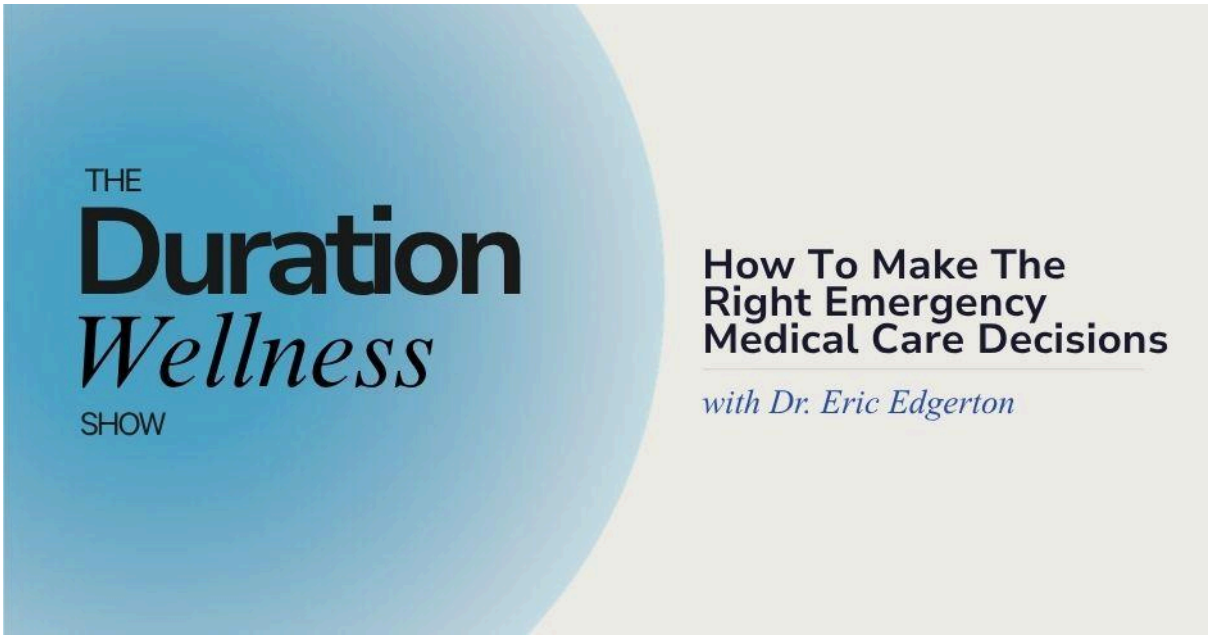

We all face sudden health choices that require swift, informed decisions. In this conversation, host Dr. Anna Marie sits down with board-certified emergency medicine physician Dr. Eric Edgerton to demystify how you can navigate emergency medical care with confidence. They break down the critical differences between a standard emergency department, a freestanding facility, and urgent care. You'll discover when it's vital to bypass driving and call emergency services, especially if you're taking specific long-term medications. Dr. Eric Edgerton also explains how establishing a strong partnership with a primary care physician serves as your best defense. Learn to recognize true physical warning signs so you can protect your longevity and secure immediate support when it matters most.

Watch the episode here

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How To Make The Right Emergency Medical Care Decisions With Dr. Eric Edgerton

Demystifying Board Certification Realities

Welcome to the show. We are back for another episode, which I am so excited about. Our guest is Dr. Eric Edgerton, a board-certified emergency medicine physician. He spends his workdays caring for patients in high-stakes emergency situations. I am so excited to have you here. I know that is a very brief intro, but if you want to give a little intro to yourself, you can go ahead.

Thanks for having me. It is exciting to be here in this context. You and I obviously go way back in our training days. It is cool to talk to you from this end of the computer. Emergency medicine board-certified since 2021, I think. When did I finally complete that? Our residency, then because of our oral boards, all of my colleagues were delayed also because of COVID. The COVID testing, we used to do an in-person thing that switched around and delayed, like a year off. It is always weird to think about those dates. Residency was in 2019, and then you complete the board certification process after that.

A lot of people probably do not know how intense it is and that you guys have to take oral boards and all that craziness.

That was quite interesting. These days, I do not even know if it went back in person. It is all Zoom now, and the format is quite intimidating. You are in a weird virtual waiting room, and someone's face pops up that you have never met, never will see again. They are a board-certified emergency medicine doctor who is administering this case. They are like, "This is a 24-year-old coming in for this, that, and the other, and your time begins now."

You have to do this crazy virtual thing, and there is a structure to it. It is a very interesting process. A lot of medicine is physical, but there is a whole mental component. Probably 90% of the job is cerebral. You have to see things, recognize, do, and then by the end of the visit or sometimes right at the beginning, you get the physical aspect taken care of. We have medicines and things, but that is medicine in general. That is your job. What do you think of this? What do we see? What do we do?

There is a lot of nuance to it that I think people do not realize, and a lot of training to get to this point. A lot of training. For you in the emergency room, what, for the average person, do you think people do not really understand in terms of the ER? What exactly does an ER do that other medical settings do not do?

Understanding The Sorting Hat Role

That is a good place to start. The emergency department and ER, emergency room. It used to be an emergency room. There was a room in the hospital that was near admissions because emergency medicine is actually a relatively new specialty in medical history since Hippocrates way back in the day. It started as a room off of the registration at the front of the hospital where they were like, "This person is very sick."

We do not really have a bed ready for them upstairs. We are going to get them up there initially, but we need to do something to stabilize their bleeding from something, and we need to stop that bleeding. It was a way to figure out an acute illness and where it needs to be. I describe my job to my

patients, friends, whoever is asking, as my job is the first fifteen minutes of everybody else's job. The ER is rarely a place where things get definitively taken care of, but it is a sorting hat for the younger crew listening to this in the Harry Potter world.

I like that analogy.

It is who needs surgery, who does not need surgery, who needs to stay in the hospital, who does not need to stay in the hospital. Can we identify something rapidly that needs a different course of therapy? Maybe someone has already been on some medicine or treatment that is having an adverse reaction or event associated with that, or they are thinking, "It does not seem like it is working and this thing has progressed." Maybe we do not have the answer for that specifically. Our role is to help people figure out where they are in a given course of an illness or issue and escalate, reassure, or say, “It looks like you are actually done with this thing. We can take those stitches out." It is rare that we remove too many other things. That is probably a sorting shipping facility, as it were.

No, I think that is a good explanation. What would you say are the most common reasons that people come into the ER?

Perceived Emergencies Versus True Medical Crises

Pain or something associated with pain. That is from head to toe. You have chest pain. That is a very common reason. Chest pain, back pain, abdominal pain are very common. Sometimes people come in for emotional distress or events. Sometimes it is something that has happened literally on the road in front of the hospital, and they come in by ambulance. It happens that they have had this pain for twenty years, and today is the day that they are just sick of it, is what we hear commonly, and that brings them into the ER too.

A lot of times it is pain, difficulty breathing, difficulty producing urine, or stooling. Some people say, "I have not pooped in ten days, and I am here to figure that out," and that can be for a number of causes. We get our thinking hats out and try to figure that out with them at the time. Pain is the biggest single reason. Blank pain, whatever it is, and it hurts, and that is what brings me here.

Tweet: The emergency room isn't always the place for definitive cures. It functions as a sorting system to get you to the right specialist.

That can be a signal for other things. That makes sense. What do you wish the average person understood better about emergency medicine?

