Not my Emergency

Legal Disclaimer: Some details have been omitted or changed to protect patient privacy

Trigger Warning: This essay discusses patient cases that did not have a positive result, including cases involving children, reader discretion is advised

 There is an apocryphal story about prolific author Ernest Hemingway. They say that he once bet some of his fellow authors ten dollars that he could tell an entire story using only six words. The story goes: “For sale. Baby shoes. Never worn.” It’s a good story, regardless of whether or not Hemingway came up with it. It brings up a lot of questions, but our minds answer them almost as fast as they come up, filling in the blanks and doing the author’s work for him. For most people those blanks probably get filled in one of two ways. Either the story will be slightly comical (“Oh I bought them online thinking they were adult shoes, silly me!”) or it will be a tragedy, the baby the shoes were for is no longer around or coming to wear them. When I read that story it is usually a tragedy; but I may be a bit inclined to think that way because I have a story of my own: “For sale: Children’s Christmas gifts. Only played with once.” My story is a bit longer, but then again, I'm no Hemmingway.

Shell shock, battle fatigue, combat neurosis, post-traumatic stress disorder. PTSD has a long history in the United States, a history that is made convoluted by being renamed repeatedly, and with each renaming we seemingly started over with figuring out what it is, and what to do about it. Of course, PTSD is much older than that. In fact, in mankind’s first written tale, the “Epic of Gilgamesh” the titular character experiences PTSD-like symptoms after the death of his friend. The writings of Herodotus and Hippocrates both contain stories of battle trauma and flashback-like dreams (Crocq). Clearly PTSD, despite its new clinical sounding name, is not a modern invention. Much like other mental disorders, it has haunted humanity throughout our long and storied history.

For about 6 years I worked as an EMT in an emergency department. The hospital I was working at was huge, and it was busy. We regularly saw hundreds of patients in just one 12 hour shift. Most of these, luckily, are fairly minor; colds, bruises, broken bones or small lacerations. However, we also saw the patients that were very sick, or very injured. Now if you ask anyone in medicine or EMS, they will tell you that you tend to get things in “waves.” You will get a series of patients, none of them related in any way, all coming in for the same things. Sometimes it’s colds, or abdominal pains, sometimes gravity was apparently pulling a bit to the left and everyone was falling. Sometimes these waves last for a few days, sometimes they go on for months. Most of the time these waves are easily explainable; a disease is moving through the community or people have been out enjoying the weather and are more likely to get hurt. However sometimes the common thread is less tangible. During my time as an EMT, the hospital experienced one of those less tangible waves. We had a period, lasting about 3 months, where we saw a large increase in the number of critically ill and injured patients, (all of them with different disease and injury modalities) and where a large number of them, unfortunately, died.

PTSD is defined by the American Psychiatric Association as “...a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances.”(*Psychiatry.org)* They go on to describe four categories of symptoms: intrusion, avoidance, alterations in cognition and mood, and alterations in arousal and reactivity. Intrusion is the classic portrayal of PTSD, it can be anything from intrusive thoughts and memories about the event all the way up to nightmares or waking flashbacks. Avoidance is exactly what it sounds like, a desire to avoid reminders or triggers related to the event, as well as a desire to avoid talking about it. Alterations in arousal and reactivity is not referring to sexual arousal, it’s talking about your flight or fight response, and how easily or how often it gets triggered. Alteration in cognition and mood is the biggest, vaguest, and most difficult to describe category. In simple terms this is changes in your thoughts and feelings, but this can mean anything from feeling guilt about the event (misplaced or otherwise) to forgetting or “blocking out” parts or even the entirety of the event, it can also mean, in the APA’s words “... being unable to experience positive emotions (a void of happiness or satisfaction).” PTSD can also worsen, or be worsened by, the symptoms of other mental disorders. Every individual with PTSD will experience a different range, and intensity of symptoms. Symptoms can be present at all times, be triggered by specific stimuli, or both.

I think it was during my fifth year working for this hospital that we had this surge of critical patients, and patient deaths. As an EMT, part of my job was to do CPR on anyone who was in cardiac arrest. During that period of just a few months I performed it on close to ten different patients. That's more than I have done in the rest of my career combined, and those were just the patients that I was involved with. A colleague of mine had three back to back shifts and on each one of them had a patient who, despite the best efforts of herself and the other staff, did not make it. She, understandably, found a different job after that - one with patients of a less acute nature. I was not involved in the care for any of those patients, but there were two cases that I was involved in during that time that stuck with me. Even years later, the intrusive thoughts about them still occasionally appear, though I am lucky in that I have never experienced flashbacks, and any nightmares I have quickly fade.

