

A Salutory Tale from a Medical Escort

Iain B. McIntosh

Editor in chief BGTHA journal

The message received from the hospital via the insurance company was short on facts and the time for the escort to reach the departure airport was short. *"Closed serious crano-encephalic traumatism + subarachnoidal haemorrhage + right clavicle fracture + left ribs fractures, date of DX 1515. Currently splint in right shoulder = aphasia of understanding + general flaccidity. OK RPT in adl-seated business + Dr. Escort + whce until sit + amb + 2 ends to hospital with neurosurgery service."*

Further information was requested by the medical escort but little more information was forthcoming from the hospital, other than that the patient was fit for discharge, wheelchair ambulation and flight transfer to the UK organised. The escort insisted that the patient's history and clinical status be clarified and verified and questioned whether the patient met the criteria for air passage to the UK. Despite this request all arrangements were made by the company for the transfer to take place. However, understandably, the airline refused to carry the patient, until he was fit to travel. The patient later deteriorated and died abroad and the doctor was stranded in an insalubrious location until return flights were organised.

The majority of air repatriation movements use nurses as escorts and only transfers with high clinical risk engage doctor support. Clinical responsibilities are not however the predominate risk factor in travelling with a patient. Once the doctor's name goes forward there is no turning back, as transfers, tickets and special air-line provisions for invalid transport are promptly put in place. Doctor and patients become pawns in a process involving insurance company, airline officials, land transportation agents, foreign hospitals, overseas and UK doctors, the patient's spouse and hospital/hotel staff. Arrangements will be made in several languages and the difficulties of air transit have been compounded by increased security. In this environment there can be mistranslations, misunderstanding and mistakes and in my experience if they may occur, they will.

Reassured by the insurance company that the repatriation programme is seamless, escorts arrive at the airport to find that the tickets are not there, or the escorts is and the patient is not or vice versa. Often tickets are there but cannot be released until the insurance company pays for them, which usually requires ever more frenzied telephone calls. The transaction finally goes through as final gate access is being announced, with security clearance still to come.

Security authorities love medical kits which brighten the official's day. They enthusiastically hunt

for forbidden sharps and blades with irrational zest and have confiscated blunt ended plaster cutters. yet routinely allow the passage of scalpel handles and separately boxed blades. One formidable German security guard insisted on retaining a 2 inch pen knife - a long forgotten item in the kit - but, when finding a full bladed scalpel returned it, as the name did not appear on her list for confiscation. Surprisingly the complex electronic oximeters, defibrillators and paraphernalia also in the kit receive scant inspection.

After a frenzied rush to departure the inevitable flight delays can leave one with an ill patient in a tiny foreign airport bereft of any patient care space a short flight can become a lengthy process testing the doctor's organisational as well as professional skills. If the patient deteriorates, dealing with an on-board emergency in a restricted space at high altitude with limited resources is a challenge to avoid. Intending medical escorts beware. The job may offer sun-bathing by the Med while a patient recuperates to fitness for air travel, but is just as likely to mean a shuttle back on the outward flight, with scarcely a glimpse of an enticing destination.