If someone understood this better. That objective emergencies and perceived emergencies are different things. Sometimes someone will say, "This is an emergency." Pain is also a relative thing. The first time a child stubs their toe, they have never had anything else happen to them before. That is the worst pain they have ever felt. That is respectable, and that is the worst pain they have ever felt. A common question that I will ask sometimes, I am not trying to be facetious, but to try to help gauge a situation very quickly, someone will say, "It is an 11 out of 10 pain in my arm or my belly or whatever."

They will look fairly comfortable, tolerating it well. Their vital signs look good. They will say, "This is the worst pain I have ever felt." I will say, "This could not be any more severe. If you stubbed your toe, you would not be in any more pain. If we added a chainsaw to this situation, we would not make this that much worse." I am not trying to be ugly in that sense, but I have to understand where they are at. If it does not look like where they are describing to where they are, there are different pain tolerances and those things.

We are just meeting these patients within fifteen minutes and trying to figure out top to bottom where in this life and journey they are at, and if they have just fallen off a building or did just stub their toe, and those are different things. Now they can be relatively more severe and perceived as more severe. At the end of the day, I need to know. Do I need to call a surgeon about you, do I need to call internal medicine, do I need to put a splint on this and have you follow up with someone, or do you need none of those things and just some reassurance of like, "Muscles hurt sometimes, and that is okay. This is a little bit of redness, but this does not represent a big infection."

That is a roundabout way of answering what I would like someone to understand about the ER, which is that we are trying to address appropriately what someone comes to us with. I do not want to push the big red button and activate all these things because that takes resources away. We are trying to appropriately treat and assess things at the appropriate time and at the level of intensity that is required, and that is quite a challenge sometimes.

It can be, but I think that is a good explanation, and also just going back to emergency medicine. You are dealing with actual emergencies. When you are seeing a patient, you are trying to establish, "Is this a true life-or-death emergency?" You are describing this pain. Is this life or death? Is it, "This is pretty severe. It is affecting you. It is not diminishing how you are feeling, but it is not in that life-or-death category." That also is something for people to remember when you are asking these questions.

Emergency Room Versus Urgent Care Differences

There are different contexts of emergency departments as well. Which is another thing that not too many people realize. Including myself, before even going to medical school, but then also before residency, you drive by a hospital on the road. It might be the hospital down the street from your house in your neighborhood that has been there for 30 or 40 years, or, "I was born at this hospital." Their resources, their team of doctors, are going to be fairly different from the team of doctors at a tertiary trauma center, tertiary care level one trauma center, or big burn center.

One of my best friends was in a big electrocution burn incident. There is a big burn center in Orlando, but he had to fly to Texas because that was the premier burn center in the country for some of his surgeries and procedures. Medicine is also a geographical thing. Sometimes someone will come in and be frustrated that we have to transfer to another hospital at one of these smaller places where it worked. We do not have the surgeon or the technology or sometimes just the medication, because of the training that is required to administer that drug from certain staff or the way that we need to monitor it for things like neuro ICU cases, those kinds of things.

That is another thing as well. Going back to the understanding piece, the medical system, there is a lot of critique, and some of it is very warranted, and some of it is, in my opinion, misplaced a little bit. The medical system is a system. It is not like a cut-and-paste, like boom, boom, here is a hospital, this can do this, this can do this, this can do this. It is regionally set up so that we can handle some of these simpler things in the smaller areas and then get someone to a higher level of care in another area with efficacy to a pretty solid degree, I would think.

That brings us into the next because a lot of people do not understand all of these nuances. Especially when people are in a semi-emergent to an emergent scenario, I think a lot of people do not fully understand, "When should I go to an urgent care or when should I go to an emergency room?" or "Is this ER down the road the ER I should go to?" It is a freestanding ER versus an ER that is attached to a hospital versus their primary care.

I have even told people they are asking me medical questions, and I am like, "You need to go to the ER." I got a message two hours later. "We are at urgent care, and they are sending us to the ER." That is why I said the ER first. A lot of people just think they are all the same. How do you think people should think about an ER versus an urgent care in comparison to their primary care?

One of the ways to consider it, and this is one of the things I talk to my patients about, is the blood pressure analogy that I give to people because there will be a lot of people who come in for blood pressure. This is not medical advice. Do not focus on any numbers. Someone may come to the ER and say, "I took my blood pressure at home, and it was X, and mine is always this. Something was different, so I came straight here." I will say, "What are you feeling at the time?" It is like, "I did this thing, and then I noticed my blood pressure was high."

I said, "How do you feel right now? Do you have any chest pain? Do you have any shortness of breath? Are you having trouble moving your hands or feet? Do you have excruciating pain somewhere?" They will say, "No, actually I feel pretty good. I do not have a headache. I do not have vision changes or trouble speaking. I do not have chest pain or abdominal pain. My urine and stool

have been just fine." Those are all just fine. I was just worried about the number. That is when I will say, "We have treatment thresholds for different things. If you are feeling bad, you are feeling ill, feeling sick, there is a spectrum of that."

You can feel like, "I am about to fall over, and this has got to be the end." If that is your feeling, it does not matter if your blood pressure is textbook over 80. You need to go to the ER because if you feel like you are about to die, please, for everything that is good and lovely, please come to us. That is my deal. That is my job. I am more than happy to get that figured out with you because that is what I trained for.

Tweet: We must distinguish objective emergencies from perceived ones. Emergency doctors look for true signs of life-or-death situations.

Those are the moments in time that we are like, "Boom, we have done the thing," and that is so because sometimes I have had even family friends say, "I went to the ER, and they thought I was crazy because I was describing this chest pain, but they just looked at me like I was nuts." I was like, "If you look and feel fine and say that you are feeling fine, that you had this little twinge, I do not think they are trying to say that nothing is wrong with you, but they are trying to, again, go back to finding where you are at and what is going on."

I am typically a long-winded individual. I know you know this. ER versus urgent care versus a freestanding ER. Urgent care and a freestanding ER are fairly similar, but urgent care would be, "I have got a runny nose, I need a strep swab or a COVID test, or I do not want to go to this family event knowing that I have this thing and spread it to someone." If you are feeling poorly and you think it is a virus or something possibly contagious, probably just skip the event, but everybody has different thresholds and how they like to deal with that, and so I will not make any assertions in that regard. If you are feeling bad, if you are concerned about an imminent life-threatening thing, absolutely ER.

The biggest ER that you can find. There is a freestanding ER five minutes further down the road. You have something else going on. With ambulances, they will tell you, or if you call an ambulance, they will take you to the closest ER. They will not take you to urgent care. They will take you to an emergency department. Urgent care is if you are walking and you are talking. You need stitches out, you need stitches in. You cut yourself or something of that sort. Sometimes urgent care can set bones. They send a lot of their stuff to us too. Not all urgent cares are exactly the same. It is a tough question to answer because this is one of those geographical answers.

It is true. They are not all the same.

They are not all the same. As if you are down the street from UF Jax, which is a level one trauma center, boom, bam. I know personally some people who have been in bad accidents right outside of that hospital and just happened to be like, that was the closest level one trauma center, and they showed up, and they got fixed and are telling the story to this day, and it is awesome. People will come to our small ones, and we will send them to bigger hospitals too. I do not know.

