CHAPTER TEN---Crazy Clinical Cases

Every Emergency Medical Technician in the State of Michigan is required to attend clinical rotations to gain experience in the real world beyond the classrooms. My basic EMT clinical included sometimes boring cases of coughs and colds by patients who use the emergency room like a doctor's office at all hours of the day and night. There were several shifts with a northern Michigan ambulance service without a single ambulance call. The best basic EMT clinical rotation occurred at Northern Michigan Hospital Emergency Room. One patient stands out in my mind.

An ambulance service brought in an 80-year-old female laying flat on her back gasping for breath with blue lips and no oxygen. The ER was quite busy, I remember, and the nurse taking report from the crew heard about the history of congestive heart failure and couldn't get the patient off the ambulance cot fast enough. She sat the lady up on the ER bed and barked an order at me, "Non-rebreather mask 15 liters per minute STAT. We are all that stand between this lady and dying. Spike that IV bag while I get the catheter in." She moved with precision and efficiency as she put cardiac monitor leads on the patient. The doctor stopped in. The nurse reported, "Crackles in all fields consistent with CHF and pulmonary edema. IV is in."

The doctor ordered, "Nitro x3, 40 of Lasix slow IV push after Foley catheter. Let me know how she does. This is a crazy place tonight."

There wasn't another nurse available to help so the nurse asked me,

"Help the lady to sit up. Hold her up from behind while I place this Foley (urinary catheter). Then we can get the Lasix in. Ma'am, this is necessary to get the fluid from your lungs and to help you breathe." With the catheter and Lasix in, we had time to get another set of vital signs and give the Nitroglycerin.

After 15 minutes of aggressive treatments, the lady's color improved and her breathing improved. I got my first compliment in the clinical setting, "You work well under pressure. You can do clinical with me any time." This nurse went off shift within the hour and the rest of the night was spent helping take care of skiing accidents with strains and tears and fractures that I got to wrap and assist with casts. With my scheduled clinical time at an end, I looked for my paperwork to get the verification signature that was required. I wasn't going to get that signature that night because the Ice God was to present several victims to the NMH ER that night and early morning.

The patient I remember most from this was an elderly man who was on his way home with his wife from a 50th anniversary dinner when he hit a patch of ice. That's the last thing he remembered before waking up in the ER. He and his wife had been snuggling on the way home. They were not wearing any seatbelts. The paramedics reported that the husband did a 'down and under' hitting his face on the steering wheel. The wife did an 'up and over' hitting the right side of her head on the windshield. I didn’t see much of the wife because she was off to CAT scan with possible head injuries and neck injuries. She did come in fully immobilized on a backboard with cervical collar. I do remember one thing about her head. The point of impact with the windshield had been covered up with

gauze wrap so that I could not see the head, but the duct tape that the paramedics had used to secure her head to the backboard was something I will never forget. The right side of her head was severely deformed in relation to the left side of her head. Even without seeing the injury site that was covered by gauze, I could tell her injuries were serious from seeing the asymmetry under the duct tape.

I spent most of my time observing exploratory surgery to the man's face. The surgeon came down to the ER to search for pieces of steering wheel in the victim's face. I remember asking why the surgeon came to the ER instead of the patient going to the OR and was told, "The OR is full from other accidents. It's a busy place we have here tonight." I stayed around the ER moving from one patient to another with my assigned nurse. (Yes, I voluntarily pulled a double shift of clinical time since there was stuff happening.)

At five a.m. I left the ER to drive back to Charlevoix to get a little sleep before my ambulance shift the next afternoon. When I left, the elderly man was getting ready to be discharged with both eyes getting puffy and black. His whole face was swollen, but he was lucky—no serious injuries. His blood alcohol content, although, got him a Driving Under the Influence of Alcohol (DUI) ticket, but also had helped him relax when he crashed into the tree. His wife was not so lucky. She would be spending a long time in the hospital if she survived the serious head injuries she had sustained. The man's family was trying to console him as I left to prepare for my next clinical experience.

Interestingly enough, I would quite literally run into him in the Wal-Mart

several weeks later when I was over on the mainland for a shopping trip and medical appointments. Our shopping carts bumped into each others near the electronics section. He, of course, did not recognize me, but I could tell from his injuries' state of healing and scarring that he was the man that I had seen that night in the ER. I stared for a moment and then walked on without saying more than, "Excuse me. Sorry I bumped into you."

