

Royal Darwin Hospital Emergency Department, Monday 14 October 2002: a medical student's memoir

David E Chapman

*... a ceaseless flow of students, nurses, doctors, orderlies:
fetching and carrying, advising; servants to the patient and their attendant team.*

Half a dozen medical students have spent the night in the Emergency Department, as the first flight from Bali brings in a dozen or so patients at 2 am. Twenty-six hours earlier, bombs destroyed two nightclubs packed with tourists and local residents at Kuta Beach, Bali.¹ Most of the first casualties to arrive are able to walk and, although their injuries are severe, they are soon ministered to in Area 3 (the “walking wounded”) and sent off to the ward. At 5 am, as the first shift of students retires to sleep, the next batch arrives: six 3rd years (of which I am one), Matthias from Switzerland and a couple of 4th years.

Didier, Director of Emergency, fills us in on what is happening and tells us to distribute ourselves into the three emergency rooms and two wards: our job is to act as runners, gophers, and extra hands. There is an unseemly wrangling for the best position, but as it turns out we all play our part. In fact, as it turned out, there weren't enough of us to go round!

Word comes that the next flight is due at 6:30 am, so there is time for a bit of a snooze and some nervous chitchat: a seasoned nurse confesses to feeling terrified that she will not be able to cope, that she won't know what to do. Didier is on the phone constantly; there is a busy flow of information from the airport, from Bali, from interstate hospitals (Box 1). He keeps everyone updated on events as they unfold. Finally, the plane has landed; there are 30 patients, all are severely burnt, one so severely that we can't tell if it is a man or a woman; six are already earmarked for the Intensive Care Unit. There is a flurry of last-minute instructions and reminders: Didier does his Churchill speech: “... great medicine ... important ... teamwork ... faith in you all ...” It could sound trite, but he means it and he will be proved right.

The first ambulance arrives. An ambulance crew wheels in a patient, wrapped in a space blanket, drips and oxygen in a nurse's hands. An anaesthetist from the airport team reports to Didier: broken forearm, estimated 20%–30% burns to the back and legs, fluids OK, obs stable. An unhurried inspection, a brief conversation with the patient and despatch into the second emergency area: he is *not* one of the seriously injured patients. The automatic doors at the entrance close on the next stretcher; nobody

1 “Didier is on the phone constantly”



2 “Ambulances bring patients every 5 minutes”



knows how or if they can be held open — mysteriously, they break and stay open. Ambulances bring patients every 5 minutes, with the same routine: update from the airport doctor, inspection, and triage to the appropriate area (Box 2). The airport team and Didier work in concert to manage the flow: there is always an emergency team waiting to receive each patient, no one is parked in a corridor or left unattended. An ICU patient arrives and is swept upstairs. He's lucky, a retrieval expert has flown with him from Bali, complete with four bags of emergency equipment. This will mean extra help in ICU for the rest of the day.

Emergency Area 1 looks like the inside of an anthill. I have a camera ... Kerrie, one of the emergency specialists, has asked for some pictures. It's too early yet for the hospital photographer, so I stand on a table in the resuscitation room, photographing the busy scene below. It looks like madness, but there is a pattern, a disciplined chaos, that resolves into four trolleys — each surrounded by a team of doctors and nurses, standing, quietly busy, playing their parts in a static choreography (Box 3). In between there is a ceaseless flow of students, nurses, doctors, orderlies: fetching and carrying, advising; servants to the patient and their attendant team.

A surgeon appears, the first of many, moving from patient to patient, assessing needs and planning the next step in treatment. On my patient, a surgeon is cutting down into the inguinal fold, looking for the femoral artery to plug in a line ... burns patients leak their body fluids at an alarming rate and we can't find a vein in his arms or legs to pour liquid into him. Our patient has two bags of fluids up at a time, one with a pressure cuff to squirt it in. I clingwrap a leg which has full thickness burns down one side, while others wrap his arms, back, and buttocks; then we logroll him and see the full extent of the burns on his back. Someone

compares the qualities of the different brands of clingwrap — which is the best for burns, which clings and which doesn't.

