At some point in your EMS career, a patient will fool you. It will make you angry and more suspicious of other patients. Some providers take such deceit as a personal affront and change their behavior. I’ve seen providers practice various pain-evoking maneuvers to try and determine whether their patient was faking. This is nothing new.

When I was a paramedic, we used the old “hand-drop” technique, which involves moving the forearm over the face of a supposedly unconscious patient and letting it go. In theory, an unconscious patient’s hand would fall onto their face, but in the feigning patient, the hand would magically miss their face.

Others preferred the “fluttering-eyelash” technique. If you lightly touched the patient’s eyelid and it fluttered, they were really awake and faking. Some providers used a hard sternal rub. I’ve also seen some physicians and nurses use the “nipple-squeeze technique.” And then, there’s ammonia. Some EMS personnel will pop an ammonia inhalant and hold it under the nose of a patient at the drop of a hat.

But what’s the point? The patient must still reason for the patient’s behavior.

The ethical, objective way to react in the field without ammonia

Although we may suspect that a patient is being less than honest, such thoughts shouldn’t impact our patient care or decision making. Before we determine a patient is feigning illness or injury, we must first exclude all other possible medical and psychiatric causes. More often than not, there’s a medical or psychiatric reason for the patient’s behavior.

CASE 1
I remember a case that occurred many years ago when a woman in her mid-30s was brought in from a bar. She had been drinking and complained of one leg jerking. The EMS personnel were sure she was faking. After all, who had ever heard of one leg jerking?

The nursing staff immediately bought into the idea that the patient was faking. She was treated curtly by the nursing staff and was placed in a room where she could be observed behind the curtains. It appeared that—when “unobserved”—her leg would stop jerking.

I evaluated her and decided to order some intravenous diazepam just in case the jerking was indeed a seizure. The nursing staff then teased me about being “too compassionate.” They further speculated that the patient was most likely drug seeking—probably for the diazepam I had given her.

Her labs and drug screen came back negative (except for alcohol). I ordered a CT scan of her head and thought I saw something in the midline. The radiology resident agreed and suggested an MRI of the patient’s brain, which I ordered. It showed the presence of a large brain tumor (meningioma) that crossed the midline of her brain, near the portion of her motor cortex that controlled her leg.

The ED staff became quiet and remorseful. Subsequently, everybody went backwards to treat her with respect and dignity. This resulted from the nursing staff’s guilt and the realization that this poor woman might have had an inoperable brain tumor. In actuality, she should have been treated with respect and dignity as soon as EMS arrived on scene, and this should have continued in the ED.

CASE 2
In November 2006, in Ann Arbor, Mich., a political protest was under way at the University of Michigan. For some reason, the protest became unruly. The police intervened, several people were arrested and a man was injured when he was pushed to the ground. Another protester, Catherine Wilkerson, MD, saw the man go down and went to his aid.

The first-arriving EMS crew provided appropriate care. Soon, a supervisor for the ambulance service arrived and quickly decided the patient was faking. He broke an ammonia inhalant under the patient’s nose and said, “You don’t like that, do you?” When he didn’t get the response he wanted, he broke another and repeated the procedure.

When Wilkerson attempted to stop the paramedic supervisor from administering more ammonia, she was removed by police and later arrested and charged with interfering with an EMS crew and police.

The patient was transported to the hospital, extensively evaluated and diagnosed with a cerebral concussion, in addition to facial contusions. It turned out he wasn’t faking at all.

The local district attorney pushed the case. Wilkerson wouldn’t settle for lesser charges, and the case went to trial in December 2007. After days of testimony, the jury found Wilkerson not guilty of all charges. Interestingly, ammonia inhalants were removed from the ambulance service after the story hit the press.
CASE 3
Although it’s not an EMS story, another highly publicized case points out the problems with ammonia inhalants. In Panama City, Fla., a 14-year-old boy was admitted to a community juvenile boot camp after stealing his grandfather’s car. The boot camp was designed to get young offenders on the right track before they end up in the prison system. The teenager, Martin Lee Anderson, wasn’t keeping up on the initial morning run that the detention officers were monitoring.

When he fell down, several detention officers and a boot camp nurse began to break ammonia inhalants, hold Anderson down and cup the inhalants around his nose. They continued this until they used at least five or six inhalants—over a five to six minute interval—all caught on videotape. Anderson never got up. CPR was started, and he was taken to a community hospital, where he died.

It was later determined Anderson had sickle cell trait—a condition that decreases the amount of oxygen carried in the blood. After the incident, Florida Governor Jeb Bush ordered the state’s attorney in Tampa to investigate. Although the initial autopsy in Panama City found that Anderson had died of “natural causes,” the second autopsy in Tampa found that Anderson died of asphyxia due to repeated ammonia inhalation. Florida ended up paying the Anderson family $5 million.

THE OBJECTIVE APPROACH
At some point in your career, you’ll encounter patients who will feign illness or injury. But it’s not the role of prehospital providers to determine whether a patient’s complaints are legitimate. Assume that such complaints are real and treat the patient accordingly.

Sometimes it’s necessary to elicit a pain response in a patient with altered mental status. But do it objectively and compassionately. It’s best accomplished through a trapezius muscle squeeze, supraorbital pressure or mandibular pressure.

The trapezius squeeze is applied by grabbing approximately 1” to 2” of the trapezius muscle near the base of the neck between the thumb and index and long fingers, squeeze and twist.

To apply supraorbital pressure, feel for the notch along the ridge of the orbital rim near the underside of the eyebrow. Using a thumb, apply firm upward pressure to the notch. Mandibular pressure is applied with the index and middle finger pushing upward and inward at the angle of the mandible. Supraorbital pressure and mandibular pressure shouldn’t be applied if a facial injury is present or suspected.

THE PROBLEM WITH AMMONIA
There’s absolutely no role for ammonia inhalants in prehospital care. We addressed this in the March 2003 issue of JEMS. Ammonia is toxic. It causes closure of the glottis and can activate the mammalian diving reflex (i.e., apnea, bradycardia).

Ultimately, ammonia can lead to hypoxemia. In most patients, this may not pose a problem. But if the patient has a disease that interferes with breathing or oxygen delivery (e.g., asthma, anemia, sickle cell trait), the results can be fatal. And, as occurred in the case of Anderson, the presence of the disease may not be known.

CONCLUSION
Remember two of the most fundamental aspects of medicine: First, always serve as an advocate for your patient. Never assume your patient is faking. Second, primum non nocere (first, do no harm). Never administer a treatment or procedure that will possibly harm your patient.