My clinical experience was not so exciting at Charlevoix Area Hospital. My first shift was truly boring, but I got my share of practice taking vital signs: pulse rate, respiratory rate, blood pressure, and temperature. We had one 10 year old boy with a hip injury. I helped wheel the patient to x-ray, assisted with the x-ray, and helped him back to the ER. While in x-ray, I covered up my body with a lead-lined covering as taught. Healthcare providers who help out in x-ray have the opportunity to be exposed, or should I say overexposed, to x-ray radiation, unlike the patients who only get exposed when they are injured.

I got to know the little boy and his mom. She had taken him sledding down one of the hills near their house and had ended up "running into a tree". I didn't question either of them, but his clothes were pretty dry for having been playing out in the snow. He didn't have any snow pants. His gloves and hat were dry, and the bruising to his leg was much closer to his buttocks. It was not my job to diagnose, but I had my own ideas about what had caused that bruising. I learned that not all accident patients were truly accidents. This situation turned out to be a "family in crisis" which required some help from a social worker and Children's Protective Services. It must be that I was becoming a psychic or just

much better at observation that I thought.

Things slowed right down to a crawl in the ER. There was always studying to do, but I wasn't much into studying after the previous case. The nurses were talking about the little boy and how his life was probably a literal "hell". I couldn't understand how anyone could do that to his/her own child, but I didn't know all the facts. I decided right then and there that I would not judge this mom or this situation without knowing all the facts.

When the respiratory therapist put in an appearance in the ER, I introduced myself, "Hello. My name is Joe, and I'm an EMT student. Things are pretty slow here in the ER tonight."

The lady answered, "Hello, Joe. I'm Ann, and I'm a respiratory therapist here at the hospital. My husband Buddy is an EMT/Firefighter with the EMS and Fire. I'm getting ready to go up to the floor and give some breathing treatments. If you're bored, you could come along and see how we do things inside the hospital." Ann took me up to the patient room's area of the hospital and I watched her wake up the patients and listen to their breath sounds. She said, "You are told about breath sounds in your EMT training. Listen to these and tell me what you hear." I listened and told her that I didn't know what that sound meant, but it sounded unusual. "You have just heard the breath sounds of a COPDer, a person with chronic obstructive pulmonary disease. This lady smoked three packs of cigarettes a day for more than thirty years. Her lungs are just worn out. Her alveoli, the little air sacs in your lungs, have lost their stretchiness. Notice how she has to sit up to breathe. Notice how she purses

her lips together and how hard she works trying to get the air out of her lungs. She will probably die fighting to breathe. I noticed from the cigarette smell that you are a smoker. I thought you would benefit from seeing how you will turn out if you continue smoking."

What a slap in the face that was! I was planning on learning something that night, but I sure wasn't planning on learning about my bad habits. She provided the patient with a nebulizer treatment to help her breathe. We moved on to the next patient that needed a breathing treatment. Ann told me to listen to the breath sounds and identify them.

"I hear wheezing on both sides," I reported. "Good," Ann responded, "inspiratory or expiratory? In the base or at the apex?" I got the respiratory emergency training that really meant something to me. This lady was a teacher waiting to jump out her body. She taught me more about respiratory emergencies in that one three hour session than I had learned in my entire EMT class. Now, this was clinical training at its best. It certainly wasn't what I had had in mind when I came to do my clinical, but it was great. I certainly hope that Ann will read this at some point, recognize herself, and take the thanks of a truly green newbie EMT who can't express the great appreciation for the learning that took place that night. Thanks, Ann.

It was almost fourteen years later that I again was involved in clinical experiences. I had been an EMT for fourteen years, and an EMT-Specialist for nine. As explained earlier, I had been fortunate enough to get a paramedic class to be offered right here on Beaver Island. These eighteen months were a

combination of ecstasy and torture with neither one gaining the upper hand. My classmates, Bev, Mike, Bob, and Karl, were very much my friends and neighbors as well as students. We shared a lot of good times on ambulance runs and in the social realm too. Since an EMT can't really talk to his other non-EMT friends about what (s)he does and with whom he has just spent time helping, (s)he relies on the ability to talk with his/her fellow EMTs. This is something that not even a wife can understand. The bond that develops between fellow rescuers is one that lasts a long time. Just being involved in one very serious emergency is all it takes to develop this bond.