That is a tough one, but you are walking, you are talking, you are breathing okay, and it is just a question as opposed to, "You are holding your side and saying something is not right in here." If that is your situation, if you are saying, "This is hurting, I cannot breathe right, something is not moving that is supposed to be moving, something is moving that is not supposed to be moving," go to the ER. We will get you figured out.

People a lot of times think that they are almost the same. That is where it is like, I think sometimes people can get into trouble because I feel like I admit people all the time. They are like, "I started out at the urgent care, and then the urgent care sent me to the ER." Now they are getting admitted. How sick they were is that they needed to be admitted to the hospital. I always tell

people it is like urgent care is really just for more easy-peasy things. Again, they are not all the same, but a lot of them will only have X-rays.

Every once in a while, they will have a CAT scan or an ultrasound, but your imaging in terms of, like, if you are having the worst abdominal pain of your life, you probably are going to want to have a picture of that. If you are going to a place that does not have the ability to do that, then you also have to think about interventions. If something needs to be done in urgent care and cannot be, that is not where you end up getting admitted to the hospital. Even for you guys, sometimes a specialist will call in, and they will see them in the ER, and then they will go home from the ER.

That does not happen in urgent care. I think that is helpful. The whole freestanding ER, I know we just talked about it versus an attached emergency department. People do not understand the difference there. If you end up being admitted, well then you are going to have to get transported in an ambulance to another hospital. You do not have and you can go into that a little bit more, but what has your experience been in terms of a freestanding emergency department versus one that is attached to the hospital?

Also, many good questions. We could probably talk for hours just on this alone, but I think this is where some people may be critical of the medical system, but this is probably a good example of how effective the medical system is. We can concentrate some of these bigger, rarer, more invasive therapies and procedures into a place where you are having this issue, and now we have a heart surgeon and a kidney surgeon and a general surgeon.

Tweet: Don't wait to find a primary care doctor. They're the quarterback of your health, managing your history and navigating complex care.

You have all these specialists under one roof that, if something is going on, as opposed to trying to put one heart surgeon way out in some Waresville that maybe they are not doing the cases and they do not get to keep up with their practice numbers and volume. Not for the surgeon's benefit, but for like if you are getting a procedure done, do you want the guy that has done 10 of them or 10,000 of them? Most people would want the one that has done 10,000. That happens at these bigger hospitals. I think more than ER versus urgent care versus freestanding, it would maybe depend also on the time of day when you choose this.

The Vital Role Of Your Primary Care Physician

If it is business hours on a Tuesday, this would be a huge moment for you to be involved with a primary care physician. It is pretty common. I do not know, maybe a 30/60 split just anecdotally. I do not know the actual number. Maybe I need to know the number of people who have a primary care doctor. They say, "It is Dr. McCarthy. I see her every year. I see her three times a year for this condition." As you said, I told them, "I think they are going to need to stay in the hospital. They need to go straight to the ER, and we can get this handled." It is a part of the system that you would have a primary care doctor to help you figure that out. In the primary care setting, or not necessarily because you do hospital stuff more than that.

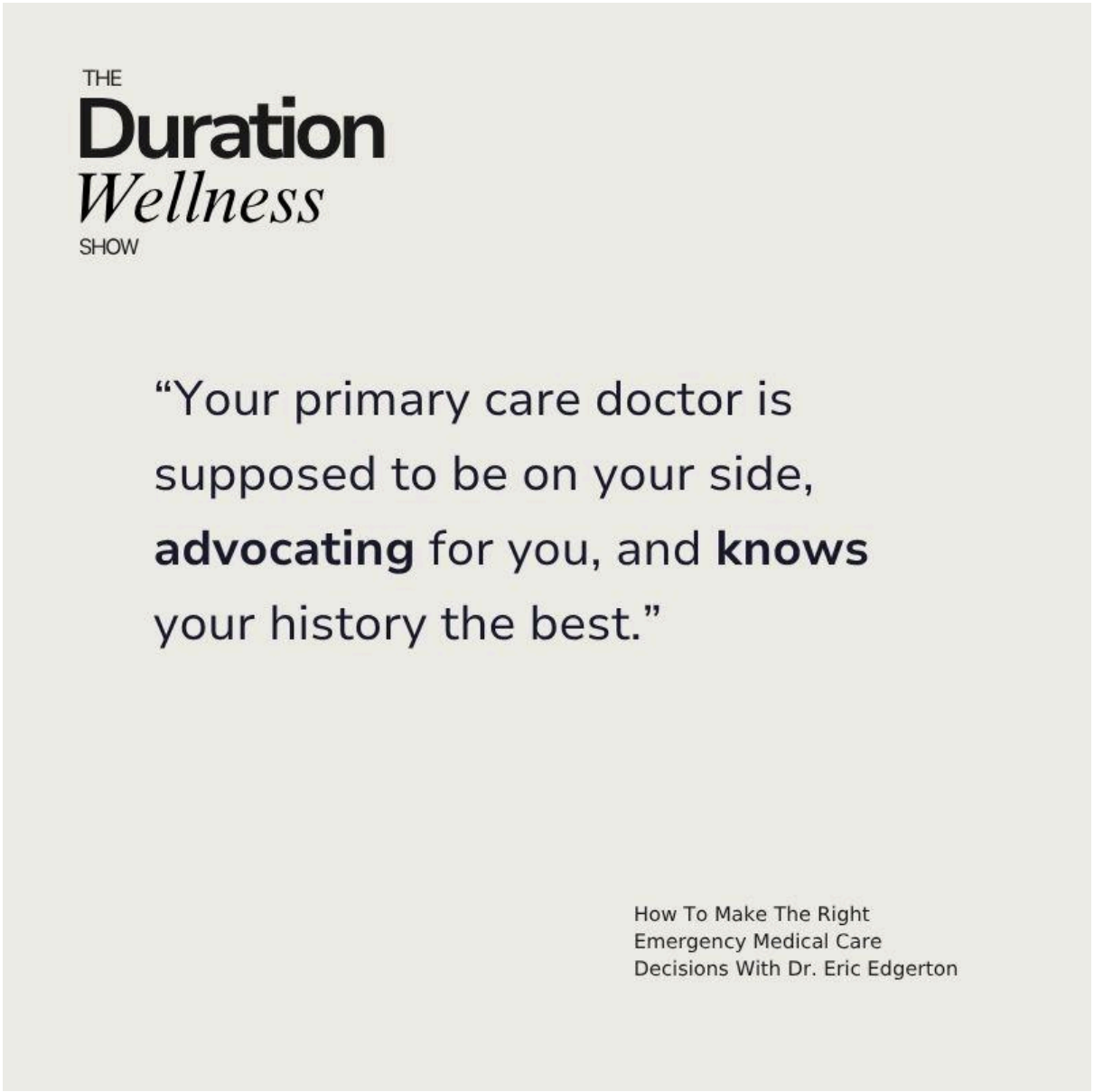
From a clinic, I think maybe we have done maybe not as great a job as we should as a healthcare system to champion our primary care doctors. The person sitting next to me in med school was primary care. The person training next to me in the ER on a few of our rotations ended up going to primary care. That is a phenomenal place to start. A lot of primary care doctors can put in stitches. They can certainly take them out. They can organize care. They can help you say, "You actually do not need to go here or go here. You just need to go here."

You can cut out a lot of the decision-making and things. There would be a fee associated with that, certainly, but they will absolutely be called the quarterback of the healthcare system. Who do you need to see next? Where do you need to go? What is the play? What are we going to do? I have got a bunch of patients who actually come through the ER, and they say, "Will you check with my primary care doctor first?"

