

EMT Clinical Judgment Study Guide – Volume 3

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This third volume is for the calls that don't feel like textbook scenarios—the chaotic ones, the emotionally brutal ones, the ones where you're alone on scene, the family is hysterical, the patient is fighting you, or everything is happening at once and you still have to decide. These are the real street-level judgment moments that test whether you can stay calm when the world is screaming. EMT Volume 3 Mantra: When the situation is ugly and there is no perfect answer, do the safest, fastest thing that keeps the patient alive long enough to reach someone who can do more. Then breathe, document honestly, and talk about it later. Disclaimer: Educational and reflective only. Not protocol. Not medical direction. Not legal advice. Your local standing orders, medical control, and your own agency policy always come first.

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Section 1: The “Everything’s Happening at Once” Calls

Scenario Snapshot	Option A	Option B	Real-World EMT Call & Why
52 y/o male, MVC rollover, trapped, screaming chest pain, SpO ₂ : 89%, BP 96/60, fire crew says extrication 8–10 min	Wait in ambulance for extrication	Enter vehicle, apply high-flow O ₂ ;, manual c-spine, monitor	Enter vehicle → hypoxia and shock kill faster than waiting. Get O ₂ on, maintain airway, reassess frequently. Extrication is fire's job—you treat what you can reach.
38 y/o female, severe abdominal pain, 8 weeks pregnant, heavy vaginal bleeding, BP 88/52, HR 124, husband panicking	Give oral glucose “in case she’s diabetic”	High-flow O ₂ ;, left lateral, rapid transport, no PO	Rapid transport + left lateral → suspected ectopic/hemorrhage. Nothing PO. Glucose not indicated without BGL check and she's unstable.
11 y/o child, hit by car, deformed femur, crying, pale, cap refill 3 sec, parent refusing to let you splint or move	Splint on scene despite refusal	Rapid extrication without splint, transport	Rapid extrication → child is in compensated shock. Splinting is secondary to getting to hospital. Explain to parent calmly, document refusal of specific intervention, transport anyway (implied consent for life threat in minor).
65 y/o male, cardiac arrest in living room, wife doing CPR poorly, asystole on monitor, 911 call was 12 min ago	Take over CPR immediately	Let wife continue while you set up AED	Take over CPR → high-quality compressions are the single most important intervention. Gently transition wife (“You did great—let me help now”), attach AED during first cycle.
22 y/o female, severe anxiety attack, hyperventilating, carpopedal spasm, SpO ₂ : 100%, refusing to calm down or go to hospital	Paper bag rebreathing	High-flow O ₂ via non-rebreather, calm coaching, transport	Coaching + transport → paper bag is outdated and risky (potential hypoxia if misdiagnosed). Anxiety can mimic more serious causes. Transport all hyperventilating patients who don't improve quickly.

Section 2: Refusal & Family Pressure Situations That Feel Wrong

Situation	What the Family Wants	What the Patient / Situation Says	EMT Gut Call & Documentation Must-Haves
78 y/o female, chest pain relieved after aspirin & 2 nitro, now "feels fine," wants to stay home with daughter	Daughter says "she's okay now, we'll watch her"	Patient pale, diaphoretic, history of CAD, initial pain 9/10	Transport → recurrent/unstable angina presumed until ruled out. Document risks explained (MI, death), patient verbalizes understanding, daughter present as witness. Strongly encourage transport.
16 y/o male, syncopal episode after football practice, now alert, BP normal, wants to go home	Parents say "he's fine, just dehydrated"	History of palpitations, family cardiac history	Transport → exertional syncope in teen = high risk for hypertrophic cardiomyopathy or arrhythmia until cleared. Document parental refusal if they insist, but push hard for ER evaluation.
45 y/o male, heroin overdose, naloxone given, now alert & furious, refuses transport	Patient screaming "I'm fine, let me go"	History of multiple ODs, SpO ₂ dropping when naloxone wears off	Transport or observe → naloxone wears off faster than opioid. Risk of recurrent respiratory depression. If he refuses and has capacity, document risks (death from re-narcotization), obtain signature. Many agencies require 15–30 min observation post-naloxone.
90 y/o male, DNR comfort measures only, respiratory distress from CHF, family begging "please do something"	Family wants CPAP / full treatment	Valid DNR presented by caregiver	Comfort care only → honor DNR. Provide morphine/lorazepam for air hunger, fan, positioning, suction. Sit with family, explain you are following his wishes. Document DNR shown and honored.

Section 3: Scene Chaos & Limited-Resource Calls

Apartment fire, multiple patients, smoke inhalation, only one ambulance → prioritize Red patients who are alert but hypoxic over unconscious (salvage probability higher).

Domestic violence, patient bleeding from head laceration, refusing treatment, abuser still on scene → stage until law enforcement clears, treat only if safe, document scene hazards.

School bus rollover, 20 kids, several crying, two unconscious → START triage immediately, Green to one area, Yellow/Red to another, request every available unit.

Example Ugly-Call Math Judgment:

Question: 60 y/o female, chest pain 10/10, BP 84/52 after one nitro, hospital 11 minutes away. Protocol says hold nitro if SBP <90. She's still in severe pain. Do you give another nitro? **Answer:** No – hold nitro, high-flow O₂, rapid transport. **Reasoning:** Hypotension after nitro = preload issue or right-sided involvement. Another dose risks crash. Pain sucks, but dead is worse. Transport is short enough to prioritize movement. These are the calls that make you question everything at 3 a.m. They don't always have clean answers, but they always have consequences. Talk them out with your crew. Debrief. Write them down. Learn. Then go back out tomorrow and do the best you can with what you've got. You're not superhuman. You're just the one who showed up. That's enough. Stay safe. Stay kind. Keep going.

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