Drama in the Skies

By Dr Pinakin V Parekh

Whenever I board a flight, I always wish for four simple things: the takeoff and landing to be smooth, the inflight entertainment to be interesting, the meals to be tasty, and the air stewardesses to look hot. The outcomes have been largely unpredictable. Sometimes, there was nothing to quibble about. Other times, much was left to be desired. Things have changed dramatically after my last flight in February this year. There is only one wish now, a wish I strongly encourage every travelling doctor to make.

February had arrived quickly. My whole family, all seven of us, including my 18-month-old daughter, were headed to Ahmedabad, India. My younger brother was getting married and excitement was in the air. A direct flight on our national carrier ensured no unnecessary time delays.

In no time, we were airborne. Looking through the selection of movies, the choice was extremely obvious: *Johnny English Reborn*, starring Rowan Atkinson! The first scene in which he was learning kungfu in a monastery was already cracking me up, much to the annoyance of my wife, who was trying to make our baby sleep.

Then something struck me as odd. Despite being tickled by Johnny's slapstick antics, I noticed a particular steward kept walking past me to tend to a passenger seated a few rows behind. Suddenly my movie paused. A wonderful voice came on over the intercom, but brought with it not so wonderful news. It asked for the presence of a doctor on board. The passengers in economy class started whispering and throwing cautious glances over their shoulders. After having heard experiences about medical situations in planes from friends, I realised my time had come.

I stood up and drew the attention of the same steward I had noticed earlier. He told me there was a passenger who was not feeling well and asked if I could take a look at her. I agreed without hesitation and he led me to the same passenger he had been serving earlier. She was a middle-aged Indian lady who was resting her head on the table in front. She was nauseated and had an air sickness bag clutched in her hands. Her worried daughter was with her three-month-old infant in the adjacent seat. I introduced myself clearly and took a quick focused history. I learnt they had just holidayed in Australia and were travelling back home to India. They had been visiting the sick passenger's son-in-law who had been temporarily posted there. Shortly after takeoff, the lady vomited once and remained nauseated thereafter. She also complained of some headache and upper abdomen discomfort. She didn't feel febrile and I made sure her tummy was not guarded. Her daughter told me she had hypertension and was on medications. She wanted me to check her blood pressure to be on the safe side.

I asked the steward if I could see the plane's first aid kit and whether there was a blood pressure set on board. As I walked towards the cabin crew area for the medical supplies, I thought that this could possibly be a viral illness or something equally benign. My aim was to make sure the blood pressure was not exceedingly high, to take her temperature and offer her an intramuscular antiemetic which would tide her through the remaining four-hour journey. The appreciative steward opened two big medical first aid kits. "First aid" was a gross misrepresentation of what those boxes contained. I was impressed by the variety of oral medications, awed by the various vials of resuscitation drugs and intrigued by the

seven French intubation set. Everything was neatly packed, labelled and compartmentalised. There was an electronic wrist blood pressure cuff and I found my vial of metoclopramide. Before returning back to the main cabin, I took my own blood pressure to make sure I knew how to operate the device. I didn't want to goof up in front of the watchful eyes of all the passengers. A small sense of performance anxiety had set in.

Suddenly, a loud disturbing commotion erupted in the main cabin. The next second, my dad had run up to me, telling me to come back immediately because something abnormal was happening. Fearing the worst, I dashed back, towards a situation I hadn't been expecting. The passenger was throwing a generalised tonic-clonic fit in her seat. Her daughter was crying helplessly beside her, while passengers around them had stood up to try to help. The uprolling of her eyes, the foaming from her mouth and the evolving cyanosis was scaring everyone. One thing was crystal clear. This passenger had now become my patient.

I turned her head to the side and the fit self aborted after a minute. She slumped in her chair and became apnoeic. There was no pulse! My mind was shouting code blue over and over again. My knee jerk reflex was to start chest compressions, regardless of how suboptimal the position was. Within seconds, two quick thinking men transferred her onto the narrow aisle and we noticed she had started breathing again. I went for the pulse again. The pulse had returned and together with it, so did my confidence. I needed more space and I needed to reach the resuscitation kit I had perused moments ago. With her in arms, we sprinted down the aisle towards the crew's seating area.

On any given day, this would have been smoothly managed in the wards. Nurses would be checking the parameters and giving oxygen, doctors would perform investigations and administer medications and the patient would be closely watched. This was different, way different. The gathered crew listened to every word I said, obliged every order I gave, but they were not medically trained. Asking for an alcohol swab drew a blank response, let alone wanting a stat hypocount or oxygen saturation reading.

