Saving Grace: a Christmas story

Caroline M De Costa

CHRISTMAS EVE, a couple of years ago. I was on call for the birth suite until 8 AM the next, Christmas, morning but was hoping to be able to stay at home with my family. At 6 pm, I did a festive round with the registrar on duty. Good — only three women in the suite, and two delivered, both delighted with themselves for getting it over before Christmas Day.

In the corner room, one woman in early labour — Grace, aged 34. Elderly for a first baby, especially for an Aboriginal woman, the registrar observes. I say hello to Grace, but don't examine her — that's why the midwives and junior staff are here. Surprisingly, no partner or family is with her.

Then I realise that I have seen Grace about our town. She is one of the "park people". Virtually homeless, living mostly outdoors, drifting back and forth between town and some of the more remote communities of the region, the park people are frequently subjected to the ire of some of the town's better-heeled residents. Recently, these residents have demanded more stringent "move-on" laws, to keep the park people out of the sight of the tourists and restaurant patrons along the town's seashore. So far, the State's Anti-Discrimination Commissioner has successfully opposed such laws, but for the park people — rather like those people back in Bethlehem whose birth experience we are celebrating tonight — it seems there is no room at the inn.

In her time, like other park people, Grace has had many visits to the hospital's emergency department. At every admission, the same comments appeared: "poor historian"; "C_2H_5OH"; "lacerations"; "bruises". She'd been sutured many times, with the new and old stab wounds noted. A large scar on her throat and another on her left breast were recorded. Unfortunately, no-one noted the scar on her lower abdomen. Longitudinal and midline. A laparotomy scar.

Grace hasn't attended any formal antenatal clinics, but thankfully, during one of her visits to casualty a while back, someone did do an ultrasound scan, so we know she is labouring close to term. Routine antenatal blood tests are being done now. She is in established labour, progressing, and all appears well. I leave it to the registrar to check the results, wish everyone a Merry Christmas, and go home.

Two hours later, I am rung by an agitated registrar and, on the strength of what I am told, go back to the birth suite.

In conversation with one of the midwives on duty, an elderly Aboriginal woman, visiting another patient, remarked of Grace: "Long time since that girl had a baby!".

"Oh no," replied the midwife, "this is her first".

"No," the woman was firm. "Had the baby when she was 13. A caesarean. At . . . " — and she named a former mission station some hundreds of kilometres away.

The midwife hastened to question Grace. Did she ever have a baby before? It was difficult for her to answer; she is indeed a poor historian. For a start, she has no teeth. Those that weren't knocked out in fights have rotted away. Also, chronic middle ear disease since childhood has made her rather deaf. But she does know that, yes, she did have a baby. A girl. Nobody in the hospital had ever asked her before; she didn't know it was important.

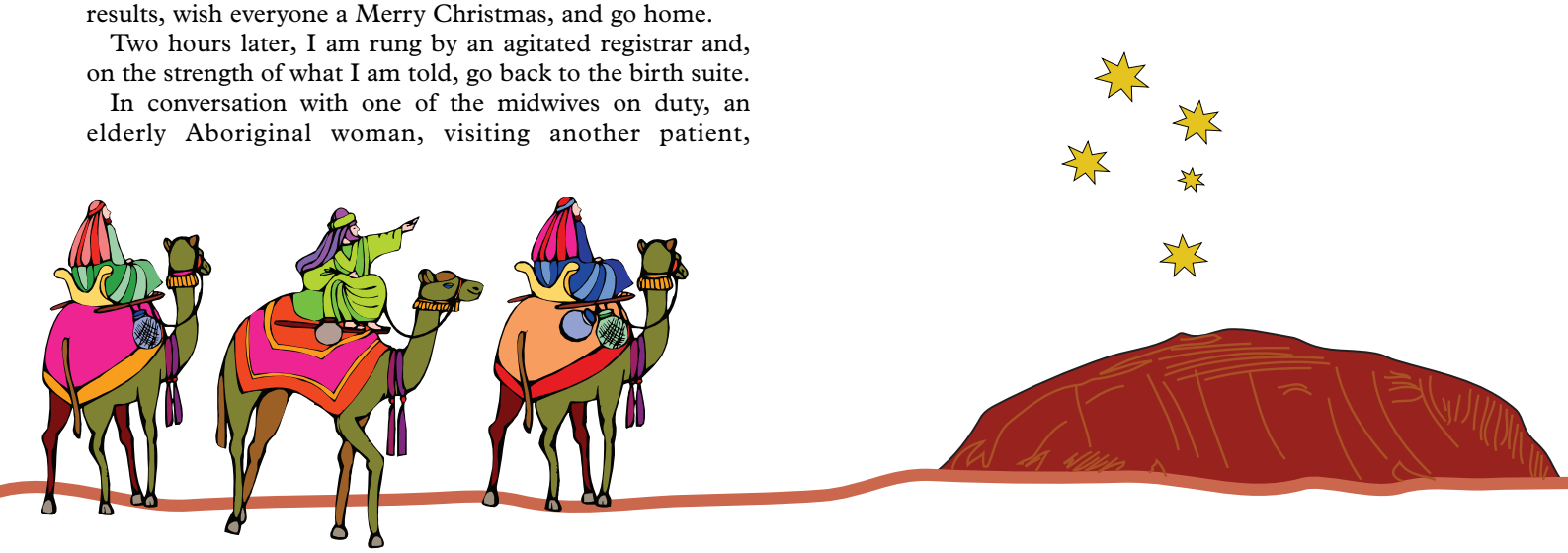
Did she have a caesarean? Grace is unsure. It was a long time ago.

