The First Time

Category: Stories
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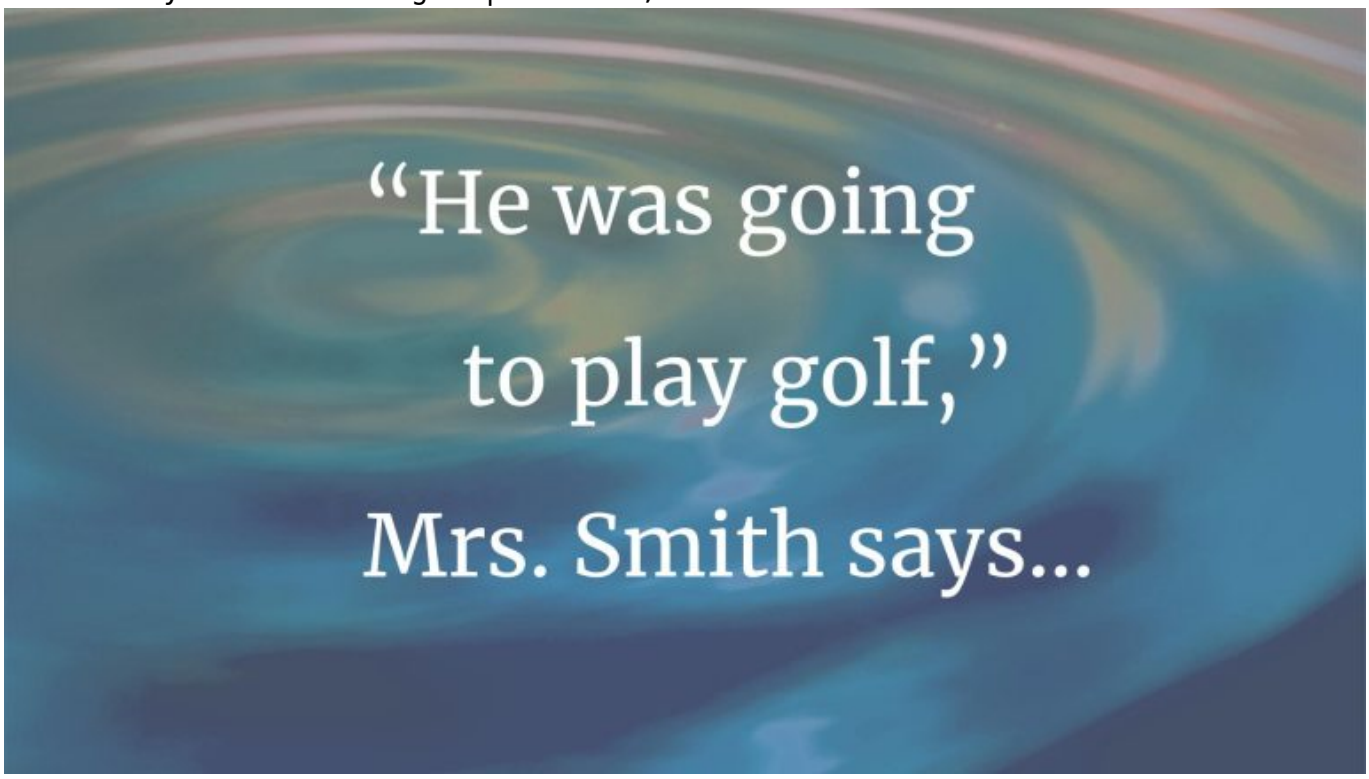

"KCE 357 to the Jerico Fire Department," says the dispatch radio at our community's volunteer fire department. I volunteer here as both an emergency medical technician (EMT) and a chaplain; I'm also the full-time pastor of an Episcopal congregation.

"Ambulance needed at 45 Lilac Court for the unresponsive person, possible cardiac arrest."

This is a high-priority call, albeit one that is common in our small town.

I hop into my car, equipped with an orange nylon "jump kit" of medical supplies, and head for 45 Lilac Court, ready to begin treating the patient before the fire-department ambulance arrives.

I knock on the door. A woman opens it.

"I'm with the fire department," I say.

"He's upstairs," she answers. "One of your firefighters is there already."

In the upstairs bedroom, an elderly man lies on the floor. My colleague Jeff turns him on his back, pressing his fingers against the man's neck.

"Pete, we don't have a pulse."

Okay, I think, *here we go again*. Jeff and I have done CPR together countless times. In a corner of my mind, I worry about the family, but I push those

feelings down deep: Speed and CPR come first.

Before we can begin, the ambulance crew enters, carrying the automatic external defibrillator (AED) and oxygen. Our radios announce that a paramedic is en route.

We administer oxygen and connect the AED. It's a simple device: First, pads are placed on the patient. Then the AED's automated voice directs us to press the "analyze" button. Depending on the results, the voice tells us to either press a button to shock the patient's heart, or to continue CPR.

The paramedic will bring medications, a heart monitor and a manual defibrillator that's much more powerful than our AED. We love it when paramedics arrive; their life-support care rivals that of hospital emergency departments.