It will be 12:00. I assure you, your primary care doctor will be happy to hear about this in the morning. I think it would be huge, and there probably needs to be a little more effort on everybody's part, patients and providers, to establish these primary care relationships. That is probably where the crushing chest pain or abdominal pain needs to be considered. Like, "This pain in my shoulder has been going on for a while."

The perfect scenario to skip urgent care and the freestanding altogether. Start with your primary, but that being said, the ER doctor here says shoulder pain should never be seen in the ER because there are plenty of things that can go wrong. After time in the trenches, you see all different things that have gone wrong. It is like, "Man, if you are concerned, come see us." Having that relationship with your primary care doctor would be absolutely massive in helping get that figured out and knowing that your primary care doctor can actually do a whole lot for you and get a lot figured out with you and for you.

No, that is definitely true. A lot of people sometimes forget about that. Your primary care doctor is supposed to be on your side, advocating for you, and knows your history the best.



To that point too, it really helps us in the ER if someone did call their primary care doctor or their primary care doctor sees them in the clinic and calls us and says, "I have got Mr. Jones here. I am worried about this thing because I have seen him for a long time and there is something different today. I do not like what he is doing." We have had calls like that that end up being a heart attack. Turns out they were having a big surgical emergency in their abdomen and had something surgically corrected that needed to.

It is one of my favorite things actually when a primary care doctor calls about a patient ahead of time and says, "I am worried about them. This is what I have done. This is what I know about them. If you can help me get this figured out." Absolutely, that makes our job that much easier and more effective. The ER without primary care, because we are not primary care. I do not focus on the same things.

I do not have their training, and they do not have mine. If you are walking, talking, breathing, and you are not having crushing chest pain, you can have a moment to make a phone call or show up to

your primary care office. A lot of them will have sick visits or walk-ins, and I would talk to them about that. There are some that end up pretty busy, and we get that, but a big place to start as well.

When You Must Call Nine One One

When do you think somebody should, instead of having a friend drive them to the ER, when should they just stop and call 911? Which is like a big question, but big things that you think people do not think of and you are like, "Why did you just walk in the door?"

Vision problems, okay? If all of a sudden one side is just black and you cannot see anything, that would be a great time. If you are having trouble speaking, if you are having trouble understanding something or following commands, or if you are with you, that type of thing. Crushing chest pain or just bad chest pain in general, and everything is relative. Sometimes things do not always present the same way. If you are in a bad spot, if your abdomen really is just killing you, "My belly."

Those are great times. Number one, the EKG that EMS typically will get in a chest pain or shortness of breath scenario, the interventions that they can do can sometimes save days in the hospital or just flat-out the initial treatment that you needed. That is super helpful. I would say chest pain, weakness, numbness, trouble speaking, shortness of breath, or trouble breathing. That is when you need the ambulance to get to you. Sometimes people, in one of the places that I work, their house is literally within a sightline of the ER.

If you can get in your car and get to our front door faster than you can call an ambulance, just come straight to us. That is a judgment call. Typically, if it is breathing, chest pain, or excruciating abdominal pain, or something is not working, like numbness, weakness, your vision, or speaking, those are the times you need to get an ambulance involved, or a trauma scenario. You fell off or something, got in a car accident, and something has been disarticulated, or fingers come off or something. Those are good times.

Also, I think sometimes people need to, you brought it up, but how far you are from the hospital. The further you are away, if this is something serious, driving there versus having an ambulance where they can actually do some interventions. I actually made this mistake with my oldest son. He had what ended up being an anaphylactic episode. At the time, he had eczema. I thought it was allergies and a worsening rash and stuff. I was like, "We need to go to the ER right away."

I was like, "We have to go to the kids'. They will be able to treat him better." We load him up in the car. As we are driving there, then he starts having more of the tongue swelling and all this stuff. I was like, "No, he is having anaphylaxis. I should have called 911." It is like, by then we are halfway through the car. It is one of those things where it is like, I should know better, and I did not.

Tweet: Driving yourself to the hospital during a stroke or heart attack can delay critical care. Let emergency services start treatment en route.

It is always hard when it is your own.

All of my medical knowledge just went out the window, and I just was not thinking. It is important, and that is something you can also talk about. EMS, they can actually do some interventions. I guess what are some of the ways that EMS can actually speed up treatment for some people? I think that is something for people to be aware of sometimes when they are deciding to call 911 versus just driving to the ER.

The three that are straight off the top of my head and I think are fairly universal are strokes and heart attacks. Depending on where EMS in your county is, some people do not think in terms of county, but that is the way kind of EMS and a lot of this healthcare stuff is sorted out. If you live in a bigger

city, your radius of livelihood and travel and those things shrink quite a bit. In the setting of a heart attack, if they can clearly see a clear-cut heart attack, depending on their location in the county, they may go ahead and take you to the cardiac interventional center.

If they do not, and there are a million different ways to assess or diagnose a heart attack, but one that would require intervention, they can get you to the correct place sooner sometimes. Stroke as well. Typical signs of a stroke would be a sudden change in vision or speech ability. “No, am I having one?" The speaking ability or understanding ability, and weakness or numbness. If EMS recognizes some of those signs and there are two options that they are right at the 50-yard line for, they may say, "We are going to go to the stroke interventional center as opposed to the other, maybe smaller place," or something of that sort, and trauma.

A bad car accident, an industrial workplace accident, something of that sort. If they can see the injury that is going to require those things and it is five extra minutes to this trauma center, that five extra minutes in the long run is actually sometimes hours extra because you are at the place that they are going to be able to do something about it as well. Certainly, thoughts or signs of a stroke or heart attack, EMS always, and bad trauma. You can be the judge of that, but if it is bad, I would absolutely call 911.

Again, I like your explanation of, like, one, there are different hospitals. That have different levels of care and have different interventions that they can do. They can do certain things. They have some oxygen. They can help. They can give some medicine. There are a lot of other things that they can actually give en route, I think.

They have epinephrine for anaphylactic events. They have pain medicine that you can get a jumpstart on your pain medicine therapy, as is deemed appropriate by them as well, because they have protocols and they have judgment calls as well. They are usually really good about administering what they can for patients because they want to see everybody feel better too.

That is great. What would you say if somebody is like, "I am going to the ER." What do they need to bring with them? Obviously, if it is a true emergency, do not stop and get all your stuff.

I would say what you got on, an understanding, open mind, because just like any other service that you might be thinking, everybody has different levels of knowledge about themselves and their bodies and how they work and how they feel. Some people will say, "I felt this all the time." Like, "Why did you come today?" "I am glad you did because this is happening." It is like, "You feel this always?" "Yeah, this is every day for me." I am like, "I wish you would have come three months ago," based on what you are telling me.

No, not three months because that is then, by definition, also not the emergency. You do not need to bring anything with you. I have an idea. Actually, if you have that yellow DNR paper, bring that. I tell people to keep that, and that is a very special scenario, set of circumstances, typically for older or terminally ill patients who do not wish to have cardiopulmonary resuscitation, CPR. If you have that yellow sign in Florida, it is a yellow-signed piece of paper.