Karl was the best hands-on student that I ever had in my class. He was a typical adult learner with no special needs. He went down to Traverse City to take the practical exam, and came back a discouraged adult learner thinking that he was not able to do the job of an EMT, let alone a paramedic. I think he got himself involved with a very poor evaluator and very poor Regional Coordinator re-tester. Karl knew the Basic EMT assessment station inside and out, backwards and forwards. He had this skill completed before he ever left my program and my exams. Something happened to him in Traverse City at that practical exam. He gave up on that patient assessment and he failed for the first time in his life. Because of this failure, he was unable to continue in the paramedic program. I don't know which person to be angry with down at that practical exam, but Karl came out of that exam experience with an attitude that I had never seen any of my students get. The attitude was an "I can't do this. I'm too dumb." attitude. He just quit trying.

Three months later he went to Kellogg Community College in Battle Creek and passed the assessment station with flying colors. Unfortunately, it was too late to be able to finish in the paramedic program on Beaver Island.

It got to the point that the paramedic students needed to do some clinical time to gain experience in the newly learned skills that each had developed. Arrangements were made for all of us to go down to do the ambulance clinical time with LifeCare Ambulance in Battle Creek. This was to be a really interesting week for all of us. On my first day of clinical, things were pretty slow, but starting at 5 a.m. for anything will seem slow to me. I'm not an early morning person, you see. A couple quarts of coffee, and I was a little more prepared for the day. Bev had left with one crew to cover one side of town, and I had left with another for our station. They apparently move the vehicles from station to station based upon the statistical analysis of the probability of an ambulance being needed at one location over another. This explanation went way over my head, but I was ready for the action.

When this day was over, my new title of "Doctor Death" was well earned. It seemed like everywhere that we were sent, the victim was no longer with the living. First we were sent to one of the fanciest hotels in town. We were admitted to the back service elevator by the manager and led up to the room containing an older man who had obviously passed away sometime the night before. It appeared that this man had been chasing a much younger woman around the room, based upon the apparel that was strewn around the room. He must have had a sudden cardiac arrest right there in the room, naked from the

top of his head to the bottom of his feet. He had apparently grabbed onto the woman as he died because he was still clutching the Victoria Secret lingerie in his hand. He collapsed face first and was found in that position by the maid the next morning. We had only been called to this location to verify that the man had indeed died.

The next call was to a bridge over a river. Two kayakers had been going down the river and found this victim hanging from the bridge. The man had taken a tow strap—one used for towing cars—and had chosen to commit suicide by hanging himself with the tow strap. The couple had seen him hanging from the bridge with his feet dangling in the water and had called 911. This seemed to have ruined their kayak outing. It hadn't turned out to be a great day for any of us, especially the man who had committed suicide. Life must have been pretty bad for this person. Yes, he was a person, a real person. This was not just a statistic. This had been a person. Right then and there, I vowed that if I had an opportunity to help someone who was as depressed and suicidal as this person, that I would do my best to make sure that the person got the help that (s)he needed. I could only hope that I wouldn't see more of this.

Unfortunately, I was to be exposed again. Bev had been in the transfer mode all day. Picking up one nursing home patient after another and taking them to the hospital for one test or another all day is not really exciting. Of course, my day had not been all that exciting either. We were suddenly paged to an attempted suicide. "Shots fired!" the dispatcher has stated. We arrive at the address before the police and were directed by dispatch to stage two blocks

away. The “all clear” scene-is-safe message was given by the city police, and we were directed into a run-down house with almost no walking room from front door to bedroom where our patient was located. What I saw will never leave my dreams! A police officer was holding a shotgun. His description of what had happened was disturbing.

“This man had placed the barrel of the shotgun into his mouth and was getting ready to pull the trigger. When he reached down to pull the trigger, he had to lean to one side to pull it. Instead of blowing his brains out, he blew off the side of his face.” That is what we were looking at. We loaded the man onto the ambulance cot. He was very combative and very bloody. We got him into the back of the ambulance. Bev’s rig had responded to the scene as well. Bev’s lead paramedic jumped into the back of the rig and attempted to intubate the patient, but couldn’t find any landmarks to go by. My lead paramedic told him to go for the air bubbles in the blood, and the endotracheal tube did end up where it needed to be to provide the patient an airway. There was nothing to secure the tube to. There were not any landmarks to know what part of the anatomy we were dealing with. My paramedic cleared the back of the rig and told me to hold that tube in place with both hands.

