

“It was like that when I found it.”

“Come on, Donny. Did you call EMS?”

The light of consciousness, such as it was, began to dawn. Donny was not happy to see us. Now, instead of sleeping peacefully, he had a headache and a hangover. The light was too bright. Assholes were asking him stupid questions.

“Donny! Did you call 911?’

Doubt wrinkled his brow. The raveled sleeve of care.

“I believe I did,” he said. He realized he had brought this on himself like so much in his jinxed life.

“Well, are you all right? What’s the matter? What hurts?”

“Yeah,” he said. “I mean, nothing.”

“Well, what can we do for you? Why did you call us?”

“Uh, well…I don’t remember.”

We took a signed refusal. We checked him out thoroughly first too, and it’s always a risk—suppose he fortuitously has a heart attack in the next hour or remembers he had a seizure or bloody stool?—but he didn’t want to go. Can’t force him. That’s kidnapping.

He went back to sleep and his mom saw us out.

“Well, if anything happens, call us back. Don’t hesitate. You have our number?”

“No, no, I don’t think I do. Let me get a pen to write it down.’

“I think you can remember it. It’s 911.”

Yeah, for 5 years my phone number was 911. Way cooler than a vanity plate.

You can get pissed off by people like Donny. It certainly does say something about our expensive medical care. We could deliver as good or better care for half as much if we could triage it to the people who need it. But if Donny got to you, you’d be pissed off most of the time, otherwise known as burnout. Crews are pretty good humored most of the time. By the time you get to a “bullshit call” in the middle of the night, you’re fully awake anyway. We kind of enjoy people like Donny. He’s funny. Besides, who really wants to run balls to the wall critical catastrophes on every outing? And how would we practice for them except on patients like Donny?

Donny was no worse than the guy we found pacing around outside his house on the sidewalk in the middle of the afternoon. We pulled up beside him, shut off the siren and rolled down the window.

“What’s up?”

“I think I may not be able to sleep tonight.”

So he dialed 911, not for insomnia, but for anticipated insomnia.

Or the old guy in a sweltering shack who couldn’t get out of his chair. His legs were so swollen and discolored he might have had elephantiasis.

What kind of medical problems do you have? He didn’t know. They have a gold plated pharmacopeia on hand—the latest antidepressants, nothing generic—paid for by Medicare or Medicaid, but they don’t know what the meds are for, or what their family members’ are for. They may or may not take them on schedule or get to the pharmacy for refills.

This guy had a whole bag full, including Lasix, a diuretic. He looked like congestive heart failure.

“Have you been taking your Lasix?

“What?’

“Your water pills? Have you been taking your water pills?”

“Naw, they make me pee all the time.”

Since it was hard for him to get up, the last thing he wanted was frequent trips to the bathroom. So now he couldn’t get up at all.

“Sir, your heart is too weak to get all the water out of your body. So that means you can have water in your lungs, in your legs, or, if you take your pills, in your toilet. The choice is yours.”

He claimed no one had ever told him this. This may be true. Family practice docs who take care of the indigent don’t have a lot of time to explain things, and their patients tend not to understand or listen. They forget easily. You can see why a physician wouldn’t want to get into an hour discussion, complete with blackboard and anatomical doll, on how fluid circulates in your body, with a slow student who didn’t realize there was fluid in his body. But it was clear this gentlemen had not made much effort to be informed. You take your body to a doc like you take your car to a mechanic. You don’t listen to the explanation. Boring. Not your job. So I make a point of sitting with my patients and explaining what’s happening to them, what the guy with chest pain can expect from the hospital, and why. It’s reassuring and patients are grateful. Besides the gratitude, I enjoy explaining things. I’m the village explainer. I miss teaching in some ways. Anyone who will gratify me by actually listening is entitled to a free lecture on the subject of my choice. I have many original or valuable insights in many areas and wide reading to back them up. It’s a disappointment to me hardly anyone listens, much less acts on my advice. A person strapped down face up on a stretcher in my ambulance has little choice. What you call a captive audience.

Still and all, though, there are calls that get old. “Assault” means no one is really hurt. “Gunshot wound (GSW)”, “stabbing,” “possible fracture,” “head injury” mean someone is hurt. “Assault” means someone is mad at someone, and wants to use the police for revenge or self defense. The cops know this as well as we do, so they take their time responding. And on psych calls and assaults we have to wait for them to secure the scene before we make it. So, 2 AM, we’re staged around the corner from the address, waiting for SO (Sheriff) to show up. Then we get to meet yet another dysfunctional family. At first they’re interesting, but, pace Tolstoy, after a while they’re all the same. Annoying. You can see why someone might want to punch one or more of them. Then we either get to do an exam, and take a signed refusal, clearing the sheriff’s officers of medical liability--why not? they protect us too--or we take someone with a bruised cheek into the ER so she can build a court case against her husband. Which he richly deserves, and which she ought to do, and which we ought to help her with. But not what any sane person feels like doing at three in the morning after two hours sleep. You call we haul.

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