I typically tell people to have that magnetized to the refrigerator because that is usually a fairly central location in the house, and EMS, if they do get called to the house, might see that and say, "Is that for Mr. Jones here?" and say, "He would not want to be intubated. He would not want chest compressions," those kinds of things. That is crucial information. Definitely bring that if that applies to you. Other than that, just come on in. We will get you figured out.

How helpful is it for patients to know their medical history, allergies, medicine?

Pretty darn helpful. We're lucky that there are plenty of allergies that are absolutely real, the ones that really, really matter, the anaphylaxis ones. One thing I will tell people, because we will ask like, "Do you take any medications? Are you allergic to anything?" and they will say, "I got a list of stuff." The premise of that, I like to explain, is Dr. McCarthy is a very good doctor, but how well do you know Dr. McCarthy? She is a stranger to you, and she is telling you to put these things in your body. I would know the doses and the names of them. Same thing.

"I have known Dr. Anderson for years." Again, this is someone who is not you, who is telling you to put this stuff in your body. For no other reason than you are just aware of your person, good information to know. Sometimes if someone is on a certain medication, then that takes some things off of our list that we have to worry about. Not that we have to worry about it, but we can say, like, "That medication treats this thing, and so we do not have to worry as much about this thing." It is important to know what you are taking because it helps me figure out what I need to figure out and how it might be affecting or interacting with what is going on and what has brought you here.

As you said, it can change vital signs, and it can also interact with some of the treatments that you might want to offer. That is something else for people to understand. It is like some of these medicines do interact. It is helpful for us to know what medications you are actually on. It adds to the whole clinical picture.

I would prefer that, in most scenarios, someone will try to mitigate some of their symptoms. Obviously, there are some things that are very severe. I will say, "What have you done or taken for this? What have you tried to make this pain better?" They say, "I haven't done or tried anything. I just came straight here." Which is, you are having this thing that you are really worried about, but we can also try some things sometimes.

Tweet: If you're on blood thinners and bump your head, go straight to the emergency room. Don't risk silent internal bleeding.

I do think something that is cool is a lot of the phones now have those emergency SOS contacts and stuff so that if somebody was picked up, it can actually have people enter their medications in there and their allergies and all of that, which I think is a really cool thing with technology now that it can help with that.

Yes, that has actually helped a lot. In cases that someone has come in completely with altered mental status, obtunded, unable to communicate, we have found receipts in pockets that are able to get us to the last person who saw them or where they came from, the store, and we say, "Was this person having these symptoms when you saw them?" Like, "No, they were a little funny, but they did not act. They weren't having this thing happen." The phone or emergency list and those things, those are actually very helpful a lot of times.

Now I think a lot of people, once they show up to the ER, they do not quite understand the process. A lot of people do not understand the whole triage process. How exactly does that work?

The triage provider, who is typically a nurse with a significant amount of experience, has the hardest job in the hospital. That is not an original thought. That was, I forget, it was from one of my training podcasts that I listened to ages ago. I think it was probably EM Basic. The guy on there, do not quote me on that, but said triage is the hardest job in the hospital because you have got to communicate to everybody else behind in the ER. This person needs immediate care, or maybe care as soon as possible, or like they can wait as long as needed, which can be very frustrating for patients because, obviously, these days, it feels like more than ever, everyone's time is either accounted for or things are moving at light speed.

A minute or an hour in today's world would be equivalent to a week 30 years ago. A lot of stuff happens and changes minute to minute. Just that in the emergency department, we are as a team, not just the doctors, but the nurses, the techs, everyone involved is pretty used to recognizing emergencies. Now, do we get that right 1000% of the time? No, sometimes vital signs might be a little reassuring when they probably do not need to be, or those kinds of things.

That is just part of the process. It is not that someone is saying that it is not serious what you are dealing with, but we have to deal with twenty people showing up at once, and someone is going to stop breathing. That is the one that takes priority because that is what we are there for. We are to prevent the loss of life, if at all possible, and the loss of limb. We try to do that as effectively and efficiently as we can. Unfortunately, sometimes feelings or arrival times do not align with those levels of acuity.

That is a good explanation because I do think a lot of people will go there and they're like, "This person just came in, and I have been waiting here for an hour." It is like, four hours. It is like, yes, but based on triage, this person was possibly imminently dying or about to have something seriously bad happen if they weren't seen right away. Unfortunately, you got bumped, not exactly bumped, but in terms of triage, this person took precedence. That is something for people to be aware of.

It is a changing thing because everything is always relative. It is constantly fluctuating. I have told people before, you never want to be the first one in line at the ER, if that makes sense. If you are the first one and the one that everyone is worried about, you are the closest to that bad thing happening. You want to get the care that you need, but you do not want to be the most interesting one in the ER at any given point.

I actually tell my patients the same thing that everybody in the hospital does, because they are like, "When am I going to see you again?" I am like, "Actually, you do not want to be seeing me multiple times during the day because that means you are really sick. That is not what you want." What would you say ER doctors are really trying to rule out first when they are evaluating a patient?

Airway. Like, are you breathing? Is there something that is going to compromise that anatomically or physiologically? Anatomy being, is your throat actively closing? Is there some mass or something pushing on that that is going to stop oxygen from getting to your heart? The way to think about that is, I can only hold my breath for, back before when I was doing some diving and stuff, it was probably close to four or five minutes, but not a lot of people can hold their breath for even two minutes. That is a very long time. Breathing is always the utmost emergency, if that makes sense. Getting air into your lungs, then the next would be the lungs themselves.

Are your lungs working like they are supposed to, or are they filling up with fluid in the wrong way? That can be bleeding or not bleeding. Do we need to do something about that imminently? The other thing is your heart getting that oxygen and putting that oxygen out to the rest of your body. If that is compromised, either an occluded artery or aorta, forbid, or something going up into your brain like a stroke, those are the things that we are going to always give precedence to. A shortness of breath, a breathing complaint. Some people have chronic breathing issues that are just saying, "It is getting a little worse."

Some are having an anaphylactic reaction, and things are closing up here. They're tightening up here, and that oxygen is not going to be exchanging itself very much longer unless we do something about it actively. Those are some of the big things we're working for to sort through and look at really quickly, and then going beyond that, then we get a little bit more imaging. X-rays, EKGs, things to look at the heart and the lungs. I guess that is another thing people understand is when you show up to

the ER, you are, for better or worse, declaring an emergency for yourself. It is my job to take that seriously.

Some people get frustrated, like, "It is not that serious." I say, "I am an ER doctor. You came to the ER, and if I do not take this seriously as a heart attack," some people would say, “Is that a common euphemism?” "I am not doing my job appropriately." I think that is another thing that I would like people to understand. It is not like, say, "You are just running up this thing to get tests done or to add, run up a bill or something." It is not about that. We are there to make sure that you do not get blown off in the ER. We are there to make sure that we are not missing a heart attack or those kinds of things. Sometimes we can pretty quickly come to that conclusion, or sometimes it is a little more convoluted, and it takes a little bit more testing and things. That is a big piece of it.

Getting into our next session, just some general education awareness for people to know. We talked about stroke and a little bit of the signs, but what would you say are major signs that people should think of for a stroke and be like, "I should go to the emergency room, or I should call 911"?

Recognizing Stroke And Heart Attack Warnings

The big things are in regard to stroke. How you should think about stroke. A stroke is a part of the brain that is not getting oxygen. If there is something in your body that is not working like it is supposed to, which unfortunately can be your brain and cognition. Some people having a stroke do not recognize that they are having a stroke. This almost takes a two-person effort here, or if you're sitting in the room talking to someone and something changes.

