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PERSONAL NARRATIVE

I Pressed Down

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Abstract
In emergency medical services prehospital care, situational awareness means that not everything is in a textbook and that not all care is about the patient in front of you.

Still Learning

I pressed down just as I had been taught in my cardiopulmonary resuscitation (CPR) training— just as I had practiced a hundred times—arms and back straight, and I felt his old ribs crack under my overlapped hands. I wasn't prepared for that sound; I was sure that the whole room could feel and hear. Would they now know how I had just injured my first-ever patient?

My unfortunate patient and I found each other on a warm Chicago evening as I began a career as a fire department paramedic. My ambulance had arrived on a tree-canopied street on Chicago's North side, evening light fading as streetlights added golden halos to a purple June sky. Falling in behind my senior officer, who was still technically responsible for my final field-based training, we gathered our equipment and sprinted up the stairs to the second floor of a red brick 3-flat. Waving arms and urgent encouragement from 7 gathered family members guided us through an open second-floor apartment door and signaled our attention to the patient lying on the living room floor.

I was about to learn from my senior officer and others more skilled than I in the art of prehospital care that many things you need to know are not in a textbook and that good emergency medical services is sometimes not only about the patient in front of you.

Situational Awareness

This scene is but a small piece of a larger story that unfolded that night, offering lessons I would carry with me throughout my career about how field-based clinical and ethics reasoning and decision-making needs to be case based and context specific rather than rule based and principle guided. As the dynamic of that evening unfolded, I slowly began to realize that apartments in this building were all occupied by siblings and that it was their father who was in distress on the floor. As I began CPR, as he was intubated, as one intravenous (IV) line was quickly started in one thready vein and then in a second, our actions were witnessed by a growing number of members of 3 generations of this

family. I remember in vivid detail the beige shag carpeting, a plastic-covered tufted brocade couch, tasseled lamp shades, and even a swag ceiling lamp in the center of the room. I suspected this family had made it through their evening meal and dessert together, since my first few breaths into this father's mouth tasted like orange sherbet. I remember my surprise and relief when I noticed the arrival of a second ambulance crew, who helped us move the patient to a better location on the floor to continue CPR. Most of all, I remember knowing that this man was probably dead before we arrived.

Yet we continued CPR. We connected the telemetry of our defibrillator and transmitted electrocardiogram (EKG) strips to a local emergency department, where the patient's death was confirmed. Nevertheless, we poured in cardiac drugs—epinephrine, atropine, more epinephrine, more sodium bicarb. We shocked the patient—once, twice, three times. Still nothing but a ruler-straight line on the EKG, and still we continued the then-current protocol for CPR and squeezed the ventilator bag: 5 compressions and a pause for a squeeze, 5 and a squeeze, 5 and a squeeze.

More family members gathered to witness our efforts. They stood silently in several huddles, speaking quietly in whispers. The sound of our activity in tearing open IV tubing kits and the rhythmic gasp of the ventilator bag filled the room as we labored. After what seemed like half an hour, the second ambulance crew helped us move the man to a gurney. He was heavy. His bowels were loose. Sweating, we continued CPR as we carried the gurney, man, defibrillator, and portable oxygen tank down the stairs and into the ambulance. After a brief discussion with the patient's eldest son about to which hospital we'd drive and who might ride with us, we left the scene and drove quickly into the humid night. Red lights of our vehicle strobed against street signs and storefronts, and darkened windows of businesses on a main street reflected the white flash of the ambulance speeding away.

What Just Happened There?

I rode in the back. We stopped the CPR we all knew was futile and radioed the hospital to confirm the "triple zero," trade talk for a death. At the hospital, we entered with our patient through the ambulance entrance, which allowed us to keep our somber business away from other patients and the waiting room. Our patient was wheeled behind a curtained cubicle and transferred by an aide to a bed. No staff rushed to our assistance. "We were done here," we well knew, as was our patient's life journey, and everyone on the inside of the system knew it. We gathered our equipment and retreated back outside to the parking lot. The evening had cooled, and I felt some of the heat of exertion drift from my body into the night.

