Flying Close to the Wind

It was almost 3 o'clock in the morning when the phone call came through.

I was the only midwife, the only staff member, on duty in the small 12 bed maternity unit in the remote hospital in far Northern Australia. There was nobody labouring this night and the antenatal women were sound asleep. I could hear the soft murmurings of the few mothers who were feeding their newborns above the swishing of the trees outside.

It was early 1984 and I had left Sydney a few months earlier to travel north to experience a different type of nursing in my own country. In the mid seventies and early eighties I had spent a few years travelling and working overseas in the UK, the Middle East and then nine months working and travelling in Southern Africa.

For the previous 2-3 years I had spent my time in my home town of Sydney working in a neonatal unit in a tertiary maternity hospital and studying for my Neonatal Intensive Care Certificate. When my studies were completed I headed north.

It was the Medical Superintendent for the region on the line, Dr Hart. Twenty minutes earlier he had received a call from a health worker at a remote M.A.P. (Medical Aid Post). A woman, thought to be about 32 weeks pregnant, had broken her 'waters' earlier in the night. The health worker had checked her blood pressure, which was normal, and also her BSL (blood sugar level) which was very high at 23 mmol/l. More than half the population up there lived with Type II diabetes. The superintendent had set in motion preparations to medivac the woman back to our hospital.

The remote community had an airstrip but even though it was late March there were still tropical storms in the region and one had come in overnight. The report from the community was that a fixed wing plane would not be able to land due to the boggy conditions so arrangements were made for a helicopter retrieval.

The helicopter was organised to leave at dawn and it was expected to take an hour to reach the isolated community. Dr. Hart wanted a midwife to accompany him and suggested that I call the morning staff in early and work out which one of us would go.

I was keen. There had been quite a few medivc retrievals during my time up there but I hadn't had the opportunity to personally participate and it was only about 6 weeks before my contract expired and I headed back to Sydney. I put my case forward, especially as the baby was thought to be preterm, and I had quite a lot of recent neonatal experience.

I called for a nurse to come over from the main hospital to mind the unit while I went to Medical Records to see if I could retrieve a clinical file on the mother. The obstetric history was not good. A grandmultipra, this baby was number seven, the last three deliveries by caesarean section and the mother had Type II diabetes. I rang Dr Hart to discuss the history. He had been in contact with the M.A.P. staff again. The mother was comfortable and having only mild irregular contractions. So far, so good.

I checked our "medivac" equipment. It was primed and ready to go, complete with full delivery set; intravenous and resuscitation equipment. At 4am. I put a call through to my morning colleague and arranged for her to come in early. As I completed my clinical notes on my patients I kept my fingers crossed that nobody would present in labour in the next hour. Our patients didn't phone ahead to say they were coming in; they generally just quietly presented at the door in established labour.

At 5am Dr Hart arrived, a car pulling up at the door to transport us the few kilometres to the helipad. We double checked our preparations and were off.

It wasn't long after takeoff that we ran into the storm and most of the flight was through heavy rain with the Bell Helicopter being buffeted by the winds. Even with the rain the view was

spectacular as the pale light of dawn gave way to a tropical sunrise viewed through the fat tropical rain drops.

Landing, there was a break in the weather and some of the men from the community were there to meet us with the village's tractor and trailer to transport us to our patient. I stepped from the helicopter into mud halfway up to my knees. Thank God for plastic sandals!

Doctor Hart had decided to check on a few chronic patients in the community while we were there and I was tasked to see the mother and assess the situation. As we passed, the village was slowly awakening; people coming out to watch the small procession as we made our way down the main thoroughfare. The tractor delivered me to a small hut, the mother laying inside on a woven mat. She greeted me with a wide smile and I breathed a sigh of relief; apparently labour had not progressed far. This had been my biggest concern on the trip out considering the poor obstetric history. I checked her blood pressure and the foetal heart; it was strong. The mother was a large woman; about 100kgs I estimated, but on palpation I thought the baby felt bigger than the supposed 32 weeks. She said that she had been leaking fluid for the past 4-5 hours but had not had any real contractions. I explained to the mother and the health worker, who had sat with the mother all night, that I needed to examine her internally to assess the situation, prior to transport. As I turned the mother on to her back ready to perform the examination, a large gush of clear fluid escaped, and with it the baby's arm, fingers warm and moving, presented between the mother's legs. No need for a vaginal examination. The picture was clear. A compound presentation of a 'large' arm. I estimated by the size of the arm that the baby was probably about 4kgs in weight, so not too premature. The only thing in our favour was that this mother was not yet in established labour. This baby was only going to be delivered one way, by caesarean section, and we had to get the mother and baby back to the hospital as quickly as possible. I sent one of the village men to summon Dr. Hart to meet us at the chopper while I commenced an intravenous infusion.

I had no choice but to ask the mother to stand and, with help from the villagers, we managed to manoeuvre her up the couple of steps into the trailer where we laid her on the woven mats. On cue the rain started again. The watching women quickly clambered onto the trailer and covered us both with a bevy of umbrellas for protection. From my kneeling position I could see nothing but the insides of multi-coloured umbrellas and hear nothing but the sound of belting rain and chattering women.

Dr. Hart was at the Chopper as we arrived on the trailer, umbrellas obscuring his view. I'm sure he had no idea what was going on. The helicopter was equipped with a stretcher and the front passenger seat was lowered to accommodate it as it spanned the front and back seat. Dr Hart and I squeezed into the back seat, myself seated beside the mother.

The trip back was tense and I kept my hand permanently on the patient's abdomen feeling for any sign of contractions; aware that establishing in labour could mean a ruptured uterus. Thankfully, there were no contractions; only her smiling face in contrast to my deep concern. I turned to Dr. Hart; he could see that concern in my face. A veteran of 20 years or more living and working in this remote region, he shrugged. "We always fly pretty close to the wind up here." He was right. Fifteen minutes after landing I finally relaxed as my patient was wheeled through the theatre doors for a successful caesarean section.