Visual changes, facial drooping, numbness in an arm or a leg, those things would suggest that now something is not working correctly. There are other, more nuanced presentations of strokes that we find and figure out, but I would not expect someone with no training in that field to be able to find it because it can be tricky. The big things would be a sudden light-switch-on, truck-accident-style headache. That is a form of stroke. It can be a sign of a stroke. Any maximal onset headache, that would be something to come in for.

In school we always heard of it as like the worst headache of your life. A thunderclap headache.

That is like we talked about before. Everything is relative. This could be the worst headache of your life. The more accurate thing that we like to talk about is maximal at onset. Something like, "I was going about my day and boom, there was a break in reality. I was fine, and now I am not fine. I am having a bad time, and it is up here in my head." That would always be a reason to come to the ER. There are a bunch of people that come to the ER for headaches. We are happy to help you figure out your headache. That is one of the things that is a big deal that we dive into. Some people are asking me all these questions like, "I've got to figure out what's going on."

Weakness, sudden onset of excruciating headache or pain, visual changes, speech issues, facial droop. There are different mnemonics and things, but I like to say if something is not working like it is supposed to, something is weak, something is numb, and it is a relatively sudden onset, within three hours, four hours, because those are the treatment windows that we can do something about these things. We get a bunch of people sometimes still that, "It started like two days ago and I thought it was going to get better." The good thing is it has not gotten worse from what this is, but now we have to figure out what it is that we can do about this.

That is important for people to know, that there is a window where, for some of these, there is intervention that can be done. It can make a huge difference. It is like recognizing those symptoms and going to the ER. Also for friends and family, as you said, a lot of times people do not quite realize. It will be like the family member or friend who is like, "You should go. You need to actually

go get this checked out. We need to call 911. We need to do something." It is important for people to be aware. I think another big one would be a heart attack. What are the classic signs, and are they always obvious?

Unfortunately, they are not always obvious. The classic thing would be the crushing left-sided chest pain radiating to the jaw and arm with some sweating. We call this typical chest pain. That is the typical sign of a heart attack. Now, not everybody will experience those things. A heart attack also is a big pot of different conditions and things because you can have some people who might call a type 2 NSTEMI a heart attack because their troponin was elevated, which is logical, technically speaking, a form of what could be considered a heart attack.

When we talk about heart attacks classically, we are talking about an occluded vessel that is supplying the heart muscle itself. Those are typically not symptomatic. Different populations: older women may not experience classic signs of a heart attack. They might have maybe just a little bit of indigestion. "I just wasn't feeling right." You would be hard-pressed to tell someone who is usually pretty good at taking care of themselves, used to taking care of themselves, like, "You should go check it out."

It is nothing, and you hate to say only come for the excruciating stuff, but if you feel like something is not right or not usual, that would be a good reason to seek medical care in some aspect. The cool thing about medicine in America, as far as the system issues, we do have the right to choose when and who we see for the most part. Some people say, "I did not want to go to a doctor." I would prefer to have that freedom than the alternative. "You did not go to the doctor in this timeframe, now you are punished." No, you chose not to, and that is okay as well, as long as that is just life on a rock flying through space.

It is important. The classic symptoms people think of are crushing chest pain, going up to the jaw, down the arm, sweating, feeling nauseous.

Straight to the back.

That is another big one, important. There is also that population. If you are diabetic, then a lot of times the way your nerves work and pain processes can be different, so sometimes they are not going to feel it the same way. Women, as you said, so there is this population where it is always, I think, a little bit different, and that is something for people to be aware of. We live in Florida. I had to ask about heat stroke. We see this all the time. I do, at least in the hospital. I do not know how much you see it. What do you think people should know about heat stroke?

Heat Stroke Awareness And Prevention

Heat stroke and brain stroke are different processes. They are not on a continuum. Someone was like, "It is a heat stroke." What is heat stroke? It is the decoupling or dysregulation of your metabolic processes due to an excessive environmental exposure. Presumably, external heat. "I was outside, I sweated too much, I now have an electrolyte imbalance, and my body temperature is consequently elevated because my body is now, number one, not able to get rid of the heat that I need to get rid of, or something has gone awry and internally is causing this kind of hyperthermia."

The big signs to be aware of in those exposure-related illnesses, which I prefer to call it, would be nausea, vomiting, sweating profusely, and then zero sweating. Bone-dry skin like, "It's really hot outside. I feel really hot. I should be sweating." That is a problem if you all of a sudden are not sweating. If you are having some confusion or trouble processing, or you are talking to your friend who now all of a sudden seems not right.

It is like, "John, like what's going on?" John is now over there stumbling and mumbling. Usually he is a pretty sharp dude. Those would be signs of a heat-related injury or illness, and excessive urinating or not urinating enough. Those would be issues, and that takes some time in these environments. It is not going to be like, "It is 110 degrees outside. I was outside for ten minutes. Now I am having a heat stroke because I do not feel good."

It is not outside. It is not comfortable, maybe, but those are "Something is not right." Sometimes those illness spectrums can be turned around with a bag of fluids and say, "How are you feeling? How are you doing? We can get you home." Sometimes it is not just a bag of fluids. Sometimes it is a lot more than that. Those are things that we are happy to get checked out as well.

I feel like it happens fairly commonly here. TPC, they actually, cause that happens here, moved the time back, which I was really happy about because last year the amount of patients who came in because I felt so bad, they were just out in the heat. You are out all day. There is not much coverage and stuff. I am happy that this year they changed the date based on that. In Florida, people forget it gets real hot. If you are out on the golf course all day in the middle of summer, it is rough.

Your instance of losses. You are sweating, and your respiratory rate goes up. People do not give credit to how much fluid you actually lose and gain by breathing. Spend a few hours on a plane going anywhere, and you will be like, "If they do not humidify this air, we are all asking for ice water or something because you do lose a lot through that." Stay hydrated and stay protected in the elements from wherever you are living.

Now, I am sure you see this a lot too. I guess also, when should people come in for a food bug, food poisoning, or when should they be worried about something more serious? A lot of people can stay home, and then there is the other category where, "You actually need to be seen, and you are getting really sick."

A tough call to say, I mean, it is tough to give maybe general advice in that regard. Some of the questions I will ask to help figure this out sometimes would be, has anybody else had similar symptoms after eating the same food as you? Like, "We ate at this buffet, and we were all pooping after that," or "I vomited, and my wife vomited, my kid vomited." That is probably food-related in that case, or we are on a road trip, and everybody had their hands in the bag of chips and something of that sort.

The duration of symptoms. You do not want to delay someone getting care, but a lot of those viral illnesses, stomach bugs, and those things will pass in 24 or 48 hours. Sometimes they do not. Usually, if you are not having the crushing chest pain and excruciating abdominal pain and those things, it is just uncomfortable. Diarrhea is uncomfortable. If it is just discomfort, then it is more likely one of those other things.

There are serious bacterial illnesses that can occur. There are bowel obstructions, all number of things, constipation. That is hard, in my opinion, to apply a one-size-fits-all thing to maybe the stomach bugs because, depending on your surgical history, that could maybe be something more ominous, depending on your age or exposures or other medical history. That is a tough one to call, but 24 to 48 hours.