Did the baby come out through that scar on her tummy? Yes, maybe. It was a long time ago.

Where is her daughter now? Grace does not know.

Obstetric dilemma: is the abdominal scar longitudinal because Grace had a classical caesar, in which case, because of the risk of uterine rupture, caesarean section should be repeated forthwith? Or — and more likely — was the longitudinal incision merely the route to a standard lower-segment operation, allowing Grace the possibility of a successful vaginal birth this time?

For the moment, all seems well. Grace is contracting regularly, has accepted pethidine, and is making progress in labour. She now lies in a clean hospital bed, surprised to be — for perhaps the first time in her life — the centre of concerned attention.



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We try ringing the hospital near the former mission for more information. It's 9.30 PM on Christmas Eve! We're told: "You want records from more than 20 years ago? You must be joking! Ring back next week."

An hour later, a further complication arises. Grace's blood has shown unusual antibodies and it will take some hours to find and crossmatch blood if we need it. We decide to ask for the crossmatch and hope that she delivers vaginally soon and that she won't need surgery or blood. Regularly, anxiously, we watch Grace's vital signs and the fetal monitor.

Another two hours later, we have blood, Grace's cervix is 8 cm dilated and the fetal heartbeat has been fine.

And then, she begins to bleed. Torrentially.

Everyone swings into action. After all, this is what we do best. Acute care.

Three wise men appear — anaesthetist, paediatrician and theatre porter — bringing not frankincense, myrrh and a manger but ropivacaine, oxygen and a trolley. In five minutes, Grace is on the operating table; another five, and a spinal block is in place. Soon, a rapid repeat caesarean section is under way.

The old scar — in fact, a classical — has ruptured and is bleeding profusely, but it's repairable and the baby is alive. On the stroke of midnight, a baby boy arrives. He is small and scrawny, covered in meconium. But when he gives a feeble cry, Grace smiles and reaches out one arm for him (a blood transfusion is running into the other) and she names him, appropriately, Joseph Christopher.

Joseph spends that night and the next in the special care unit. He starts to breastfeed. Grace is eating three meals a day, including turkey and plum pudding. But it's Christmas time, the hospital is short of staff and many beds are closed, so even at this inn Grace cannot stay too long.

On Day 5 post-op, Grace and Joseph are discharged "home". As Grace has no home, a place is found for her in a hostel, with domiciliary visits planned. On the first visit, the domiciliary midwife finds things are OK; the next day, Grace and her baby have gone.

A few days later — in fact, on New Year's Day — Grace presents to the emergency department again, this time with Joseph. He isn't feeding well and is bringing up feeds; and, he has a fever.

But we can deal with all that. It's another acute problem, not one of those complicated social issues that, in hospital practice, just have to be put into the "too-hard" basket.

The paediatric registrar arrives, Joseph is admitted and a drip is put up.

And so the cycle of disadvantage starts all over again — unto a new generation. ❑

BOOK REVIEW

Practical response to disaster

Major incident medical management and support. The practical approach. Advanced life support. 2nd edition. Hodgetts TJ, Mackway-Jones K, editors. London: BMJ Books, 2002 (xv+222pp, $81.60). ISBN 0 7279 1391 3.

BUSHFIRES, BUS AND TRAIN CRASHES, and multiple shootings happen in Australia and this is why the Major Incident Medical Management and Support (MIMMS) course was started in about 1995. The course has flourished since then, and now, with terrorism and biological threats very real after September 11 and recent events in Bali, this concise and comprehensive second edition is timely. This volume aims to teach all doctors (from GPs to emergency care specialists) a practical approach to a situation where they are at the scene of a disaster where the number of injured exceed the available resources. It sets out a structured approach and outlines the roles of the various services involved.

The clinician will find that this approach is clearly explained. Aided by tables and diagrams, the reader is shown how to assess the scene, communicate appropriately with the services, use an accepted quick triage sieve (in the field using respiratory rate and capillary return), deal with the dead, and do practical procedures from airway management to femoral nerve blocks. Various topics, from media interaction to chemical and radiological incidents, are covered, although biological agents seem to have been forgotten.

The great strength of this work is that it is relevant and very practical. It is supplied in a loose-leaf folder so that it can be updated, and there are spaces to record specific local details. In spite of a respected Australian contributor it does have a British flavour, but the principles are universal.

In our fast-moving and troubled society, no doctor, whether a rural GP or a city doctor, can be sure he or she will escape being caught up in a major incident. Having medically responded to several of Australia's major disasters I have done the MIMMS course, and I always take this excellent manual with me. Both are to be recommended most highly.

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