The subsequent two hours were unforgettable. It was a dramatic exercise involving the various skills of Clinical Medicine. The MBBS had prepared me for it and the MRCP had polished me for it. I wish things were as simple that day. Out of nowhere, my physical examination, practical dexterity, differentials, clinical judgement and communication skills were all collectively put to the test.

My patient was on the floor, only opening eyes and localising to pain. Grossly, all limbs did move and the pupils looked symmetrical. We struggled for a while to remove her tight jacket so that I could get a cannula in. That took time and I eventually ended up cutting her sleeves. There was no cannula stopper and hence I ran a slow normal saline drip to secure the end and keep the access patent. This had to be the first drip set I primed in the last few years. Her sugar level was fine and there was an oxygen tank to provide supplementation, never mind that it was full 100% therapy. The immediate concern was her blood pressure. With the cuff reading constantly above 200 systolic, an intracranial bleed was my biggest worry. However, with her being drowsy and in the absence of intravenous antihypertensives, there was nothing I could do to control it. She slowly became more responsive over the next half hour and as time progressed, her blood pressure improved. She turned confused and restless. My cubital fossa cannula was threatened and I was really desperate to keep it in place. Anything could happen at any time and having a line was of paramount importance. We tried to physically restrain her.

It took me some time to understand the gravity of the complex situation I was in. I vaguely remembered that from the medico-legal stand point, a physician's liability in undertaking Good Samaritan acts on planes was not clear. I knew I could be implicated if something went awry. Yet, I made that lady my responsibility. I was examining her and performing procedures without asking anyone. Her shocked daughter came into the curtained-off area frequently, only to witness things that fuelled more panic. I told her what I was doing and why I was doing it. I told her what I thought was happening. I think I even used the term "dangerously ill".

Inevitably, the cannula dropped out. It was painful. The pain tripled as she threw another two-minute long fit barely seconds after. I could not believe how coincidental that was. It was back to square one. She became postictal again, making my repeat cannula setting easy. This second fit cast away the dilemma I had. The plane had to land. She had to get to a hospital. Period. The crew got the pilot to talk to me. Ahmedabad was 2.5 hours away. I explained that she needed investigations quickly and our destination was too far. Her condition was unstable and continuing the journey would be risky. The pilot was wise. He listened without interruption and agreed with what I wanted. The plane was to make a medical diversion to Chennai, the nearest city, which was approximately 45 minutes away. Everyone – her daughter, the other passengers and even her husband (who was in India) – was informed of the unplanned landing via the inflight phone. The staff went about carrying out the necessary arrangements while I sat next to my patient, holding a syringe filled with diazepam.

Things remained relatively calm till landing. A local medical team headed by a senior registrar from Chennai's Apollo Hospital came onboard via the emergency hatch and took over her care. They transferred her across to the height adjustable platform on the runway and I told her daughter that this was the best I could do given the limitations. As the platform was being lowered, I saw her having another fit. The plane remained on the tarmac for the next hour or so. After helping the crew with their documentation, I drew the curtain open and walked towards my seat. The patient's daughter had thanked me before leaving and I knew I had made a difference. But when one passenger stood up and applauded, only to be followed by everyone else, the feeling was simply overwhelming. My

parents brimmed with pride and my wife started tearing. I felt like a Bollywood movie hero.

Luck had been on my side that day. I had a heads up regarding an ill patient before she really deteriorated. I also had a chance to orientate myself to the medical kit well in advance. The decision to land the plane had not met with any resistance as well. And the family had been understanding and did not doubt my management. Most importantly, things would have been crazy if she remained asystolic.

Through internal contacts, her husband got hold of my number and contacted me a few days later. She had been discharged and was already in her hometown. The investigations were normal and he had been told it was likely secondary to uncontrolled hypertension. I was lucky that the patient had a good outcome.

It was nice receiving a thank you letter from the airline. A complimentary upgrade to first class on the return flight was absolutely fantastic. I flew home sipping champagne and laughed through the remainder of the *Johnny English* movie. Food in first class definitely tasted better, the stewardesses were amazing and somehow even the takeoff and landing felt smoother! But my only wish now is for no more drama in the skies. SMA

Pinakin is a medical registrar in Changi General Hospital. He is desperately waiting for Cardiology Advanced Specialty Training to open again (fingers crossed!) and if that doesn't quite cut out... well, there's always Bollywood!