All medicine, very nuanced, but yeah, I always tell people like, if you are able to keep enough fluid down, and everybody knows their body the best. I also think that is where sometimes people need to use some common sense of, "Is this debilitating and you are not able to eat and drink, and you feel really, really bad?" Versus like, "Diarrhea is pretty miserable, a stomach bug is miserable, but you are still functioning and fine, and you are a relatively healthy person."

There are the differences there too, but yeah, stomach bugs are the worst. They just messaged me actually that there is a stomach bug going around in my son's daycare. Looking forward to that. The gift that keeps on giving, daycare. Concussions. I think that is another big one. What would you say a concussion looks like, and when should somebody get checked out?

Again, another tough one because a concussion is a head injury without radiologic signs of head injury. One of these things where there is a good description of what we can see, and that is another age and symptom-dependent as well as medication-dependent thing. If you are a young kid playing sports and get bonked in the head and go, "Whoa," and you are seeing stars for a second, there are grades of concussions, but that would typically count as a concussion.

Someone who probably needs to be checked out imminently in the emergency department is someone who has lost consciousness completely and then regains consciousness. If they do not regain consciousness, for sure, they need to be in the ER. Someone who is vomiting very soon after this event or after a little bit of delay, and they are just repetitively vomiting, that is typically a big issue.

Someone who has numbness, weakness, or those signs of a stroke that we already talked about, or vision changes. It might take a few hours in the ER to get some of that information back, but that is the check, and we are happy to do the check. The vomiting, change of vision, inability to speak, numbness, weakness, or signs of a visual head injury like evidence of something that is way out here or depressed, anything of that sort, always straight to the ER.

As you said, medications are important because I think so many people are on baby aspirin or blood thinners. It is always what I tell people. If you are on anything like that, automatically go to the ER.

Someone who has got Afib and is on Eliquis or Warfarin or Pradaxa or any of those other anticoagulant medicines, which are incredible medicines that have done a lot of really good things for people, also has the opposite edge of that too. If you have that turns a potential trauma into a bigger deal. I tell everybody if you bonk your head and you are taking one of those "make you bleed" medicines or blood thinner medicines, just come to the ER. If we do nothing else other than get a head CT to say, "There is no blood there," and that is it, it is just the risk that you undertake.

You do not want to miss it. Again, the medicine is doing its job. It's thinning their blood, which means bleeding is then easier if you have something like it is better to get it. Allergies. We talked a little bit about this, my mistake with my son, but what do you think people should know about allergic reactions and when they become an emergency?

Allergic reactions, when they are an emergency, the things that we are looking for are signs of hemodynamic instability. Low blood pressure, high heart rate, pulses that are maybe weak and thready, not really doing what they are supposed to. Shortness of breath, something that feels like it is grabbing up here and changing the way that your voice sounds or how easy it is to talk, or profound abdominal pain, or sudden-onset nausea, vomiting, diarrhea that you really weren't expecting. Allergies. You can be allergic to anything, unfortunately.

It is your immune system's processing of a protein that is encountered. You can be allergic to another person, you can be allergic to a medication, you can be allergic to bees. Having one allergy does not make you more likely to be allergic necessarily to everything else, but if you have a strong family history of allergies, then genetics being what they are, you may. Everybody's immune system is different, so you are not guaranteed to have them. What we're looking for is trouble breathing, sudden onset, cramping, vomiting, diarrhea, which we'll typically treat with a version of epinephrine.

If you have an EpiPen, some people have EpiPens and allergies, and they are well familiar with that and say, "If you use your EpiPen, come get checked out." There is about a twenty-minute lifespan or half-life we call it that epinephrine efficacy, so maybe it completely reverses everything and you will need the windows, but sometimes it is a little persistent, especially if you ate something and did not puke that thing up. Something is under the skin that needs to come out, that kind of thing.

Which I do think is important to know, and that is why, like with the kids, they actually have the two EpiPens, is because you can get that where you need a second dose because of that. It's very important. If somebody has that, then go to the ER. If you use your EpiPen, then go to the ER. What would you say? We talked a little bit about stitches. I think that is a common reason to come to the ER. What do you think people should know in terms of, like, if they cut themselves, when should they go to the ER? What should they know about that?

All cuts are different. Sometimes there is a little paper cut. I have actually put a number of Band-Aids on where I say, "Look, this really does not even need stitches. We will put a Band-Aid on it," and some people are very relieved at that, and some people are upset by that, but that is what it is. Certainly, if anything is squirting, like if blood is doing that deal, absolutely come to us before you get to us. Depending on the severity or comfort level and where this thing is, if it is on your fingertip and you can put one finger on it to stop the bleeding, put one finger on it.

If you can stop the bleeding with two fingers, put two fingers on it. Things that are not as helpful are. Someone grabs a glob of towels and just puts all this stuff on it. Maybe it keeps the blood away from the person who is helping, and maybe that is what it takes to get them here. A general rule for treating something that is bleeding is if you need the bleeding to stop, use the smallest square footage or square inches that you can. If it takes one fingertip, one fingertip. If it takes two, it is two. If it takes three, it is three. If it takes your whole hand, put your whole hand on it.

A lot of times, one or two fingers will do the trick. For cuts and things, alcohol and peroxide are good for intact skin or maybe very minor abrasions, but they are not the best for open, broken skin. If you know it is a smaller cut, but you think, "That's going to need stitches." If you have clean water nearby, like running tap water, you can flush it, wash it with that. That can be helpful depending on the size and severity. If you're like, "Dude, my finger's almost coming off," come to us, and we'll do it at that point. If it is a smaller cut that nothing is hanging off, it is just broken skin. Avoiding the peroxide maybe is a better move than dousing it in peroxide because that can be cytotoxic, slow healing, worsen scarring, those things.

What about burns? What should people know about that? If they burn themselves in the kitchen or something?

Cool water for as long as you can before you come to us. Not ice water, but just cool water in a sink for as long as you absolutely can. If it is a water splash burn, those things. Oil burns are maybe a little bit different because, depending on the contact, do not put baby oil or any other oil-based thing on it acutely because that can intensify some burns, especially if it is a thermal burn. There are various types of burns.

There are chemical burns and acid-base burns, but almost universally, large amounts of cold running water over a burn are good things. That is the first and the last thing that you need to do, and we can get you taken care of and figured out if you need to go to a burn center. I have sent plenty of people, and I will send plenty more, and/or I will sometimes talk to the surgeon about a follow-up visit.

Fevers. People get sick. They get fevers. When should they be really worried about a fever?

That is a huge one because that is one of our five vital signs that we have. What is your temperature? A fever is a response from the body to deal with stress or illness or some chemical signaling. That can

be from heat stroke, like we said, or a heat-related exertional thing, and if you measure your body temperature after a marathon, oftentimes, you will have an elevated temperature. When the fever is associated with something else. From the pediatric side of things, a fever in isolation, truly isolation, is your body responding to something. If it is just responding to something that it is dealing with and you feel okay, not having trouble eating, drinking, peeing, pooping, then great. That is good.

Now, if you have a fever in conjunction with excruciating abdominal pain or profound shortness of breath or a yucky wound or something on your arm or hand or foot, those can be big issues. That comes down again to knowing yourself, knowing if you do have a primary care doctor, and say, "I'm not feeling great. I've got this thing." They can sometimes sort that out with a phone call. Sometimes it will be, they will recommend, "Just head on to the ER and get checked out," and you may call for something to change or get worse.