“Don’t let go. Don’t let the tube come out. That’s the only thing keeping him alive right now. I’ll bag him. Don’t lose that tube.” I rode in the back of the rig and alongside the cot into the ER with my hands inside a person’s face holding on to a tube that was his lifeline. When we arrived in the ER, the patient was moved onto an emergency room cot, but my hand was still there holding the

tube. The nurse told me to let go, but I couldn't let go. I knew that when I released that tube, the patient would die. It took my lead paramedic to come into the room and tell me to let go of the tube.

He said, "Joe, we need to clean up the rig and get ready for the next call. The nurse will take over control of the airway. Let's go—NOW!" I let go of the tube and went out to clean up the rig. There was blood all over everywhere in the back of the ambulance. We spent more than an hour cleaning up the mess. When we were done, I got another compliment, "You work pretty well under pressure." I'm thinking to myself, "What pressure? I do this every day. Yah, sure you do, you idiot." This was the day that they coined my trainee name of "Doctor Death".

The next morning everyone wanted to know if they HAD to take "Dr. Death" as their trainee today. No one wanted to take me since I seemed to have been the jinx of the day before. The last crew in—that'll teach them—was required to take me out. It was pretty slow that day as we pulled into our "station". As we sat there drinking coffee and eating doughnuts, we were watching what appeared to be a drug house directly across the street. People were coming and going into and out of that house very frequently from about 10 a.m. until noon.

We kept watching the house until I finally spoke up, "Are we going to just sit here and watch this drug house or are we going to report it?"

"How do you know about these things, hick boy?" the lead paramedic asked me.

“It can’t get much more obvious than this,” I said. “The people in that house can’t possibly have that many friends. There have been people of every color, every race, and every possible dress style enter that house in the last two hours. The people on the porch are obviously lookouts because they are still there. The boy on the back side of the house is also a lookout. They probably have someone else on the other side of the house in the back.”

“You’re pretty observant for a medic want-a-be,” he said. “Well since you’re so interested, we’ll show you what happens when the police try to make a bust.” The lead medic got on the radio and reported what appeared to be a drug house at the address across the street from our location. It wasn’t twenty seconds, and every person within the entire block was gone. I mean completely gone from the neighborhood.

“They monitor every frequency in the city,” he said. “They know where the police cars are, and they know when the cars are dispatched. When we come back here tomorrow, you’ll see the same lookouts in the same positions with the same stuff going on. By the time the police car arrives here, there will be no one in that yard but the kids who live there and their mommy. The police will only catch them if someone can get on the inside of that house by being undercover. That’s a pretty dangerous place to be.”

“Did they know that you reported them?” I was becoming a little scared.

“No, they don’t monitor our ambulance frequency, but as soon as the dispatcher called on the police frequency, they knew,” he said. “It’s pretty hard to get ahead of the drug dealers in this town.”

“I’m glad we don’t have this going on, on Beaver Island,” I said.

“You probably have more going on there than you know. They just hide things better there,” said the lead medic as he took a pull on his Diet Coke. We were called to another nursing home to transport another patient to the hospital for an MRI. We hung around and transported the same patient back to the nursing home. When we got back on station, the same lookouts WERE there. The same boy was at the same back corner of the house. Business was going on as usual at the station.

My hospital clinical time was spent entirely in the Charlevoix Area Hospital ER working with assorted nurses, but, as already mentioned, there were two nurses who really were great teachers, Sue and Bev. The one time that sticks in my mind was when a patient came into the ER with some serious illnesses. The other nurse came into the office and asked, “Who wants to start an IV?” I, of course, was there for just such a reason.

“I will,” I chimed in cheerfully. “Okay, here is the IV tray. Go on in to A-2 and start the IV on the HIV-positive lady. Be very careful when you start this IV,” the nurse was being deadly serious now.

Sue said, “Do you want me to come in with you? I’ll gladly coach you through this one.”

“No thanks,” I said. “There has to be a first time for everything,” and I grabbed the IV tray and entered the room.

The lady sitting there on the ER cot was obviously an old hand at getting stuck with needles, and she said, “What they do? Send me the rookie or what?

