

Whose opinion should prevail?

In the first part of our three-part series on whose advice is best followed when treating patients abroad, Dr Frank Gillingham, Medical Director, HTH Worldwide, puts forth the hospital doctor's point of view

One of the many valuable lessons I learned during residency training some 28 years ago was that one should always assume that a referring practitioner knows at least as much, or perhaps more, than you do. I can remember listening to numerous derogatory comments about older physicians, whom many of my young colleagues regarded as being out of touch, after referring patients to our teaching hospital. We believed that since our attending doctors were the experts, those who looked to us for help simply lacked our clinical competency. As the years have gone by, I have come to realise that many of those physicians were referring patients to us because they did not have the equipment, or the specialty training, to take care of complex cases. And as we would soon discover, many of those same referring physicians had a much better understanding of their patient's pathology than we could ever hope for. So as I began my career as the medical director of a company who



Part one: the hospital doctor

insures expatriates, students and leisure travellers across the globe, I had to remind myself of the

same lesson – those who are treating my clients know and understand at least as much, and probably more, than I do about them.

Cases in hand

A few months ago, a young woman on a study abroad assignment from the US fell and broke her hip in Capri, Italy. She was transported to a small local hospital in Sicily. Unfortunately, it was late Friday afternoon, so by the time her family and our staff heard of the accident, the attending orthopedist had left for the weekend. It was very difficult to get any information, but we were assured that the young student was not in need of emergency surgery. Meanwhile, a US orthopedist and friend of the patient's family convinced the parents that the patient needed immediate medical evacuation back to the US, and that if she did not have surgery within 48 hours, she could lose her hip. Of course, the US orthopedist assumed that the young lady had a displaced fracture of the neck of her femur, and he was correct in asserting that if that were the case, she would need immediate repair to save the circulation to her hipbone. However, he was wrong in assuming that the treating physician in Italy would not be aware of this danger and worse

yet, that he had abandoned his patient for the weekend. As it turns out, the fracture was not displaced, and there was little threat that postponing

surgery would put her hip at risk. When we were finally able to contact the Italian orthopedist, he was insulted that we assumed our patient was being 'mistreated in a third world country'.

Another case involved a missionary who was shot in the chest trying to defend his parishioners from thieves. During his sermon, two young men entered his church and held his worshippers at gunpoint while cleaning out their pockets and purses. The brave, if not ill advised, priest decided that he had enough, and attacked one of the two thugs. The second planted a single shot into his left chest, and the two fled with only half the loot. Our client was rushed to the local clinic. Although his vital signs were stable, it was determined that the bullet had ricochet off a rib, penetrating the diaphragm and



lodged itself in the capsule of the spleen. In the US, insertion of a chest tube followed by immediate surgical exploration of the abdomen would have been the standard of care. In Africa, where our missionary was stationed, prudent observation is often the norm in trauma care. In this case, a chest tube was inserted to drain the small amount of blood in his chest cavity, antibiotics and intravenous fluids were administered, and the patient was monitored for sudden blood loss, fever and severe abdominal pain. Those of us who were involved in this case wanted the patient airlifted to a centre with more sophisticated trauma

capabilities, but the attending surgeon insisted that the patient could be safely observed in his facility. The patient recovered without incident, and was

discharged in good condition having never needed exploratory surgery for his abdominal injury.

To fight or to fly

Patients themselves must be considered in the decision paradigm about moving from one treatment facility to another. Although it is often a knee jerk reflex to want to go home, or to a more sophisticated 'Centre of Excellence', to obtain definitive care, patients must be educated that evacuations are fraught with dangers of their own. Not only can a patient's condition deteriorate during transport, but also the transportation vehicle itself may present high risk. In the 25 years that I have been involved in the emergency medical system in Los Angeles, US, there have been at least a dozen paramedic helicopter crashes resulting in serious injury or death to patients. Several were being transported for relatively minor injuries or illnesses. One particularly tragic incident involved a Los Angeles County paramedic searching for a lost stretcher who leaned on a helicopter portoon without being properly tethered. He plunged almost 100 feet to his death. It is not to say that those of us who participate in decisions about evacuating patients should not be cautious and circumspect, but being the patient's advocate does not always mean insisting on an evacuation when local care is adequate. Although we would all like to see guidelines for the medical evacuation of patients, they are not practical. Guidelines fall into the same category as treatment algorithms – they may be useful for some, but cannot be used in all situations. Anyone who has practiced medicine knows that algorithms have limited value. In California, US, where I practice emergency



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medicine, the responsibility for the patient stays with the treating physician until the patient is received at the next hospital. We are reluctant to allow patients to leave our facilities until we are comfortable that the benefits of transfer outweigh the risks. Our laws require that we document the advantages of transfer in the medical record. So the medico-legal burden for moving a patient is with the transferring, and not the receiving physician. Even in places where the laws are not so stringent, most physicians would not allow a patient to be transferred simply because another, non-treating physician wanted them to do so. Finally, we occasionally come across a patient seen by a local physician who is neither happy with the local care, nor willing to be evacuated home. This is the patient who

never seems satisfied, no matter what options are available. They present unique challenges to everyone involved: the treating physician, the medical director of the assistance/insurance company, and the private physician back home. Our company was involved in a case with a middle aged man in Moldavia, in Eastern Europe, who had a variety of symptoms, including visual blurring, double vision, unilateral

headache, intermittent fevers and a non productive cough with shortness of breath. Among others, he was evaluated by a local neurologist, who felt that there were significant enough neurological findings to warrant a more in-depth evaluation. Nonetheless, the patient decided to forego any additional work-up in favour of waiting it out. At the same time, he wanted to be reassured by us that his condition was not serious, and that a delay in his evaluation would not be detrimental. He was not in favor of returning to the local providers, as he was unhappy with the physical facility and lacked confidence in the physicians who had examined him. His game plan was to wait a week or two to see if his condition improved, and to return home to the US if it did



not. In this case, the patient was unwilling to agree to the two most viable options: returning to the local hospital to complete his work-up, or be evacuated to the US immediately to have his condition evaluated by his own physicians. Since there was no way that our medical team could provide the reassurance that a delay in his evaluation would not be detrimental, we continued to insist that he obtain care as soon as possible. Ultimately, the patient agreed to return home to the US when he developed a rash after a few days of waiting it out.

Primary carer knows best

So who is the best one to make a decision about medical evacuation? Although guidelines might be

useful for those of us requesting evacuations, there is little doubt the opinion of those with primary responsibility for the patient should prevail. Most practitioners are aware of their own limitations and those of their facilities. It is the rare physician, from any part of the world, who does not ask for help when there is an obvious need to do so. It is important not to be quick to judge the inadequacies of others, and making decisions for financial considerations can backfire. Equally it is necessary to listen carefully to the patients and their families. But to me it seems it is the opinion of the providers who are caring for your patients that should be the final word in most cases.

Next issue: The assistance doctor's opinion

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