Sometimes we'll see it and say, "I do not really see anything right now on your labs or imaging," if we got labs or imaging, or say, "This is the first few hours of this thing that you're experiencing. Maybe come back in 24 or 36 hours, see what has progressed, if there are more symptoms or something for us to chase or evaluate." Because right now, it is hard to say where this exactly might be coming from. Fevers are a tough one because they can be very simple and just be related to some kind of rhinovirus. A rhinovirus infection is not the exact same in every single person because some people are immunocompromised, some people do not produce a fever, or those things traditionally.

I always think of our jobs, even though they are very different. You are on the emergency side and the hospital side, but we are like detectives. It is like, "You got this fever and then what's all of the other parts that's going with it. Are you walkie-talkie? Is it like COVID and flu season? Are you having all the other COVID and flu signs?" Or "Do you have this high fever and your leg looks horrible, and that could be a really bad infection?" Or "Do you have this new really bad abdominal pain and other stuff that is going along with it?" Again, as you said, when you have a good primary care doctor, that is where it can kind of help because then they know your history, they know all this. There is so much that goes into it.

It is huge. That is the takeaway from the ER conversation is get a primary care doctor. They are so good at what they do, and they can be such assets to your life and healthcare.

Prevention, part of what I love the most about medicine is, "Let's see what we can prevent." You see tons of crazy stuff all the time. What would you say are some of the top emergencies that you wish people knew how to prevent?

Probably some of the basic plain Jane boring stuff. Helmets. That is a huge thing if you are riding a bike, especially e-bikes these days.

I know. I feel like every time I turn around, there is another e-bike crew that is just like, nice little helmets and they are flying. They are going faster than a motorcycle.

Wear a helmet because your brain, you got one of them and they do not heal super great if something does happen to them. Helmets are crucial. Seatbelts, I mean, the simple stuff. I used to not grow up like seatbelts because they are not cool or fun or whatever, but man, it makes a difference when we see someone in the ER, and they had their seatbelt on. It is like, "Did you have your seatbelt?" They said yes.

Like, "I'm really glad you did because the other person in the vehicle did not have their seatbelt on, and they're in a very different situation right now." Helmets, seatbelts, simple things. I am a proponent of living life and being adventurous. Do not shy away from a challenge or an adventure or some physical thing, but just do it with safety in mind, if that makes sense. Helmets and seatbelts, that is a pretty simple thing.

I know it really is. I feel like now, seriously, there are always all these e-bikes. I call them e-bike gangs, but it'll be like a bunch of kids riding around, and they're flying, and there is no helmet.

One of the issues with those too is they are silent. We are biological creatures with senses to tell us what is happening where, and those e-bikes make next to no noise. If it were a motorcycle, you can hear it coming. Unfortunately, that is, for better and worse, the e-bikes are silent. You do not give any warning to anybody other than a "Wah." If something's happening and because they cannot hear you coming, they might pull out or something. That is a whole different can of worms.

I know. It is also on the same line of like, since it is a bike, a lot of them will be on the sidewalk, but then on the road and then back on the sidewalk and on the road. People are not looking for them in all areas where they will be riding them. What would you say is like one of the biggest safety mistakes that you see at the gym or at home, people playing with their kids? Are there any that stand out to you?

It seems that we have a lot of bedtime head lacerations in toddlers.

I actually believe it, though, because it is like wrestling an alligator. It is wild.

Jumping onto the bed, running through the house, just got out of the bath, got a free spirit, and they are too because they're wet until you're trying to grab them. It's literally like an alligator. Yeah. If you had to put my money on the table or cards on the table, whatever you want to call it, I am not a gambler. It is pretty inevitable that at 8:00, 9:00, 10:00 PM, little ones getting ready for bed, jumped off of something, were running through the house and bonked and have just a little forehead laceration. I do not know other than what you would normally do to prevent that. Just keep your toddler in a small soft cage and a little bubble. Nothing bad will ever happen to them.

I have learned my lesson of keeping the bathroom door closed, though, when I get them out of the tub so that there cannot be a sprint after.

Down the hallway to the right. That's just something that happens, but it is funny that it's like 10:00 and it's like, "A little Johnny was running a little quick."

Anything crazy at the gym that you can think of? I feel like I always see those videos of people being idiots at the gym, but there's like nothing that really stands out to me. Probably, if you're using weights, make sure the clip is on, just common sense things.

Depending on the gym, there is certainly a lot of increased safety equipment and things that are safer these days because they are not relying on just a free weight or free bar. That is where some of the weird stuff comes from. Training within reason with goals, not just trying to get in there and be a Hercules and just, "I'm going to go all the way to the top," and doing what you can, sticking within growing, but have a spotter, use the stuff that is not either on a track or one rail system with caution, just within your know your limits, or find your limits with caution.

That makes sense. What would you say a household has for emergency supplies? What should be in their emergency kit? Kind of like a first aid kit, I guess. I am the worst with this. I had to search all over for band-aids the other day. I need this advice.

Band-aids are very helpful. You could keep some antipyretic which are fever reducers. Tylenol or Motrin are more comfort things, but it is okay to use those within reason, and band-aids and some form of antihistamine can sometimes be helpful. There are a number of medications. Commonly, Benadryl or diphenhydramine can be good for minor irritations or hives or something of that sort.

If you are reaching for those things, also have a suspicion like, "I wonder if something else is going to go on or get worse." Reaching for all these medications either routinely or over a period of time, that

may be a time to get a hold of some medical professional, a primary care doctor. If you are reaching for the over-the-counter stuff at home, then that would be good to call them about.

I need to get all my band-aids. It is like we literally just have one size that I found now. I am like, "This is the worst."

It is cool they have the whole multi-size whatever, and you do not need them until you need them.

I know. That is the issue. Is there any basic first aid knowledge that you think everybody should know?

If one finger stops the bleeding, if two fingers stop the bleeding, that is probably the most effective. Do not check it for ten minutes. That was the other piece I missed. If it is a small little cut that you can put a finger over that stops the bleeding, do not check it because you keep looking at it, stretching it out, trying to look at the bottom. You are just going to disrupt the clot or those things. That is probably the big safe one that I would let everyone know about.

That makes sense. Well, I think this was great. Is there like one thing that you wish every patient knew before walking into the ER?

You cannot speak for everyone and every provider or every ER experience because there have been as many people on the planet as many opinions of an ER. The ER is not going to be the most comfortable place, but it is typically full of people who are trying to get you help and get you figured out and to get your situation handled. It is one of the things that makes us tick and makes us happy to help someone feel better and get that thing that was an emergency handled or taken care of. The people are there to help you feel better and identify and treat emergencies. That is always going to be our goal and our wish. It is.

I also think like you guys have to be heart-strong because we talked about it a little bit, but it is like there is that whole triage aspect of trying to figure out which patients could die on you right away versus hopefully will not. Also, treating everybody and figuring out things just like somebody that you do not know, that you have never seen before, that you are just now, "Here is a situation and how on the scale of emergent is it?" That is something important for everybody to remember too. This was awesome. Thanks so much for coming on the show. It was so much fun, and I am sure we will do another episode soon. As always, this is not intended as medical advice. This is for educational purposes only.

If you are having a problem, come to the ER, and we can get it figured out.

You guys are there. Thanks. It was good seeing you. Have a good one.

See you, Anna.

Important Links

- Dr. Eric Edgerton
- Dr. Anna Marie McCarthy on Instagram
- Duration Wellness on Instagram