You're old enough to know what you're doing. I sure hope that you do. I don't want to be poked more than once. You get just one chance, and then I start screaming for the doctor to come in here and do it himself." I got everything ready as I had been taught. Gloves were on. Goggles were on. I was ready to do my job.

"All right," I said. "You are going to feel a slight pick when the needle goes in. Are you ready?"

My patient didn't miss a beat when she said, "Well, honey, I'm not the one that's shaking. Are you sure you can do this?" The needle went in just fine. Her hand didn't jerk, and mine quit shaking as I hooked up her IV solution, secured the catheter and tubing, and thanked her.

"What are you thanking me for, son? You're the one that did the job," she said as I proudly walked back into the office.

"Good job, Joe," Sue said as she smiled proudly.

Another patient was brought in by Boyne City Ambulance from Boyne Mountain. This patient was a 26-year-old male patient who had been skiing down the hill and had gotten off the normal ski path and had skied right into a tree. He was still in all of his fine ski clothing with his expensive ski jacket and ski pants when he arrived in the ER. As the nurse began to cut off his clothing, he was pretty smart-mouthed, "That coat cost more than your entire closet full of clothes."

Sue spoke pretty nicely, "And it won't be worth a thing when I'm done with it." I helped her cut the rest of his shirt and undershirt off when I noticed that his

back was bruised badly on the right side. I also noticed that his back wasn't moving normally when he breathed.

"Sue, I think we have a flail segment on the right back," I spoke clearly and concisely. She looked and then listened to breath sounds.

"Go get the doctor, right now," she commanded. The doctor came in and listened to the breath sounds that Sue had allowed me to hear.

"Diminished breath sounds are almost always an indication of a pneumothorax after an injury," Sue stated to me. "I'm guessing this young man will end up with a chest tube and a few days in the hospital." She was absolutely correct. I was allowed by the surgeon to stay on and observe the chest tube being placed and hooked up to the vacuum. The smart mouth was gone from our patient, and no further comments came from his mouth until it was time to move him up to the floor of the hospital for his room that would be his home for a few days.

It was then that he said, "The doctor told me to thank you. Your observation about my back got me the needed treatment. I guess I should apologize for being such a jerk when I came in. Thanks for your help."

What worked well outside in the field on Beaver Island with BIEMS continued to work well in the Charlevoix Area Hospital ER. Bev was a registered nurse as well as an EMT and a paramedic student so our relationship on the Island was easily expanded to include doing clinical work in the ER. Bev and I worked **with** each other. Neither one worked **for** the other.

When one young man came in after a snowmobile accident with no

apparent external injuries, Bev said, “Joe, go ahead and get vitals, and I’ll start with the history.” I took a pulse rate: 120. I took a respiratory rate: 30. I took a blood pressure: 80/60.

“Bev, you need to check this,” I said. In the ER, I was not able to make any treatment decisions, but I knew that Bev would act on the information that she got.

“Perhaps, you’d feel better lying down,” Bev suggested to our 22-year-old male patient.

“I think I would,“ he whispered. “I’m getting a little dizzy.”

We got him lying down in time before he passed out. As we would find out later in the diagnostic process, this young man had ruptured his spleen during his accident and was bleeding internally. The two large bore IVs that we started were a good start toward stabilizing this young man. We helped get the patient ready for transfer to surgery, and Bev asked me, “Why didn’t you say anything about his blood pressure being so low?”

I answered quite honestly, “If we had been outside the hospital, I’d have been shouting orders, but inside the building, it was your patient, and your call. I didn’t want to disrupt the entire ER, so the quickest way to the needed information was the path that I chose.”

“Well, we both know that you can take vital signs and start IVs. I just wanted to make sure you know that I know that,” Bev stated in a matter of fact tone of voice.

Bev, Sue, and I also were Advanced Cardiac Life Support (ACLS) Instructors. We participated in helping provide one program for the Charlevoix Area Hospital doctors and nurses. I remember this one quite well because our PowerPoint presentation was the hit of the course. There was not much really special about the presentation on Tachycardia (fast heart rates) except that it was projected on the wall and made an image about six feet tall. This must have been one of the first presentations of this kind that they had seen because we got a standing ovation from the group.

Our MegaCode Station was one that we made challenging for all participants as well. I'm guessing that BIEMS had an increase in reputation after that ACLS course. We knew what we were talking about and presented it in a way that entertained. Even us rural EMS hicks know a thing or two about emergency medicine and teaching of emergency procedures.