

The Royal Flying Doctor Service

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The Royal Flying Doctor Service, or RFDS, is close to every rural Australian's heart. Five aircraft in Alice Springs cover central Australia, an area of desert the size of Spain. People in need call the flying doctor, hundreds of miles away, by telephone or radio. These aircraft, really airborne ICUs, can be wherever help is needed in 45 minutes.

Rural Australians leave the flying doctor radio on, much like the ubiquitous CB radio here. Listening to the chat provides a sense of security to those living on thousand-acre homesteads in the desert. Our radio operator, Diana, would say "good night" and "good morning" each day, to be answered by a chorus of "g'day" and "behave yourself this evening" from her listeners.

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Flying doctors are important to those travelling in the desert. Picture standing in the middle of a sandy beach, only there's no ocean and no trees. The horizon is visible, unchanged, if you turn slowly in a circle. The ground is red, the sky deep blue, and there are no clouds. Occasionally the line between earth and sky is broken by a small tornado or dust devil, called a "willie

willie" here. There are mirages: mountains on the horizon with silvery reflections stretching for miles. All in a moving haze like the Northern Lights.

Negotiating this dry ocean is like sailing; it's a vast terrain where one is unlikely to encounter another, and where death lurks if the means of transport breaks down. Vehicles carry spare everything — especially maps and radio. Routes are called "tracks": aptly, as they are often no more than a line in the sand. If speed is used unwisely in these choppy waves of sand, it's all too easy to flip. Many people carry winches for getting out of the dunes; some vehicles are equipped with snorkels for traversing temporary rivers created by flash floods. If something breaks down, the likelihood of a passer-by coming to

the rescue is nil. If one does encounter a fellow traveller, there's an outbush camaraderie like nowhere else. Stock is taken of working parts, batteries swapped for beer, and all the rest.

A standard fixture in Australian four-wheel drives is the Flying Doctor radio, whose voice might be the only one heard for long stretches of the journey. Every 200 kilometers or so, there's a fuel and beer filling station. People gather sporadically; sometimes there's nobody around for days or

weeks. Other times there's a crowd gathered around the bar, watching cricket. The owners are often cattle farmers who provide the basics out of necessity, as travellers stop in regardless. It becomes a business: the farm becomes a roadhouse, a cool low-ceilinged place with saddles hung over the beams and perhaps a trophy or two from a victory at the camel races.

Central Australians are a long way from medical help. If someone is sick or injured, the RFDS is called. As the doctor on call, I would be phoned or radioed for advice. Based on the information I could get, and it was often patchy, I would decide whether the situation could be managed where it was, if a plane and nurse should collect the patient, or if I should fly out too. I consulted with patients, family members, community nurses, Aboriginal health workers, and barmaids.

Working in the air is unique. I remember flying back to Alice Springs with a bronchiolitic who was stable enough to tolerate an extra 2 hours while we diverted in another direction to assess someone else. The second patient was a young Aboriginal football player who had dislocated his shoulder. Normally I could have reduced this on the ground and let him stay in his community. Today it was getting late, and the aircraft had to take off before dark, since the airstrip was unlit. So we brought the boy aboard, started the IV, mixed the drugs as we taxied, and reduced his shoulder after take off.

Each aircraft was beautifully equipped. There were cellular phones

Boutilier's Point, NS

so I could call a consultant if need be, but only on the newer planes. On the older Chieftain, there was an intercom so the nurse could speak to the pilot, and a radio so the pilot could speak to the doctor on call in Alice Springs. I was puzzled one day when the nurse told me, via the pilot, that the patient had had a run of "Victor Tango." It took a while for me to realize the nurse was telling me about ventricular tachycardia. The Australian sense of humour being what it is, the patient could just as easily have been trying to dance.

Most of our patients were Aborigines. The average life expectancy for an Aboriginal male is 50. Their health problems are many, relating largely to malnutrition, low socio-economic status, cultural displacement and squalor. Alcoholism is common, as is type II diabetes, and more than half of the population has severe, progressive renal failure. For a variety of reasons, Aborigines are vulnerable to strep and other pathogens. Acute rheumatic fever is common, as are other streptococcal infections. Septicaemia strikes suddenly and, by our standards, unexpectedly — often causing brain and spinal abscesses. Pneumonia is rampant in all age groups. It is often fulminant, resulting in ARDS (adult respiratory distress syndrome). Unfortunately, violence is common, both because of alcohol abuse and because a degree of physical retribution for crime is culturally accepted.

Aborigines don't complain. I was surprised one evening in Emergency to pick up a chart on which "headache" was the presenting complaint. I approached the patient, sidling up crab-like, with no eye contact. I touched his arm and asked what tribe he was from, trying to gain his trust. He told me he'd never been in hospital, never been sick. OK. When I asked him to remove his cap, I found his shaved scalp a roadmap of recent scars.

The notes on his chart said he'd been run over by the train less than a month ago; a CT report said he had broken every bone in his head. It's amazing he survived; more so that he discharged himself from the ICU a week after the accident. Perhaps a ceremony, hundreds of miles away at home required his presence. Or perhaps there was an important card game.

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More dramatically, another Aboriginal man checked in saying he felt "unwell." He had a knife in his right eye. Escorting him quickly (and carefully) into the resuscitation room, he told me it had been there for a week. I thought it was a mistake — that the language barrier was playing a role — but his family later confirmed that he had been stabbed 7 days before. While arranging for a surgeon, I asked why he'd left it so long. "It didn't hurt," he said with a shrug.

There were rewarding moments: a smile from a grandmother as she thanked me for tending to her little ones. Eye contact was rare, and flattering to me.

We attended clinics when not on call, flying each morning to an Aboriginal homeland. Those days were great fun. They often included invitations to ceremonies and dances, and opportunities to watch the local people, many who were famous artists or painters. Most communities had a clinic with one or more resident nurses who worked with Aboriginal health workers. The latter helped communicate, despite substantial cultural and linguistic differences (the locals spoke 12 languages).

Not all of our patients were human. I remember speaking to Elizabeth, a colleague, on the phone. I was on call in

Alice Springs and she was in Nyrippi, an Aboriginal community 100 km away. Suddenly she cried: "Oh my God, there's a pig in the clinic!" I heard squealing and grunting and skittling sounds like cats on linoleum, losing purchase on a tight turn. Colin, wonderful Colin, the nurse at Nyrippi, had sutured the village pig's cuts and was trying to remove the stitches.

On the surface, Aboriginal life appears Western, but in reality, old traditions and beliefs are intact. Aboriginal elders appoint a "*kadatje* man" to "payback," or right, a particular offence that was perpetrated in a community. Nobody but the elders know who the appointee is; someone different is assigned to deal with each deed. The *kadatje* man works at night, concealing his identity by camouflaging his footprints, since Aborigines are expert trackers. To this end, he drags emu feathers, dipped in blood, behind him as he walks through camp, looking for the individual he must pay back.

These men actually exist. Kay, the nurse who runs the RFDS in Alice Springs, tells of working in a small surgical hospital in Queensland. Under her care were patients with IVs and chest drains, and one patient in a body cast after surgery for spinal tuberculosis. Because of the heat and humidity, the patients were being nursed outdoors on verandahs. Kay was horrified to find, one morning as she began her rounds, that all the patients were gone — nowhere in sight, and not to be seen again. The *kadatje* man's "footprints" had been spotted, and the patients knew better than to stick around.

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