PTSD is most commonly associated with veterans, and for good reason. In 2020, 16 veterans committed suicide per day (VA.gov). Every day. PTSD is a huge factor in that statistic. However, veterans are not the only group commonly affected; other commonly affected groups include first responders, healthcare workers, and victims of abuse. It should be noted that all of these groups tend to have higher suicide rates than the national average as well. It is also important to note that PTSD is not limited to those groups, anyone who experiences a traumatic event of any kind can potentially develop PTSD. However, while almost everyone will experience some or all of the symptoms of PTSD shortly after such an event, not everyone will actually develop PTSD itself. A diagnosis of true PTSD requires the symptoms last beyond what could be considered the “normal” grieving or recovery period. For many people the symptoms will fade during that time, assuming they are not repeatedly exposed to more trauma.

America, as a whole, has a problem with mental health. Historically, talking about anything related to mental health has been taboo, and actually asking for help? That has been seen as a weakness. This is getting better slowly, however, this is still a serious problem in some of the communities most affected by PTSD, and for somewhat different reasons. For example, in some military and police communities it is still seen as a weakness and there is a stigma attached to seeking help, or even admitting there is a problem. There are shades of that in the EMS community as well, but there are other things that complicate the problem too. We are often taught that no matter what we may be responding to, no matter the reason that people called 911, it is “not our emergency.”

In psychology, there is a concept called magical thinking. It's what you do when something bad happens, you start thinking “if i had just made this one tiny decision differently” or “if they had just done *that* instead.” We all do this, chances are you have done it in the last couple of weeks. Magical thinking is also what differentiates those two patients who stuck with me so much.

The first, a girl no older than 2 or 3, I couldn’t stop replaying in my head. There were so many ‘what ifs’, so many decision points I wanted to change, all of them before she even got to us. I was so angry. “If that button battery just hadn’t been left out.” Then she never would have swallowed it, it wouldn’t have gotten lodged somewhere in her GI tract, where it began eating away at her internally. “If the other hospital had just gotten better x-rays.” Then they would have seen the button battery, surgeons would have been called, ORs prepped and the battery removed before it had done too much damage. “If they had just transferred her to us, a more capable hospital, sooner!” Instead, she sat for hours in some other hospital while they debated sending her to us. If this, then that. If this one little thing was done differently, then maybe this little girl would have been fine, or would have gotten the surgery she needed in time to remove the battery. Magical thinking, all of it, but in reality she would be sent to us far too late, and with far too little information; she was crashing before she even came through our doors. We labored in the dark, ignorant of what was causing the problem, doing everything we could to save her as she bled out from the internal wounds caused by the battery.

“Remember, it’s not our emergency.” A common enough phrase to hear in EMT and paramedic training. The reasoning behind this is well intentioned. It is meant to remind us to remain calm. People call us when they are experiencing an emergency situation and it is our job to help, something we cannot do if we allow it to become *our* emergency. We must insert ourselves into the whirlwind of chaos, the maelstrom of impassioned emotions and heights of stress, and we must become an island of calm for people to cling to. This is a good thing to teach, but it does have some unintended consequences. There is an odd guilt that comes from admitting that you have PTSD from *someone else’s* emergency. From someone else’s trauma.

There is always a heavy silence after the doctor calls time of death. It’s strange, it's not *actually* silent of course; equipment is often still beeping, alarming, or otherwise making noise. The family members of the recently deceased are crying, sometimes screaming. Outside the room there is still a busy emergency department, and those are never silent. Yet, in that moment, which seems to last forever and simultaneously take no time at all, everything does really seem quiet… muted. It's an eerie feeling, and one that I don’t think could ever be adequately described. For the staff involved, the silence is often a mixture of things that are happening. It's a sign of respect, some innate, animal desire to not disturb the family as they begin grieving. It’s our own internal processing of the events that just occurred and thinking about what we need to do next. It sounds callous, and to an extent it is, but we need to continue doing our jobs. We need to move on to the next patient, even after such a tragedy. After all, it’s not our emergency.

