

Paramedic Clinical Judgment Study Guide – Volume 2

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This second volume emphasizes higher-difficulty clinical judgment, edge cases, gray-area decisions, conflicting priorities, resource-limited environments, and situations where textbook answers collide with real-world constraints. It builds on the foundational judgment guide and is designed for paramedics preparing for NREMT psychomotor & cognitive exams, critical care transport certification, or real-world high-acuity practice (2025–2026 standards). Core Mantra for Advanced Judgment: When two “correct” actions compete, choose the one that most rapidly reduces mortality or irreversible morbidity while preserving future options. If you can’t do everything, do the thing that buys the most time for the things you can’t do yet.

Disclaimer: Not official. Not protocol. Not a substitute for medical control, local guidelines, or system SOPs. Use for study and discussion only.

Section 1: Competing Priorities – Choose One

Scenario Snapshot	Option A (Textbook)	Option B (Real-World Pressure)	Winning Choice & Reasoning (Advanced Judgment)
28 y/o GSW to chest, agonal respirations, BP 68/P, absent R breath sounds, 18 min to trauma center	Immediate needle decompression	Immediate RSI + positive pressure ventilation	RSI first → hypoxia kills faster than tension in this patient. Decompress after airway secured & ventilated.
62 y/o inferior STEMI, BP 84/52, clear lungs, 22 min to PCI	500 mL NS bolus + cautious nitro	Hold all preload/afterload agents, rapid transport	Hold everything except aspirin/heparin → right ventricular preload dependence. Fluids only if profound hypotension persists.
4 y/o drowning, pulseless, asystole, parents screaming to “do something”	Standard pediatric BLS/ACLS	Aggressive airway + early epinephrine + transport	High-performance CPR + early epi + immediate transport → pediatric ROSC rates improve with short on-scene times.
45 y/o status epilepticus × 12 min, midazolam 10 mg IM given 8 min ago, still seizing, SpO ₂ : 88%	Second benzo → levetiracetam → RSI	Immediate RSI with ketamine + propofol	RSI now → airway/ventilation/oxygenation is the most immediate life threat. Seizure control secondary once airway protected.
70 y/o fall, suspected pelvic fracture, SBP 82, HR 118, 45 min to Level I trauma center	Pelvic binder + 1 L crystalloid + TXA	Pelvic binder + TXA only + permissive hypotension	Permissive hypotension strategy → crystalloid dilution worsens coagulopathy. TXA + binder + rapid transport.

Section 2: Destination Dilemma Scenarios

Presentation	Closest	Specialty Center	Judgment Call & Rationale
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Presentation	Facility (20 min) Closest Facility (20 min)	(38 min) Specialty Center (38 min)	Judgment Call & Rationale
52 y/o STEMI, ongoing pain, Killip Class I, BP stable	Community hospital with thrombolytics	PCI-capable center	PCI center → door-to-balloon time trumps thrombolysis in most systems (unless transport >120 min or contraindications to PCI).
9 y/o near-drowning, GCS 6, intubated, SpO ₂ ; 91% on 100%	Adult Level II trauma center	Pediatric Level I trauma/PICU	Pediatric center → pediatric-specific post-arrest care, neuro protection, ECMO availability if needed.
34 y/o eclampsia, post-seizure, BP 210/130, 28 weeks gestation	General hospital with OB call	High-risk perinatal center	Perinatal center → magnesium infusion already started, but fetal monitoring, possible crash C-section, NICU ready.
19 y/o penetrating neck zone II, expanding hematoma, stridor developing	Closest trauma center (Level II)	Level I with vascular surgery immediately available	Level I → airway catastrophe imminent; need for hybrid OR, angio suite, immediate surgical airway backup.

Section 3: Termination of Resuscitation – Gray-Zone Cases

Common Termination Criteria (2025 Consensus):

- Asystole/PEA >20 min of high-quality CPR + no reversible causes addressed
- Traumatic arrest without witnessed signs of life on scene
- Prolonged submersion >25 min in warm water (adult)
- Rigor / dependent lividity / decapitation / incineration

Gray-Zone Judgment Calls:

Situation	Factors Favoring Continuation	Factors Favoring Termination	Paramedic Judgment Edge Case
38 y/o witnessed VF arrest, bystander CPR 4 min, down time 28 min total, 3 shocks, amiodarone given	Young age, witnessed, immediate bystander CPR, EtCO ₂ rising to 18–22 mmHg	Prolonged low EtCO ₂ ; (<10 mmHg) despite excellent CPR, no ROSC after 25+ min	Continue if EtCO ₂ trending upward and transport time short; consider termination if flat capnography after 30 min high-quality CPR.
16 y/o pediatric drowning, pulseless 22 min submersion (cold water), asystole	Pediatric, hypothermia possibility, parents present	Warm water drowning, prolonged submersion, fixed pupils	Continue resuscitation & rapid transport to ECMO-capable pediatric center if water temperature <20°C and submersion <60 min.
92 y/o nursing home patient, unwitnessed arrest, asystole, dependent lividity present	Family requesting “everything be done”	Clear signs of irreversible death	Termination appropriate despite family wishes if clear signs of death (rigor, dependent lividity, livor mortis). Compassionate explanation required.

Section 4: Resource-Limited & Austere Environment Judgment

Prolonged entrapment (45+ min) → early pain control + ketamine dissociation + monitor for crush syndrome/hyperkalemia.

Rural arrest, 60+ min to hospital → consider field termination earlier if no ROSC after full ACLS package.

Mass casualty with limited ambulances → prioritize Red patients with highest likelihood of salvage (e.g.,

tension pneumo over cardiac arrest).

Active shooter scene → triage in warm zone only after clearance; do not enter hot zone.

Example High-Stakes Math Judgment:

Question: 75 kg trauma patient, SBP 70/P, HR 136, penetrating abdominal wound, 32 min to trauma center. Protocol allows 1 L crystalloid bolus then TXA. You have 1 L NS left. Give bolus or hold for permissive hypotension? **Answer:** Hold crystalloid → give TXA 1 g over 10 min only. **Reasoning:** Penetrating torso trauma → permissive hypotension strategy (SBP ~90 or radial pulse) reduces clot disruption. Crystalloid worsens coagulopathy. TXA is the priority volume expander here. Mastering advanced paramedic judgment means embracing uncertainty, quantifying risk, and making peace with “least bad” options. Debrief every critical call. Talk through the “what-ifs” with your crew. The best paramedics aren’t the ones who never make mistakes—they’re the ones who recognize the knife-edge decisions and own them. Stay sharp. Stay safe. Stay humble.

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