

EMT Clinical Judgment Study Guide – Volume 2

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This companion guide focuses on practical, gray-area clinical judgment that EMTs face every day—situations where protocols give options, patients don’t fit neatly into boxes, families push back, scene conditions complicate things, and you must decide fast with limited tools. It is written for the NREMT cognitive exam (2025 format), skills testing, and real street medicine. EMT Judgment Core Rule: When in doubt, control what is killing them right now and get them moving to someone who can do more. You can’t fix everything—but you can buy time.

Disclaimer: Not official. Not a protocol replacement. Always follow your local standing orders, medical control, and agency policy. Use for study, discussion, and mental rehearsal only.

Section 1: Classic EMT “Which One First?” Dilemmas

Scenario Snapshot	Option A	Option B	Correct EMT Judgment & Why
45 y/o male, MVC, chest pain + paradoxical left chest movement, SpO ₂ ; 88%, BP 110/70	High-flow O ₂ ; via non-rebreather	Manual stabilization of flail segment + O ₂ ;	Manual stabilization first → flail impairs ventilation more than hypoxia alone at this stage. Apply O ₂ ; immediately after.
19 y/o female, severe asthma attack, silent chest, accessory muscle use, SpO ₂ ; 91%, speaking 1–2 words	Assist albuterol MDI with spacer	Immediate transport + high-flow O ₂ ;	Transport now → silent chest = near respiratory arrest. Albuterol assist en route if possible; do NOT delay.
68 y/o female, chest pressure 7/10, pale, diaphoretic, BP 92/60 after one nitro dose	Give second nitro dose	Hold nitro, high-flow O ₂ ;; rapid transport	Hold nitro → SBP <100 is contraindication. Hypotension after nitro suggests preload dependence or right-sided involvement.
32 y/o male, heroin overdose, respiratory rate 4, SpO ₂ ; 82%, pinpoint pupils	Naloxone 4 mg IN	BVM ventilations first	Ventilate first → hypoxia kills faster than opioid effect. Give naloxone during/after initial ventilations.
55 y/o male, syncope, now alert, BP 108/68, HR 88, history of “heart problems”	Refusal if he signs	Transport anyway	Transport → syncope in patient >50 or with cardiac history is presumed cardiac until proven otherwise. Refusal high-risk.

Section 2: Transport vs. Stay-and-Play Judgment Calls

Presentation	Closest Hospital (12 min)	Specialty Center (28 min)	EMT Decision & Reasoning
58 y/o male, chest pain 9/10, 12-lead shows possible inferior STEMI, BP stable	Local community ER	PCI-capable hospital	PCI-capable → even if only 16 extra minutes, reperfusion time matters more than thrombolytics in most systems.

Presentation	Closest Hospital (10 min)	Specialty Center (28 min)	EMT Decision & Reasoning
65 y/o male, deformed femur, pale, cap refill 4 sec, alert		Specialty Center (28 min)	Children decompensate fast; pediatric-specific shock care, imaging, and surgery save lives.
29 y/o female, 30 weeks pregnant, sudden severe headache + BP 180/110, vision changes	Closest hospital with OB on call	High-risk perinatal center (35 min)	Perinatal center → suspected preeclampsia/eclampsia; magnesium, fetal monitoring, possible urgent delivery needed.
40 y/o male, GSW to thigh, arterial bleed controlled with tourniquet, BP 80/P, alert	Local trauma center (15 min)	Level I trauma center (32 min)	Closest trauma center → tourniquet is working; time to surgical control is critical. Do NOT bypass for higher level if delay >15–20 min.

Section 3: Refusal & Capacity Gray-Zone Cases

Situation	Patient Wants to Refuse	Red Flags / Family Pressure	EMT Judgment & Action
72 y/o male, chest pain relieved after 3 nitro, now feels “fine,” wants to go home	Alert, oriented, understands risks	Wife begging you to take him	Transport → recurrent chest pain in 70+ y/o is presumed ACS until ruled out. Refusal extremely high-risk even if currently stable.
17 y/o female, abdominal pain, possible ectopic, parents refuse transport	Patient wants to go, parents say “she’s fine”	Patient pale, tachycardic, BP 92/60	Transport → life threat overrides parental refusal in minors when imminent danger exists. Document, involve law enforcement if needed.
42 y/o male, syncopal episode, now alert, refuses transport	Capacity intact, signs refusal	History of arrhythmia, family says “he always does this”	Transport → syncope with cardiac history = high risk of sudden death. Document risks explained clearly.
88 y/o nursing home resident, fall, hip pain, alert, refuses transport	Patient adamant, DNR on file	No acute life threat, stable vitals	Accept refusal if capacity confirmed → comfort care focus; document thoroughly.

Section 4: Scene Constraint & Limited-Resource Judgment

Prolonged extrication (30+ min) → early pain control (if able), monitor for shock, communicate with rescue crew.

Rural arrest, 45+ min to hospital → high-quality CPR + early defibrillation; consider field termination if asystole after full measures (per protocol).

Multiple patients, only one ambulance → prioritize Red patients with highest salvage probability (e.g., tension pneumo over cardiac arrest).

Domestic violence scene → stage until law enforcement clears; do not enter alone.

Example Tough-Call Math Judgment:

Question: 65 y/o female, chest pain, BP 86/54 after one 0.4 mg nitro SL. Protocol: Hold nitro if SBP <90. Hospital is 9 minutes away. Do you give a second nitro? **Answer:** No – hold nitro, high-flow O₂; rapid transport. **Reasoning:** Hypotension after nitro suggests preload or right-ventricular issue. Additional nitro risks profound hypotension. Transport time is short enough to prioritize movement over repeat dosing. These are the calls that separate good EMTs from great ones—when the book says one thing, the patient says

another, and the clock is ticking. Practice these out loud with your partner. Role-play the refusals, the family arguments, the “I don’t want to go” moments. The more you rehearse the uncomfortable decisions, the calmer you’ll be when they’re real. Stay safe out there. Trust your gut, but back it with solid assessment. You’ve got this.

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