I locked eyes with my senior officer for a long moment. "What just happened there?"

"Wadaya mean?" he asked.

I continued, "Back there, in the apartment. We had 2 crews work on a dead guy for nearly an hour. Why didn't we just call the code? It's a busy night."

My senior officer explained, "Well, there was his family. We could have called it. But they were all there watching, and, well, by working it, that whole family will always get to say, 'Those people from the Fire Department did everything that they could for Gramps and it was just his time to go.' Sometimes, Dave, the performance matters more than the outcome."

Treating the Whole Scene

Paramedics' medicalizing and deconstructing an ill or injured person into that scene's clinical components often too narrowly construes a patient in terms of clinical data.[1] A drug overdose, for instance, would be distilled into focused elements of drug type (if known), the route of administration (inhalation, oral, or IV), prophylactic use of naloxone, a guarded airway, perfusion, and respirations. Paramedics are trained to perform a rapid assessment, to stabilize and package, and to transport with an absolute adherence to protocol and medical professionalism: time and efficiency are critical. Medicalization assumes that the victim is suspended in a clinical vacuum and not a part of a larger environment in which he or she receives care in front of witnesses. A virtual "privacy curtain" is drawn around the victim and clinician behind which a quiet struggle ensues for the paramedic between empathy for the patient and a need to remain objective and distant.[2]

However, firefighters and paramedics are trained to "treat the whole scene." This roughly translates into being aware of your surroundings and is sometimes referred to as situation awareness or mindfulness.[3,4] My previous understanding of mindfulness was to be sensitive to environmental context. A shift in wind if you'd rather be upwind than down, a whiff of diesel at a vehicle accident, or the smell of natural gas in a basement. Or, to continually test how spongy the roof of a burning building feels under your boots or to always be fearful of the bow truss roof that, with a snap of a main chord, can crush you beneath its unbearable weight on a snowy day. To be mindful and to treat the whole scene means to watch the crowd at a shooting and to make sure you don't end up with more victims than you started with (arrival at a shooting often starts with the question by a paramedic of "Who's got the gun?"). Paramedics engage with and are witnessed by family members and bystanders as they provide care on the public streets and in private homes under the most challenging of circumstances. Because paramedics are guests of honor at someone else's surprise party, what paramedics do and where they do it puts them in a larger environment of care than their hospital-bound contemporaries, with paramedics' mistakes and missteps committed in public view. Readers are sure to recognize that truth telling as an ethical value is also at risk in this story. Equity, perhaps, too, is at risk, as 2 ambulance crews are not available to meet needs elsewhere in the community. So, too, at risk are characters and values of paramedics who recognize potential for futility of care they provide and consider whether and when deceiving onlookers, including members of a patient's family, is ethical.

The new mindfulness meant that the accident scene and all of its occupants become players in a larger clinical picture and elements in a larger assessment and a larger plan of care. When the drowsy-lidded, thick-tonged, drug-overdosed attempted suicide earnestly asks the paramedic, "Who called you?" (a completely uninteresting bit of information to the clinically focused), she may actually be asking if a lover called 9-1-1 after a farewell call or text message. She is asking, "Who cares about me?" in addition to "Who cares for me?" Thus, treating the whole scene, as I was learning, also meant to treat the whole patient as well as family, friends, and bystanders. To focus only on curing or stabilizing injury clinically denies the opportunity to help heal the illness, which is shared by the larger community that orbits the patient.

Decades later, with a new job in a small coastal town in Connecticut, I left the village coffee shop one sunny morning and noticed a small crowd gathered across the street at the gas station pumps. I approached and could see that an elderly gentleman was lying

on the ground. Two other men were kneeling on either side of him, speaking at him and trying to rouse him by gently shaking him. I joined them at their friend's side and checked for a pulse and looked for signs of life. Nothing. I positioned myself and checked again. Still nothing. I looked up and saw that I was now surrounded by a sea of sunburned knees, plaid shorts, and Sperry Topsiders and heard myself say, "Let's help this man.... Call 9-1-1." I felt for the zyphoid process, positioned and overlapped my hands on his sternum, and.... I pressed down.

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