Paramedic Clinical Judgment Study Guide – Volume 3

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This third volume dives into the darkest, most morally and clinically punishing decisions paramedics face—the ones that haunt you years later, the ones where every option feels wrong, the ones that separate street-seasoned medics from textbook technicians. These are the calls where evidence is thin, time is short, family is screaming, protocols are silent or contradictory, and you are the final court of appeal. Mantra for Volume 3: When there is no good answer, choose the path that preserves the most human dignity possible while still fighting for life. Then live with it.

Disclaimer: Purely educational / reflective. Not protocol. Not legal advice. Not medical direction. These are real-world discussion points only—your system's rules, medical control, and your own moral compass govern every actual call.

Section 1: The "No Win" Resuscitation Calls

Scenario Snapshot	Path A (Continue)	Path B (Terminate)	Brutal Judgment Reality & Most Defensible Choice
24 y/o female, unwitnessed arrest in apartment, asystole, rigor present, young daughter crying in next room	Full ACLS package, transport	Immediate field termination	Termination → clear signs of irreversible death (rigor). Continuation only prolongs agony for child and crew. Explain gently, allow family time with body.
9-month-old SIDS-like presentation, parents did CPR for 15 min before calling, asystole on arrival, parents begging "please don't stop"	Aggressive pediatric resuscitation + rapid transport	Compassionate termination after 20–30 min high-quality CPR	Continue briefly (20–30 min total high-quality efforts) → pediatric cases almost always warrant extended efforts + transport to ER for family closure & official pronouncement. Termination on scene extremely rare in infants.
88 y/o DNR patient in nursing home, witnessed arrest, staff says "he has a DNR but the family wants everything done"	Ignore DNR, full code	Honor DNR, terminate immediately	Honor DNR → valid DNR trumps family wishes on scene. Document DNR presented, explain to family that you are legally bound to follow it. Offer emotional support and chaplain if available.
35 y/o construction worker, crush syndrome after 4-hour entrapment, hyperkalemic arrest (peaked T-waves, wide QRS), 45 min to trauma center	Calcium, bicarb, insulin/glucose, albuterol neb, transport	Field termination after initial stabilization fails	Aggressive treatment + transport → crush syndrome hyperkalemia is potentially reversible with hospital dialysis/CRRT. Field termination almost never appropriate if witnessed and entrapment <6–8 hours.

Section 2: Destination & Resource Allocation Nightmares

Presentation	Option A (Closest Appropriate)	Option B (Farther "Better" Center)	Ugly-but-Real Decision & Why

Presentation	Option A (Closest trauma center)	Option B (Farther Level I (ECMO, hybrid OR capability)	Ugly-but-Real Decision & Why
48 y/o penetrating chest wound, SBP 68/P, tension physiology relieved by needle decompression, 18 min to Level II trauma center, 44 min to Level I	Level II trauma center	Bypass to Level I “Better” Center)	Level II → every minute of ongoing hemorrhage matters more than marginal upgrade in surgical capability. Bypass only if Level II cannot handle (e.g., no surgeon on call).
14 y/o pedestrian vs. truck, GCS 4, decerebrate posturing, blown left pupil, BP 180/100, HR 48	Adult Level I trauma center (12 min)	Pediatric Level I trauma center (38 min)	Adult Level I → herniation is time-critical. Pediatric-specific neuroprotection is secondary to reversing ICP now. Hyperventilate briefly, mannitol if protocol, fastest neurosurgical capability wins.
Active shooter scene, multiple Red patients down, only two ambulances available, one patient in cardiac arrest, one with GSW to neck & expanding hematoma	Transport arrest patient first	Transport neck GSW patient first	Neck GSW → salvageable airway catastrophe imminent. Arrest patient has already received full measures with no ROSC → lower priority in resource scarcity. Triage is cruel but necessary.

Section 3: Ethical & Emotional Minefields

Situation	Family / Bystander Pressure	Protocol / Legal Reality	Paramedic Gut-Level Call & How to Survive It
17 y/o male, suicidal overdose, alert but combative, refuses transport, parents screaming “make him go”	Parents demand restraint & transport	Patient has capacity, cannot force transport	No restraint for refusal → competent adult/minor (in most states 17 is adult for medical decisions). Document capacity, risks explained, parental concerns noted. Offer crisis hotline info. Leave if safe.
40 y/o female, terminal cancer, DNR comfort care only, now in respiratory distress from pneumonia, family begging for intubation	Family wants “everything” despite DNR	DNR is valid; comfort measures only	Honor DNR → provide aggressive comfort (morphine, lorazepam, positioning, fan, oral suction). Explain that intubation violates her wishes and would prolong suffering. Sit with family.
6 y/o child in cardiac arrest after prolonged abuse, obvious patterned bruises, parents claim “he just stopped breathing”	Parents want resuscitation continued	Mandatory reporting + continue resuscitation	Full pediatric code + transport → child abuse does not change resuscitation obligation. Report to authorities en route or on arrival. Document injuries objectively.

Section 4: One Final Brutal Judgment Framework

What is the immediate physiologic killer right now? (Fix that first.)

How many minutes until definitive care changes the outcome? (If <15–20 min, move fast.)

What intervention preserves the most future options? (Airway > oxygenation > circulation > everything else.)

What choice lets me look the family / my partner / myself in the mirror tomorrow?

If I’m wrong, what is the harm? (Act in the direction that minimizes irreversible loss.)

Example Final Gut-Call Math:

Question: 55 y/o male, PEA arrest, 22 min of high-quality CPR, EtCO&sub2; consistently 6–8 mmHg despite excellent compressions, no reversible causes identified, family begging to continue. Transport time 28 min to E D . **Answer:** Field termination appropriate after medical control consultation. **Reasoning:** Persistent EtCO&sub2; <10 mmHg after 20+ min excellent CPR is strongly associated with zero chance of meaningful

ROSC. Continuation only prolongs distress. These are the calls that don't leave you. They change you. Talk about them with trusted crew, mentors, or critical incident stress debriefing. Write them down. Learn from them. Then go back out and do it again—because someone has to. You're not expected to be perfect. You're expected to show up, think hard, act with courage, and carry the weight afterward. Stay strong. Stay human. Stay in the fight.