We hook up the defibrillator and press analyze.

"No shock advised," says the defibrillator. "Continue compressions."

We begin CPR. That takes two people, and there are now five in the room. I want to get this man onto a longboard, downstairs and into the ambulance, where we can work more effectively.

But our new protocol states that we should begin CPR in the home—and that, when the paramedic arrives, he should deliver cardiac care on-site. If that is unsuccessful, he should contact the hospital and declare the patient deceased without transporting them to the hospital.

This new protocol is intended to save the system lots of money and resources. But as a chaplain working with many families who've lost a loved one, I find the policy very nervous-making.

It's deeply upsetting for a family to have a loved one heading for the hospital in cardiac arrest. But being told that your loved one has died at the hospital is less emotionally devastating than hearing that news in your home—especially with your loved one's body still there. I believe that time, and a little physical separation, can be very helpful—but this new protocol doesn't give the family even the short ride to the hospital to contemplate the possible loss of their loved one.

I also believe that this approach can be emotionally brutal for the paramedic and EMTs. Their entire focus is on saving lives: The team puts immense effort, both physical and medical, into reversing a cardiac arrest.

Previously, when only a doctor at a hospital could declare a patient dead, the EMTs and paramedics would continue CPR on the way to the hospital. Now, though, the duty of notifying the family falls to the paramedics—who might be feeling terrible that they've just failed to save a life. It feels wrong to me.

As Jeff and I continue CPR, the paramedic, Greg, sets up the monitor and IV lines. I hurry downstairs to ask the family for a basic medical history. It

includes some heart disease; the man had been upstairs getting ready to go to the golf course, says one relative, when she heard him fall. She went up and shook him; when he didn't respond, she called 911.

I go back upstairs. Greg uses meds that I've only seen administered in the hospital and shocks the man several times. Jeff and I ask if we should load the man onto the longboard and get him to the hospital.

"No," says Greg. "We're going to do everything we can in the home first."

After about twenty minutes, which seem like hours, we still find no heartbeat.

Greg looks at us. "I'm going to declare this to be an unsuccessful resuscitation and the patient to be dead. I'll contact the hospital to get that reaffirmed."

The call is made, and the physician confirms cause of death.

"Is it all right if I say a prayer?" I ask the crew. They agree, and I commend our patient's soul to God.

Greg heads for the door, looking shaken. I walk next to him, because I know he's going to notify the family, and they will need my support as a chaplain.

On the landing, Greg pauses.

"I've never done this before, and no one's given me any training," he says. "I'm really nervous, Pete."

As a hospital chaplain, I often work with physicians doing their first death notification. I tell him what I tell them:

"Just be straightforward and compassionate. Tell them that despite everything we have tried, their loved one has died. And then, full stop. Sometimes the family will become very emotional right away, but most often there will be a stunned silence. I would wait five or six seconds, and if no one says anything, ask them if they have any questions, and tell them that you're sorry for their loss. I know that phrase sounds trite, but families tell us that it's one of the most helpful things they hear from hospital personnel."

We walk downstairs to the living room, where the family is gathered.

"I'm looking for Mrs. Smith," Greg says. She identifies herself. Greg takes a deep breath and says, "I'm so sorry. Despite everything we tried, your husband has died."

Everyone in the family starts talking at once, and I can see that Greg would rather leave than deal with this emotional chaos. Who wouldn't?

"Let's stay just a little longer," I suggest, "and see if anyone has any questions."

“Is there anything else I could have done?” asks Mrs. Smith.

“No,” says Greg. “You called 911 as quickly as possible, and we arrived as quickly as possible.”

“Then why did he die?” she asks.

“I don’t know, Ma’am. You might need to ask his doctor,” Greg replies. He waits a moment, then says gently, “If it’s okay with you, I’m going to leave.”

“Thank you,” Mrs. Smith says.

Shifting into chaplain mode, I bring the family upstairs to visit the body, say a prayer and advise them of the funeral-home and police protocols to be followed.

“He was going to play golf,” Mrs. Smith says, “and then we were going to get together with friends and go out to dinner.” Pain, devastation and confusion, all in one sentence. “How can this have happened?”

All I can say is: “I don’t know, but he was well loved and well cared for and looking forward to this day.”

Which is true. And my feelings of *This totally sucks* and *Damn* and *I wish we could have saved him* can only be shared back at the firehouse, with the others who were on the call.

Death is a part of emergency medicine—indeed, of medicine of all kinds. And, as many philosophers and religious leaders would remind us, death is the one experience that awaits us all. Given that, I find it ironic that we don’t train first responders how to talk to patients’ families about death.

It’s incredibly hard to figure out what to do when you’ve had no preparation, haven’t thought much about it and likely have no one else there to assist you. While every paramedic has seen a lot of death, telling a family of a loved one’s death and then compassionately reaching out to the grieving family members may be new territory.

If we could offer first responders training in this area, it seems to me that we’d be giving *them* some care as well—caring for the caregivers. And that, in turn, would benefit us all.