Jacqui, our team leader, asks the patient if he can remember what happened: "I was sitting at the bar, there was an explosion and I caught fire ... I rolled on the ground to put it out ..." We can tell which side was closest to the bomb — the burns are worse on that side. The nurse asks if he has been in contact with anyone; she brings a mobile phone, so he can phone his mum. The human cost of the bombing strikes home: the

burns, shrapnel wounds, infected wounds, blood, urine, moans of pain as we prod and poke. All these make up the professional part of the unfolding drama. We examine and analyse, put up drips, take blood, carefully record the location and extent of burns, peel off bandages, clingwrap body parts. It isn't hard, it's not horrific. Not at the time. It's what we do, the bread and butter of medicine. We fold our professional armour around us with our white gowns. But hearing a young man, twenty-something, good-looking, strong, ask to speak to his mum on the phone — that is the hard part, the side that isn't protected by a white gown. He's letting her know he's alive, that he's in safe hands (we've told him, "you're in the Royal Darwin Hospital ... we'll take care of you"), that he's going to be all right. But we know he isn't going to be all right: OK, he will live but, in between our thoughts of what to do next, we know that his future is going to be full of pain and disfigurement and mental trauma, and many of his hopes and dreams were burnt up along with his back and legs.

Over on the far trolley, one patient is really seriously ill ... off to ICU, but not just yet. His arms are burnt all round and the tissue under the burnt skin is swelling, compressing the muscles, slowly killing them, releasing toxins that will inevitably poison him. A surgeon carefully cuts full length down his arm and into his hand, releasing the tight sheath around his muscles, giving them a chance to stay alive. It looks like an anatomy lesson. The surgeon methodically cauterises small arteries, gently holding the patient's hand as though reading his palm, while the smell of burnt flesh is sucked from the room by the air conditioning. Didier complains about the lack of medical students ... I think everyone is here; we are all part of the team.

Hours pass, and the last patient heads off to the ward: time for a break. There are 10 family-sized pizzas in the tearoom, ordered from the local pizza shop by a wellwisher in Adelaide. I photograph the empty resuscitation room, then snap an emergency nurse beside a neatly made-up trolley, waiting for the next patient — it all looks so normal. Tired people sit and drink tea, eat curry, pizza, sandwiches from downstairs in catering. We go for a walk, up to the ward. Everywhere there are signs of planning and preparation: boxes of fluids, dressings, trolleys, instruments. In the cafeteria are trays of food, cold drinks, desserts ... the whole hospital plays a part, the "sharp end" functions so well because of those backstage. We hear later of the office staff phoning the families of patients, working as hard as we did to inform, reassure,

3 "Trolleys — each surrounded by a team of doctors and nurses"



sympathise; they are at a different sort of sharp end.

The next plane lands with 20 more patients and the performance begins again: slick, smooth, fast. After all, we are seasoned now. The first night has been a success, even the students look professional; we are not just runners now. There are tasks to do which are ours: organise bloods; remove dressings; record the history, examination and assessment; clingwrap there, lift here.

There are moments of time to watch and appreciate the choreography, the choreographers and

the dancers — the emergency teams move with familiar precision and practised teamwork. The ring-ins slowly integrate into their rhythms, so by the end of the day it all seems like some grand ritual. The emergency specialists are like satellites, constantly orbiting each team, assessing, coordinating, advising, helping.

By the middle of the afternoon it is pretty much all over for the students. The next plane has just two patients and then there are no more. We walk up to the ward ... "is there anything we can help with?" We take some blood, struggling to find any sort of vein, finally going for the foot because there is nowhere else. The patient says, "they all find it hard". One of us has to take blood from a line and doesn't know how to do it, so I guide her through it: set up a sterile field, glove up, clean the bung, take 10 mL and discard, take the sample, flush the line, flush it again, clean it, clean it ... it's precious.

It's time to go home; 12 hours of adrenaline needs dissipating, we need to talk to each other. Someone offers his place, another cooks dinner; we have a beer and begin the debrief, reliving the day.

For the next 2 days we are tired. There is a sense of anticlimax. The normal world has gone on around us and it goes on still. Suddenly, the hospital looks no different, except for odd stacks of boxes here and there that have yet to be returned to stores. We have an official debrief and hear the big picture — the confidence that Darwin could handle it, the thoroughness in the planning. We hear the stories from other places, and we praise the work of Denpasar Hospital and the Balinese, and our colleagues there, and on the tarmac at the airports. We feel important and proud to have been part of the grand dance.

But someone asks about our patients: where have they gone and how are they and will they be all right; and there is a moment's quiet, and we each have our own thoughts.

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Reference

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