 In the past, if I had a difficult patient case, whether a death was involved or not, I would walk outside, go around the corner so I couldn't be seen by my coworkers, and take ten deep breaths. Ten breaths, with the cool night air caressing my skin and soothing my lungs. I would feel whatever emotion I needed to, then put it in a box to be dealt with later, and go back to work. The entire process took less than three minutes and, usually, that one action was enough to process and recover. With this two-year-old, it was a bit different. I was so mad, repeating so many things in my head. All the “what ifs”, all the questions, I kept returning to the same image, over and over: looking down at her and doing CPR as blood and bits of acid eaten tissue poured out of her mouth; the slow creeping realization in that moment that something had been missed and that anything we did from this point on was likely to be futile. I knew it was going to be harder to process than others. I knew ten breaths wasn't going to be enough.

The treatments for PTSD are almost deceptively simple in theory. They include, but are not limited to, medication and different forms of cognitive behavioral therapy (CBT). However, there are a few caveats and complications. First, medication can be good for controlling the symptoms, however, (much like pain medication) it does nothing for the underlying problem and (much like with other mental disorders) is generally going to be useless long-term on its own. CBT consists of a number of different techniques, including various forms of talk therapy, either in group or individual format. This may or may not involve reliving the experiences that caused the trauma, depending on the specific technique used. Another incredibly helpful technique for treating PTSD is to talk about the experience with people who have gone through the same or similar experiences. These techniques have proven to be very effective when fully embraced by the patient and the clinical practitioner. However, there is an issue. People with PTSD tend to want to avoid anything that might trigger their symptoms or make them relieve the event. It is one of life’s greatest cruelties, when the symptoms of a disease actively fight or prevent the cure, and all too often that is what happens with PTSD and mental health as a whole.

The second patient stuck with me for reasons quite distinct from, and yet, very similar to the first. She presented to a small clinic affiliated with, and run by, the larger hospital I worked for. Which is why we were able to learn more about her story. On Christmas day, she had been playing with her siblings and their new toys when she scraped her leg on a table. A minor injury, not even worthy of going to an urgent care for, and she didn’t. A few days later, however, they realized the scrape had gotten infected and once she started feeling ill, her parents took her in quickly. They took her to one of our clinics, where she was quickly diagnosed with a systemic infection, otherwise known as sepsis. Antibiotics were started and she was transferred to us. Again, all entirely normal, we saw thousands of patients like this every year. It wasn't until she was en route to us that things took a turn. In very rare, and very advanced cases of sepsis, sometimes the antibiotics can be, essentially, overcome by the infection. In even rarer cases, this can trigger a septic storm, which can then cause severe organ damage and failure (Greenfield, et al.). This can happen very quickly, and in the time it took for her to fly to us (they had elected to transfer her via helicopter), she had gotten exponentially worse. Three days earlier, this seven-year-old had been playing with her Christmas gifts. She was happy, normal, without a care in the world. Before she got on the helicopter, she had been smiling, talking to her parents and the nurse who would take her to us, saying that it was exciting to be able to ride in the helicopter. By the time we saw her, she wasn’t even conscious. By the time her parents arrived (they had driven), I was doing CPR on her.

They say no plan survives contact with the enemy, and that is true in medicine. Things get messed up. We are only human, so mistakes get made. There are unforeseen complications or reactions. In the really serious or prolonged cases, things almost *never* go exactly right or exactly to plan, but ironically they did here. Everyone did *exactly* what they should have done, in *exactly* the right way, at *exactly* the right time. And yet, this young girl still died, despite everything we did for her. There was no magical thinking with this patient. There was nothing to change or “what ifs” to go through. We did everything right, and we still lost. *That's* what made her stick with me. That and I pictured her parents going home that night, seeing her Christmas presents still strewn about. Did they pack them up? Could they? Would they even be able to stand the sight of those plastic reminders or would they need to get rid of them as fast as they could? Or would they feel the need to keep them? Totems of all they had held dear, all they had lost. That's when I begin to feel the guilt. How dare I feel traumatized by something that is so much worse for them. *It's not my emergency.* Where do I get the right to feel bad about this, when this will clearly be the worst night of their lives.

That’s the funny thing about mental disorders though, they are essentially your mind fighting itself. There is a common trope in literature called “Create your own villain”. It’s pretty much exactly what it says on the tin: the hero of the story, through their own actions, creates his own greatest nemesis, the villain. The mind does this with mental disorders, and much like the villain in a classic comic story, PTSD will come up with increasingly ridiculous ways of avoiding, or escaping, the metaphorical “prison” of healthy thought. *Like feeling guilty about the way you feel.* Luckily, the story has its heroes too. Treatment and therapy *do work*, and there are plenty of people who have made it their mission to help.

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