Learning to become an EMT

There is no calmness after a storm when someone dies. There is no peace. Time doesn't freeze. Birds don't stop singing. The rain doesn't stop. Life just continues. The pager goes off. You put on a smile before greeting your next patient, pushing away the loss of your last call. You sit down in the back of the ambulance and take it all in.

Lights and sirens.

The dispatch came in as difficulty breathing. It was flu season. The illness had reduced my shift from our usual five-person crew to a short-staffed crew of three. I was leaving at 10, leaving Marshall and Craig to fend for themselves overnight. The all too familiar sounds of the ambulance took over the bay as we pulled out of the building with our blue and red lights. I passed the exam that would allow me to take care of patients by myself three days before my shift. As a reward, my crew chief, Craig, thought it would be good for me to take lead in this call. Our patient would make a good introduction to the world of the primary patient caregiver.

It did not take long for me to recognize that our patient was in worse condition than we originally had thought. In cases of flu, or COVID, patients will present with fever and difficulty breathing. In those cases, we administer oxygen, transport in the position of most comfort and let the hospital handle the heavy lifting. What presented different about this patient was that she had severe difficulty breathing, yet she was cold and dry. My mind raced for explanations, as her condition worsened. When I walked in to introduce myself as the EMT that would be taking care of her, she could respond. By the time we wanted to initiate transport she had lost all abilities to communicate.

We called paramedics to assess patient care, and for once they were not angry. They saw the severity of the situation and tamed their anger towards EMTs. Upon reading a blood sugar,

we discovered that our patient's blood sugar was well above 700 mg/dL. The recommended blood sugar is 100 mg/dL. Our patient was diabetic in diabetic ketoacidosis (DKA). DKA, a silent killer, is often not detectable until it's deadly for the patient without immediate hospital interaction. Marshall initiated fast transport to the hospital.

Lights and sirens.

Before we could even leave the parking lot, I tried to speak to my patient. She did not respond. I took her pulse. It was gone. Gone, gone, GONE. The human mind becomes sharp in moments of stress, and I remember every word that came out of my mouth perfectly.

"Craig radio for more help. We have a code" We.have.a.code

The medics initiated intubating while Craige shouted to start compressions. 1, 2, 3,…30, two respirations. The radios that had been quiet until now exploded like birds hatching from the nest, flying everywhere, trying to be heard, trying to find someone to help a crew of three EMTs.

After 5 rounds of CPR, we got a pulse back. The patient was intubated. We were ready to roll. The patient's family was waiting in the house, unaware that their loved one had just been dead for a couple of minutes. Her pulse was gone until gentle hands, hands who had never hurt anyone, broke her ribs just to bring her back. We initiated transport once again.

The success rate of CPR is less than 15%. Even when you get a pulse back there is no guarantee that the pulse will stay. I was not the exception. Alternating with Craig and the paramedics to be on compressions, we got a pulse back 6 more times. Like a cat, our patient had been strong, and came back to life 7 times, before leaving one last time. I wheeled the stretcher into the hospital while the paramedics were straddling the patient and doing CPR. We left the patient with a pulse in the hospital. Her last pulse. It wasn't until we saw her obituary one week later that we knew what happened to our patient.

For a while my hands felt guilty. If I had done CPR better, maybe she would have made it. If I had trained more, maybe the outcome would have been different. If I had just been better, she would still be alive. My mind became the screeching radio in the bay, filling the space with meaningless words and distracting me from the fact that I was given an impossible situation and succeeded in bringing someone back to life seven times. I felt guilty about not achieving it an eighth time, and for one second, I let that grief consume me. Until the pager went off again. Lights and sirens.

The voices in my head shut up. My head focused on the new call. I practiced my smile. I rehearsed the words again, “Hey, I’m Joana. I’m from the emergency squad; how can I help you today?” I let the sirens drown my thoughts. And then I remembered what I was told in my first ever shift. You WILL see people die. The words from my crew chief ran though my head, a reminder of the cost of being an EMT. You need to learn to grieve properly. To not blame yourself for everything that happened and to show strength for others. The world does not stop for tragedy; be ready to survive it when it happens.

I don’t remember many of my calls. Yet I consistently come back to that Wednesday night in September. My skills were the best they have ever been, and still someone died. I grieved the death of my patient for a long time, thinking that it was my fault. It wasn’t. I was a good EMT. Then I remembered the reason why I became an EMT in the first place; I wanted to make an impact on someone’s life. I wanted to be the comforting person that patients will look at when they are lost. My patient might’ve died, but their family saw how we operated and how much we fought to bring them back.

The pager went off again. I felt a sense of obligation rise in my chest. The birds didn’t stop singing. The rain didn’t stop falling. And overall, the world did not stop. Ever since I have

continued to learn and become aleader in emergencies and medicine. The world will not stop to grieve for me. So why should I stop learning for one second?